Republika ng Pilipinas
Kagawaran ng Edukasyon
Tanggapan ng Pangalawang Kalihim

AIDE MEMOIRE
19 February 2021

THE ROLE OF DEPED IN THE IMPLEMENTATION OF THE PHILIPPINE NATIONAL DEPLOYMENT AND VACCINATION PLAN FOR COVID-19 VACCINES

The Department of Education Task Force COVID-19 (DTFC) provides the following updates to the Secretary on matters relating to the **Philippine National Deployment and Vaccination Plan for COVID-19 Vaccines (NDVP)**, what transpired as part of and as a result of its ratification, and key issues and decision points.

I. Philippine National Deployment and Vaccination Plan for COVID-19 Vaccines

The Philippine National Deployment and Vaccination Plan for COVID-19 Vaccines was approved and ratified by the Inter-Agency Task Force for the Management of Emerging Infectious Diseases (IATF) through **Resolution No. 95** dated **21 January 2021**.

Following this, the National Task Force (NTF) Against COVID-19 in **Memorandum Circular No. 5, s. 2021** dated **26 January 2021** directed **all implementing agencies**, Regional and Local COVID-19 Task Forces, and all Regional and Local COVID-19 Vaccination Operations Centers, Local Task Forces, and Local COVID-19 Vaccination Operations Centers **to implement and adopt the same**.

The acknowledgement section of the NDVP notes that **agencies under the COVID-19 Vaccine Cluster**, which includes the Department of Education (DepEd), have contributed to the development of the plan.

A. Salient Features

1. Based on the NDVP, the following roles shall be played by different levels of governance:

    a. **Local government units (LGUs)** are the lead in the implementation of the program

b. **National government agencies and regional counterparts** shall provide strategic directions and technical and logistical assistance, cascade policies and guidelines, and capacitate implementers.

2. The approved Philippine NDVP for COVID-19 Vaccines details the national structures, coordination mechanisms, and plan for vaccination, covering seven phases:

   Phase 1: Scientific Evaluation and Selection
   Phase 2: Access and Acquisition
   Phase 3: Procurement and Financing
   Phase 4: Shipment and Storage
   Phase 5: Distribution and Deployment
   Phase 6: Implementation of Nationwide Vaccination
   Phase 7: Assessment, Monitoring, and Evaluation

3. The Department of Health (DOH) will provide a Department Memorandum detailing the operational guidelines on vaccine distribution (e.g., vaccine storage and cold chain requirements, delivery and deployment mechanisms for each specific vaccine.)

4. All vaccination activities, whether the COVID-19 vaccines to be administered have been procured by the National Government, the private sector, or the LGU, shall be closely coordinated with DOH and shall follow DOH policies and guidelines. **No vaccination activity shall be conducted without the guidance and the knowledge of DOH.**

B. NDVP Features Which Have Implications on DepEd

Features of the NDVP which have implications on the Department as one of the implementing agencies of the plan, include the following:
(1) Governance: the COVID-19 Vaccine Cluster;
(2) Vaccine Distribution and Deployment; and
(3) Implementation of a Nationwide Vaccination.

1. Governance: The COVID-19 Vaccine Cluster

CLUSTER	TASK GROUPS
COVID-19 Vaccine Cluster	**TG Vaccine Evaluation and Selection** Lead: DOST Members: DOH, FDA, RITM, Vaccine Experts
	TG Cold Chain and Logistics Management Lead: DOH, TGRML Members: DBM, DILG (PNP), DND (AFP, OCD)
	TG Diplomatic Engagement and Negotiations Lead: DFA Members: DOF, DOH, NTF, DOST
	TG Immunization Program Lead: DOH Members: DOJ, FDA, DILG, DSWD, DepEd, AFP, DOTr, DICT
	TG Procurement and Finance Lead: DOF Members: DOH, DBM
	TG Demand Generation & Communications Lead: PCOO Members: DOH, NTC, PIA

SUB TASK GROUPS
STG Planning, Policy & Technical Support Lead: DOH Member: DOJ, OCPLC, DepEd, DILG STG Sec
STG Registry, Data Management & M&E Lead: DOH Member: DICT, DSWD, DepEd STG Sec
STG Program Implementation Lead: DOH Members: DILG (BFP, PNP, BJMP), DSWD, DepEd, DND (AFP), DOJ (BuCor), DOTr (PCG) STG Sec
STG Safety Surveillance & Response Lead: FDA Member: DOH (EB, DPCB, FICT) STG Sec

The COVID-19 Vaccine Cluster is composed of six Task Groups (TG), including the **TG Immunization Program** of which **DepEd is part of**. Led by the DOH, the TG Immunization Program is tasked to:

i. Plan and craft policies, guidelines and standard operating procedures related to the COVID-19 vaccine deployment and program implementation;

ii. Estimate potential numbers of target populations that will be prioritized for access to vaccines stratified by target group and geographic location;

iii. Identify potential COVID-19 vaccine delivery strategies;

iv. Create a data information system for all vaccine recipients;

v. Provide capacity building and trainings to implementers;

vi. Develop or adopt existing policies and implement AEFI/Post-marketing surveillance and monitoring framework; and

vii. Ensure or craft guidelines, procedures and tools for planning and conducting vaccine pharmacovigilance activities.

Under the TG Immunization Program are four **Sub-Task Groups** (STGs), **three of which DepEd is part of** namely:

(1) STG Planning, Policy & Technical Support
(2) STG Program Implementation
(3) STG Registry, Data Management & M&E

The national organization structure of the COVID-19 Vaccine Cluster is complemented with the activation of a **COVID-19 Vaccine Operations Center (VOC)** at the **national, regional, and local levels**. VOCs support the Incident Command Systems of the COVID-19 Vaccine Cluster.

National COVID-19 VOC	headed by the COVID-19 Vaccine Cluster Chair
Regional VOC	led by the Centers for Health Development with the participation of other government agencies and the Regional Task Forces Against COVID-19
Local VOCs	led by LGUs

The national government enjoins all regional offices and LGUs to establish their own VOCs as soon as possible. The implementing units such as government hospitals are tasked to forward all concerns and reports to the City/Municipal Health Offices, which in turn report these to the VOC.

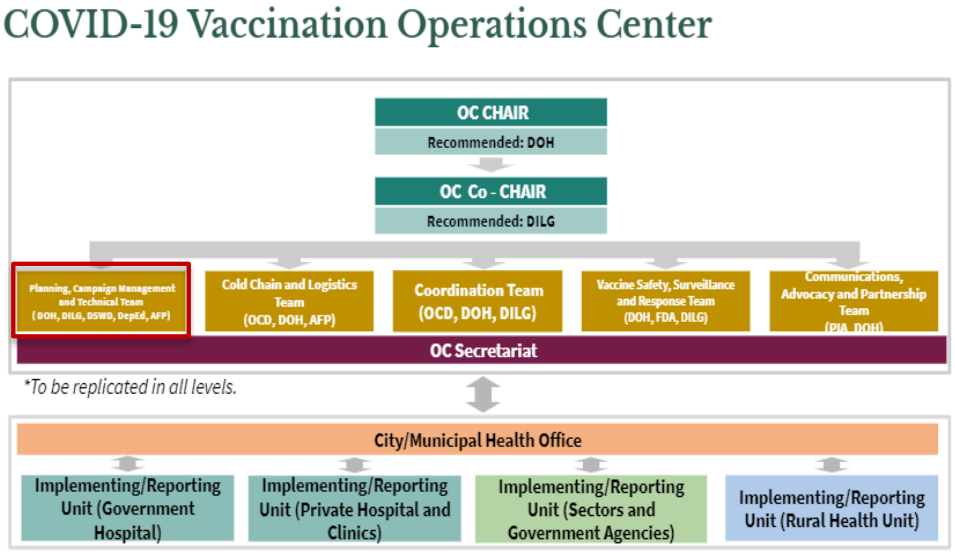
Three months prior to the vaccination activity, the VOCs are required to conduct regular meetings and to submit readiness assessments on a regular basis to the overseeing VOC.

During the campaign period (as determined by DOH), all VOCs are required to operate for 24 hours in a week and to submit daily bulletin detailing coverage, refusals and deferrals, and Adverse Event Following Immunization, and Adverse Event of Special Interest monitored.

After the campaign period, all VOCs are required to conduct a program implementation review and submit the final coverage report.

The VOCs are further comprised of teams. **DepEd is involved in the Planning, Campaign Management, and Technical Team** which focuses on:

- policy development
- information campaigns
- capacity building
- setting-up of VOCs



2. Vaccine Distribution and Deployment

The identification of eligible populations is guided by the WHO Strategic Advisory Group of Experts on Immunization Values Framework for the Allocation and Prioritization of COVID-19 Vaccination, and the recommendations of the National Immunization Technical Advisory Group (NITAG.)

The Plan has identified Priority Eligible Groups 1 to 12. Below are items pertinent to the Department:

- **School Health and Nutrition Personnel**, along with other medical frontliners from other government agencies, will be part of the **Priority Group No. 1** for vaccination.

  Per discussion during the TOT, school health personnel are being prioritized because it is anticipated that for the vaccination of **teachers,** categorized under **Priority Group No. 6**, DepEd's school health personnel augmented by other local health professionals, if needed, will do the inoculation.

- **Non-teaching personnel** are under **Priority Group No. 7** (all government workers), while eligible **students** (i.e., students in primary, secondary, and tertiary levels and in vocational institutions) are listed under **Priority Group No. 9**.

  The Plan notes that the vaccination of **students below 18 years** will depend on the recommendations of WHO and NITAG, with the concurrence of the COVID-19 Vaccine Cluster.

3. Implementation of a Nationwide Vaccination Plan

The vaccination program shall be implemented in phases, taking into consideration the availability of vaccines, logistics, and cases in geographical areas.

The implementation is divided into three phases:

Phase 1: Pre-implementation Phase - where preparations for the actual vaccination activity are carried out;

Phase 2: Implementation Phase - the actual vaccine administration schedule; and

Phase 3: Post-implementation Phase - where all activities and reports to conclude a certain round are completed.

It is reiterated that the implementation of the program shall be led by the LGU, guided by the policies of the Vaccine Cluster and the DOH, while NGAs and its regional counterparts shall provide strategic direction, technical, and logistical assistance.

The workforce for the vaccination campaign shall engage a diverse set of professionals. These include **teachers, counsellors,** pharmacists, **medical and allied health professionals** and interns.

The recommended composition of vaccination teams includes **DepEd personnel** who may play the **role of a health educator**[1] **or documenter/recorder and vital signs-taker** [2] who support medical practitioners.

Mentions of **teachers** however qualify them as **"volunteers from partner agencies**", along with social workers and medical students.

Those involved in the vaccination program shall be targeted by a **national training plan**. Medical staff from national government implementing agencies such as DepEd are listed as the participants in the following trainings:

Date	Training
29-30 December 2020	Core of Trainer's Training
12-13 January 2021	NCR and Luzon cluster trainings
14-15 January 2021	Visayas and Mindanao cluster trainings
20-21 January 2021	BARRM cluster training

In terms of facilities, **DepEd clinics – which are considered health facilities of government agencies – are listed as among the implementing units or establishments authorized to conduct the vaccination activity.** DepEd shall work with LGUs to ensure that all implementing units adhere to proper protocols.

It shall also be noted that upon the initial field implementation of the plan and based on reports received by the BLSS-SHD, some areareas in the school other than the clinic (e.g., covered courts,

[1] Tasked to man the health education area; ensure that equipment and IEC materials are available in the vaccination post/area; provide information to vaccines, particularly on the benefits of vaccination, the possible adverse reactions, and how to seek help if there is adverse reaction either by answering their queries or providing them with IEC materials; facilitate the signing of informed consent; coordinate with social mobilizers and navigators for those who are deferred and those who refuse on-site.

[2] Tasked to man the registration area; ensure that documents and identification presented by the vaccine are valid; ensure that all information and data are encoded in the data management system; assist other team members, especially on vital signs taking; submit daily coverage, refusals, and deferrals to the C/MHO.

multipurpose halls/rooms, large offices in the school) have also been identified as venues for vaccination activities.

II. DepEd Engagement and Activities for the NDVP

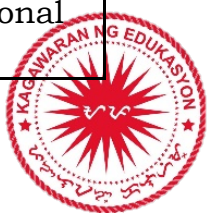
The organizational structure of the COVID-19 Vaccine Cluster was approved during the 82nd Meeting of the IATF held on 29 October 2020, where DepEd was represented by its Undersecretary for Legal Affairs.

Following the agreements in the said meeting, **the Undersecretary for Legal Affairs recommended to the Secretary the designation of focal persons from the DTFC and/or the Bureau of Learner Support Services-School Health Division (BLSS-SHD) as representatives to the Task Group.** Designation letter dated 05 November 2020 was thereafter sent to the Secretary of Health. A similar letter dated 04 January 2021 was likewise sent to the Chief Implementer of the NTF. The DTFC on 02 February 2021 however further proposed to the Secretary the updating of DepEd's roster of representatives. In particular, the BHROD and ICTS were added for registry, data management, and M&E matters. The proposal of the DTFC has been approved by the Secretary and new correspondence to the NTF and the DOH has been signed.

Immediately after the 05 November 2020 designation, **DepEd's designated representatives to the Vaccine Cluster, through the BLSS-SHD and their field counterparts, have attended Cluster-initiated activities through the DOH.**

The most essential activities with the involvement of DepEd health and nutrition personnel include the national (Core of Trainer's Training) and regional trainings described above. School health and nutrition personnel have participated in the trainings, specifically five from the Central Office and at least three from each Region.

Date	Activity
29-30 Dec 2020	COVID-19 Vaccine Core of Training of Trainers (TOT)
11 Jan 2021	Dry Run of the TOT on COVID-19 Vaccination
12-13 Jan 2021	Regional TOT on COVID-19 Vaccination- Luzon Cluster (Participated in by regional school health personnel representatives)
14-15 Jan 2021	Regional TOT on COVID-19 Vaccination- Visayas and Mindanao Cluster (Participated in by regional school health personnel representatives)



21 Jan 2021	Coordination Meeting for Training and Implementation Arrangement of the COVID19 Immunization Program Implementation
01 Feb 2021	DOH-DepEd Coordination Meeting for COVID-19 Immunization Program Implementation (Convened by the BLSS; attended by the Disaster Risk Reduction Management Service [DRRMS] and the Bureau of Human Resource and Organizational Development [BHROD])

It was emphasized during the discussions that **formal communications must be made by the DOH and that official agreements must be reached before any role of DepEd is finalized**, any information is cascaded to the field through official issuances, or DepEd personnel further involved in future trainings. **Thus far, no such formal communication has been received**.

Moreover, DepEd attendance to the following has also been registered by the Central Office:

Date	Activity
23 Nov 2020	3rd Task Group COVID-19 Immunization Program Meeting
02 Dec 2020	Meeting on the Proposed Program Implementation Plan for COVID Vaccine
16 Dec 2020	Vaccine Logistics Summit
22 Dec 2020	Consultation on the Proposed Program Implementation Plan for COVID Vaccine
08 Jan 2021	Coordination Meeting for COVID-19 Immunization Program Implementation
27 Jan 2021	TG Immunization Program - COVID-19 Sub Task Group Planning and Policy Meeting

A bulk of the activities have been completed after the IATF's approval of the Vaccine Cluster on 29 October 2020, and before the 21 January 2021 ratification of the NDVP. DepEd participants note **the approved Vaccine Cluster structure and that framework of the NDVP guided the conduct and contents of the completed trainings and meetings.**

DepEd school health and nutrition personnel likewise continue to be engaged and invited by their Regional DOH offices and local government units to participate in their activities.

School health and nutrition personnel have expressed to the BLSS-SHD that **they need guidance from the Central Office, through an official issuance and an orientation internal to DepEd,** before they can proceed and fully participate in the initiatives led by their respective DOH offices and LGUs.

III. Participation in the AKAP Guro CONNECTed's COVID-19 Vaccines Education Campaign

On 12 February 2021, the BLSS-SHD, through Dr. Maria Corazon Dumlao, received communications from the Office of the Secretary (OSec) about a request from the DOH for DepEd to support **AKAP Guro CONNECTed**, an education campaign of UNILAB that seeks to contribute to the DOH's efforts on COVID-19 vaccine demand generation.

The campaign, which will be **launched on 20 February 2021**, intends to organize a series of orientations with teachers and principals all over the country in order to equip them with the correct and timely information about the COVID-19 vaccines straight from the country's medical and scientific experts. The schedule of the webinar series is as follows:

Schedule	Target Participants
27 February 2021	NCR and Northern Luzon
06 March 2021	Southern Luzon
12 March 2021, 9:00-11:00 a.m.	Visayas
12 March 2021 2:00-4:00 p.m.	Mindanao

Dr. Dumlao specifically received instruction from the Secretary, to attend the preparatory meeting on 15 February 2021 and to address items 1 and 2 in the request of the DOH, namely:

(1) the issuance of a memorandum to Schools Division Offices to invite schools to attend the launch of the campaign on 20 February 2021, and
(2) the provision of a 3-minute video of a Solidarity Message from the Secretary.

The third item, which is to provide the Secretary's signature for certificates of participation, will be handled by OSec.

The BLSS-SHD has prepared a separate Complete Staff Work providing the details for this assignment and the necessary follow-through activities as Annex C of this AM.

IV. Recommendations

The DTFC requests for the Secretary's guidance on how to proceed in light of the inclusion of DepEd in the approved plan, the NTF's directive to implement the same, and the Secretary's recent instruction to Dr. Dumlao to attend to the DOH's request for support for the AKAP Guro CONNECTed program.

A. Support to the NDVP and Promoting Informed Decision

DepEd, as a member of the IATF and as a contributing party to the NDVP based on the acknowledgement section of the document, shall support its implementation, while also **remaining circumspect and exercising due diligence** in all its functions, particularly with regards to the dissemination of materials and conduct of information and education advocacy campaigns.

DepEd's membership in the Planning, Campaign Management, and Technical Teams of the VOCs at various levels is **proposed to focus on promoting informed decisions** on vaccination, within government's massive information campaign on the benefits, risks, and other matters associated with vaccines (e.g., strengthening health/immune system to minimize possible side effects).

This emphasis on promoting informed decisions shall **guide DepEd's efforts to adopt/align with the government's BIDA Solusyon Plus sa COVID-19 campaign**, through the amendment of the DepEd Required Health Standards, and the development of a comprehensive communication plan in DepEd, as earlier communicated to the Secretary and the ExeCom through DTFC Memo No. 327 dated 02 February 2021.

The updated and unified nationwide behavioral change campaign—which the NTF requested DepEd to fully adopt—aims to align national efforts and messaging on COVID-19 vaccine advocacy.

All IEC initiatives, including those proposed by partners such as the AKAP Guro CONNECTed Vaccine Education Campaign, shall be aligned with the DepEd-contextualized BIDA Plus campaign.

Operationally, the information campaign shall be implemented by the DepEd Public Affairs Service, with technical inputs and clearance from the DTFC-19. It is emphasized that DepEd messaging shall remain focused on building capacities for informed decision on vaccination.

B. Voluntary Involvement of DepEd Personnel in Vaccination Teams and Ensuring Provision of Necessary Support

1. **DepEd school health and nutrition personnel** as medical frontliners are among the top priorities among the eligible groups because they may be tapped for actual vaccinations. **It is recommended that their involvement in actual vaccination remain voluntary**, similar to the current arrangement in other DOH-led immunization programs implemented in DepEd.

   It is further recommended that a consultative discussion be conducted with school health and nutrition personnel to identify possible issues and concerns encountered in their initial participation in DOH-/LGU-led activities and as follow-through activity to their participation in the regional TOTs and local roll-out of training-orientations.

2. **Teachers**, who based on the plan, may be tapped on a voluntary basis as health educators or documenters/ recorders, and vital signs-takers. Consistent with the Secretary's pronouncement that teachers are trained to teach rather than administer vaccines, **DepEd may encourage willing teachers to volunteer only as health educators.** Among the efforts that DepEd can undertake to encourage such participation is supporting the AKAP Guro CONNECTed program endorsed by the DOH.

   The engagement of teachers as volunteers must further be compliant with DepEd's no disruption of classes policy. Teachers may volunteer as long as no classes are disrupted and clearance is given by DepEd leadership (e.g., school head or Schools Division Superintendent.)

3. Similar to health personnel and teachers, **involvement of any guidance counselor for the provision of counseling and psychosocial support shall likewise be voluntary.** It is underscored that the specialized practice of the guidance and counseling shall be limited to Registered Guidance Counselors.

4. Aligned with existing DepEd policy on the engagement of its personnel for LGU-initiated COVID-19 activities, DepEd volunteers should be granted by the NTF, through the LGUs, proper trainings, personal protective equipment, sanitation resources, and applicable remuneration or allowances. The **Schools Division Superintendent** shall ensure proper coordination with the LGU for such necessary arrangements, including the schedule of deployment.

5. The **safety** of DepEd personnel shall be the utmost consideration in their participation in the program in whatever capacity. Participating remotely or virtually whenever possible shall be the top option. **Participation of DepEd personnel in face-to-face/onsite vaccination activities, especially prior to their turn to receive the vaccine, is highly discouraged.**

   DepEd shall explore the feasibility of additional monetary and/or non-monetary support for these concerned personnel, subject to availability of funds and existing rules and regulations. Relevant provisions in existing issuances on employee welfare and allowable remunerations shall be reiterated.

C. Coordination for the Use of School Clinics and Other Identified Areas in the School Premises

On the use of school clinics and/or other identified areas in the school (e.g., covered courts, makeshift tents set up in open areas, multipurpose halls/rooms, large offices in the school) as vaccination centers or implementing units based on the Plan, **the same process that applies on the use of schools as quarantine or isolation facilities may be retained**.

With existing policy delegating the assessment, approval, and coordination on the use of schools as quarantine or isolation facilities to Regional Directors, the same may be maintained especially as the existing system highlights close coordination between DepEd, the LGU, and health authorities. Like what has been done with the use of schools for quarantine or isolation, a framework Terms and Conditions to be entered into by DepEd and LGUs for the use of schools for vaccination purposes may be provided by the Central Office for the adoption of field offices.

This high level of coordination would facilitate the selection of school-based health facilities with sufficient capacity and equipment to respond and refer to Adverse Event Following Immunization, Adverse Event of Special Interest cases, and sufficient human resources. The Plan likewise stipulates that LGUs shall ensure that all implementing units adhere to the protocols required for an implementing unit/vaccination post/site.

With the reality that a number of schools already serve as quarantine or isolation facilities, health and LGU authorities must select between using schools for quarantine/isolation or for vaccination purposes as **the simultaneous use of schools for both should not be recommended.**

Consistent with the pronouncement of the President—"If there is no *malaking mga* coliseum *o* gym, then we will utilize the schools. *Kung maaari lang huwag muna… Kulang talaga,* then my order is to utilize the public school. *Wala pa namang klase.* Public school buildings, *kung wala*," [3] —the **use of schools for vaccination activities shall be the last resort**. This is also consistent with the spirit of RA 10821 which instructs that schools can only be used as an evacuation center as a last resort to allow for learning continuity and the displacement of learners and personnel from schools in times of emergencies, and which likewise guided the use of schools for quarantine/isolation facilities.

In addition, DepEd's position on the limited use of schools for vaccination should also be informed by plans for the resumption of face-to-face and school-based engagements. **It is ideal that the finalization of the policy on face-to-face engagement precede the formalization of DepEd's commitment and action plan on the implementation of the NDVP**, so that the Department may better actively define and proceed with how it intends to pursue learning continuity for the coming school year. Schools in areas which are candidates for the resumption of feasible limited face-to-face learning should explicitly be excluded as possible vaccination sites.

The safety of the school personnel reporting onsite in schools and the uninterrupted operations of the school for learning continuity, shall be the top most consideration.

D. Database and Monitoring System on Vaccination, Engagement of DepEd Volunteers, and the use of DepEd Schools

It is recommended that DepEd creates its own database system of employees who register for vaccination in their LGUs. The database can be linked or drawn from the existing database of the LGUs, if feasible. In addition, the database will cover the status of the teachers, i.e., whether they have already received vaccination and other related details on this matter. Another database shall be developed to monitor the use of schools as vaccination centers. The same can be linked with or drawn from the database of the LGUs, if feasible.

With regards to teachers who will volunteer as health educators or documenters as part of the vaccination team, a database is also suggested for the ICTS to develop. This can be linked or drawn from

[3] "The government may use public schools as vaccination centers if there's no available space especially in the urban areas as the government gears towards COVID-19 mass vaccination drive, President Rodrigo Roa Duterte said on Monday," PCOO, https://pcoo.gov.ph/news_releases/aside-from-camps-schools-may-be-used-as-vaccination-centers-president-duterte/

the database of the DOH. To guide the ICTS, these planned database systems shall be discussed with the DOH and the National Task Force through the Vaccine Cluster – Sub-Task Group Registry, Data Management and M&E. The DepEd database systems can be accessed and managed at the regional, division, and school levels.

E. Responsibility of Governance Levels

DepEd must further define the roles, responsibilities, and accountabilities of each governance level in the implementation of DepEd's action plan for the NDVP. As a guiding principle, the next higher governance level shall be responsible for providing policy, strategic, and technical oversight to offices and personnel under its jurisdiction (e.g., matters that cannot be resolved at the school level shall be elevated to the Division; Division-level matters shall be elevated to the Region; etc.)

A separate monitoring and feedback system dedicated to compliance with DepEd guidelines and DepEd-specific concerns (e.g., experience of personnel on volunteering, use of school facilities and resources for NDVP implementation) may also be set-up.

The Honorable Secretary is requested to approve the urgent drafting and release of appropriate correspondences and issuances for the abovementioned recommendations.

KAGAWARAN NG EDUKASYON

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DEPARTMENT OF EDUCATION
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OUA MEMO 00-0221-0056
MEMORANDUM
02 February 2021

For: **Leonor Magtolis Briones**
Secretary

Subject: **UPDATED LIST OF DEPED OFFICIAL REPRESENTATIVES FOR THE COVID-19 IMMUNIZATION PROGRAM**

As agreed in the 82nd Meeting of the IATF-MEID last 29 October 2020, DepEd Secretary submitted to DOH a letter dated 05 November 2020 designating DepEd's representatives to the COVID-19 Immunization Program Management Task Group. For the Task Group, the Secretary named Undersecretary Alain Pascua as permanent representative and BLSS-SHD Dir. Lope Santos III as alternate; while for the TWG she named Dr. Dumlao as permanent representative, with SHD Ms. Girlie Azurin and Mr. Gian Adao as alternates.

On 04 January 2021, DepEd Secretary—for the same purpose—wrote Vaccine Czar Secretary Carlito Galvez Jr., designating for the Task Group, Undersecretary Pascua as permanent representative and DRRMS Dir. Ronilda Co as alternate; while for the Sub-Task Group, DRRMS Mr. Orlando Barachina as permanent representative and BLSS-SHD Dr. Dumlao as alternate.

In view of the differing letters to DOH and to the Vaccine Czar, attached for your approval is the proposed updated list of official DepEd Representatives for the COVID-19 Immunization Program. Also attached are drafts of the Secretary's letters to Secretary Duque and Secretary Galvez Jr. endorsing the same.

For the consideration and approval of the Secretary.

ALAIN DEL B. PASCUA
Undersecretary

REPUBLIC OF THE PHILIPPINES
INTER-AGENCY TASK FORCE
FOR THE MANAGEMENT OF EMERGING INFECTIOUS DISEASES
NATIONAL TASK FORCE AGAINST COVID-19

DESIGNATION OF AGENCY REPRESENTATIVES TO THE COVID-19 VACCINE CLUSTER

This is to officially designate the following officials and personnel who shall represent the Department of Education (DepEd) in the COVID-19 Vaccine Cluster's Task Group (TG) Immunization Program and its Sub Task Groups (STGs):

TG/STGs	Name	Position	Staff/Division	Contact No.	Email Address
TG Immunization Program (Principal)	**ALAIN DEL B. PASCUA**	Undersecretary	Office of the Undersecretary for Administration	8-637-6207	usec.admin@deped.gov.ph
TG Immunization Program (Alternate)	**LOPE B. SANTOS III**	OIC/Director	Bureau of Learners Support Services (BLSS)	8-635-3763	lope.santos@deped.gov.ph
	ELLA CECILIA G. NALIPONGUIT	Director III	Bureau of Learners Support Services (BLSS)	8-635-3763	ella.naliponguit@deped.gov.ph
STG **Policy, Planning and Technical Support** (Principal)	**DR. MARIA CORAZON C. DUMLAO**	Chief Health Program Officer	BLSS-School Health Division (SHD)	8-632-9935	maria.dumlao@deped.gov.ph
STG Policy, Planning and Technical Support	**GIAN ERIK M. ADAO**	Education Program Specialist II	BLSS-SHD	8-632-9935	gian.adao@deped.gov.ph

TG/STGs	Name	Position	Staff/Division	Contact No.	Email Address
(Alternate)					
STG **Registry, Data Management and M&E** (Principal)	**ABRAM Y.C. ABANIL**	Director IV	Information, Communication Technology Service (ICTS)	8-631-9636	abram.abanil@deped.gov.ph
	ATTY. ANNE RACHEL C. MIGUEL	Director IV	BHROD	8-633-7237	anne.miguel@deped.gov.ph
STG Registry, Data Management and M&E (Alternate)	**MARIBLANCA P. PIATOS**	Medical Officer IV	BLSS-SHD	8-632-9935	mariblanca.piatos@deped.gov.ph
	BELINDA C. BELTRAN	Nutritionist Dietitian	BLSS-SHD	8-632-9935	belinda.beltran@deped.gov.ph
	MARIA CLARISSE LIGUNAS	IT Officer III	ICTS-SDD	8-633-2092	mariaclarisse.ligunas@deped.gov.ph
STG **Program Implementation** (Principal)	**DR. MARIA CORAZON C. DUMLAO**	Chief Health Program Officer	BLSS-SHD	8-632-9935	maria.dumlao@deped.gov.ph
STG Program Implementation (Alternate)	**GIRLIE G. AZURIN**	Senior Education Program Specialist	BLSS-SHD	8-632-9935	girlie.azurin@deped.gov.ph

TG/STGs	Name	Position	Staff/Division	Contact No.	Email Address
	VONERICH B. BERBA	Education Program Specialist II	BLSS-SHD	8-632-9935	vonerich.berba@deped.gov.ph

The above designated officials shall be expected to fulfill their roles and responsibilities as members of the TG and the STGs.

Approved by:

LEONOR MAGTOLIS BRIONES
Secretary
DEPARTMENT OF EDUCATION
Date:

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Republic of the Philippines
Department of Education
OFFICE OF THE SECRETARY

03 February 2021

SECRETARY FRANCISCO T. DUQUE III, MD, MSc
Secretary
Department of Health
Sta. Cruz, Manila

Dear **Secretary Duque**:

This refers to the Department of Education's (DepEd) designation of representatives to the COVID-19 Vaccine Cluster made via a letter dated 05 November 2020.

Following internal discussions, the Department respectfully submits its updated roster of representatives to the Task Group on the Immunization Program and its various Sub Task Groups.

Thank you very much.

Very truly yours,

LEONOR MAGTOLIS BRIONES
Secretary

Republic of the Philippines

Department of Education

OFFICE OF THE SECRETARY

03 February 2021

SECRETARY CARLITO G. GALVEZ JR.
Chief Implementer of the National Task Force Against COVID-19
Vaccine Czar

Dear **Secretary Galvez**:

This refers to the Department of Education's (DepEd) designation of representatives to the COVID-19 Vaccine Cluster under the National Task Force Against COVID-19 made via a letter dated 04 January 2021.

Following internal discussions, the Department respectfully submits its updated roster of representatives to the Task Group on the Immunization Program and its various Sub Task Groups.

Thank you very much.

Very truly yours,

LEONOR MAGTOLIS BRIONES
Secretary

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Republika ng Pilipinas
Kagawaran ng Edukasyon
Tanggapan ng Pangalawang Kalihim

DepEd Task Force COVID-19
MEMORANDUM No. 327
02 February 2021

For: **Secretary LEONOR MAGTOLIS BRIONES**
Undersecretary DIOSDADO M. SAN ANTONIO
Other Undersecretaries and Assistant Secretaries
Director LOPE B. SANTOS III, BLSS
Director RONILDA R. CO, DRRMS
Director ABRAM Y.C. ABANIL, ICTS
Director JUNE ARVIN C. GUDOY, PAS
Director ROGER B. MASAPOL, PS
Other Concerned Bureau and Service Directors
Regional Directors and the BARMM Minister of Education

Subject: **DISSEMINATION OF/ALIGNMENT WITH THE BIDA SOLUSYON PLUS SA COVID-19 CAMPAIGN**

The National Task Force Against COVID-19 and the National Incident Command-Emergency Operations Center are leading the roll-out of the updated nationwide behavioral change campaign against COVID-19 dubbed **"BIDA SOLUSYON PLUS SA COVID-19."** The campaign aims to continue encouraging Filipinos to take an active role in fighting COVID-19. It is a unified campaign to align national efforts and messaging on COVID-19 Vaccine Advocacy.

All government agencies are requested to **fully adopt** the BIDA Solusyon Plus sa COVID-19 Campaign in our policies and guidelines, especially on minimum public health standards and other COVID-related policies. All agencies are also requested to **ensure** the **widest dissemination** of the campaign in all offices and attached agencies through available channels (e.g., social media, agency website, email and SMS blasts to employees, IEC materials), and to **align related initiatives** with the messaging of the campaign.

In this regard, the concerned member-offices of the DTFC (QRRT members per DO 44, s. 2018) are instructed to:

1. Coordinate with the Office of the Secretary, Planning Service, and other concerned units, for the issuance of a **revised DepEd Order on the Required Health Standards in DepEd, aligned with the latest updates and messages of the BIDA Solusyon Plus campaign** (to be led by the BLSS-SHD and DRRMS); and

2. Develop a **comprehensive communication plan for the promotion of the required health standards in DepEd, contextualizing the BIDA Solusyon Plus campaign in DepEd**, and maximizing available platforms in DepEd to ensure that all key stakeholders—DepEd personnel, learners, and parents—are reached (e.g., DepEd TV, DepEd Commons, DepEd Facebook pages, learning modules), for the adoption by the field offices and schools (to be led by PAS, ICTS, the OUCI, BLSS-SHD, and the DRRMS).

All other offices are enjoined to ensure that the programs, policies, and activities implemented related to the Department's COVID-19 response are aligned with the key messages of the BIDA Solusyon Plus campaign.

Attached is the **NTF Memorandum No. 01, s. 2021 with subject "Reiteration: National Behavior Change Campaign."**

For future queries regarding this concern, please contact **Dr. Maria Corazon C. Dumlao**, Bureau of Learner Support Services-School Health Division, DTFC Secretariat, at (+632) 8632-9935 and email at maria.dumlao@deped.gov.ph or blss.shd@deped.gov.ph.

For appropriate action.

ALAIN DEL B. PASCUA
Undersecretary
Chairperson, DepEd Task Force COVID-19

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NATIONAL TASK FORCE AGAINST COVID19
National Incident Command – Emergency Operations Center
RESPONSE CLUSTER
Camp General Emilio Aguinaldo, Quezon City

29 January 2021

MEMORANDUM
No. 01, s. 2021

FOR : **NTF Response Cluster Member Agencies and Partners (Distribution List Attached)**

FROM : **LEOPOLDO J. VEGA, MD, FPCS, FPATACSI, MBA-H**
Head, National Task Force Against COVID-19 Response Cluster
Undersecretary / Chief of Staff, Department of Health

SUBJECT : **Reiteration: National Behavior Change Campaign**

In line with the efforts of the government to integrate the various important messaging for the COVID-19 pandemic, reiterate the national behavior change campaign, and develop one-messaging that is consistent across agencies against COVID-19. It is critical and vital to reflect the recent scientific developments and emerging preventative measures to combat the virus.

The Task Group Prevent, on behalf of the National Task Force Against COVID-19 and the National Incident Command - Emergency Operations Center, the Response Cluster chaired by the Department of Health (DOH) together with the Department of Interior and Local Government (DILG) and the Presidential Communications Operations Office (PCOO), is currently leading the roll-out of the updated nationwide behavioral change campaign against COVID-19. The **"BIDA SOLUSYON PLUS SA COVID-19"** aims to continue to encourage Filipino people to take an active role in the fight against our common enemy: COVID-19 *(the "contravida")*. This is a unified campaign with the Task Group Demand Generation under the Vaccine Cluster to align national efforts and messaging regarding the COVID-19 Vaccine Advocacy.

The campaign seeks to build upon the original BIDA behaviors through the following behavioral messages of the BIDA Solusyon Campaign:

BIDA	Principle
B - Bawal walang mask at face shield	Wearing of Personal Protective Equipment decreases the risks of COVID-19 transmission.
I - I-sanitize ang mga kamay, iwasan ang kulob na lugar	Proper hand hygiene prevents transmission of COVID-19 by ensuring that your hands are not contaminated before touching your eyes, mouth, and nose. It also prevents spreading the virus on surfaces or objects if your hands are contaminated.

	The COVID-19 virus may remain suspended in the air and accumulate in enclosed spaces, thus increasing the risk of transmission. Adequate air ventilation is needed.
D - Dumistansya at limitahan ang pisikal na interaksyon sa iba	Higher risk of COVID-19 transmission occurs between people who are within 1 meter of each other. Prolonged and close physical interaction increases the risk of transmission. Limiting interaction decreases the risk of infection.
A - Alamin ang totoong impormasyon	Proliferation of Mis/Disinformation on COVID-19 puts the public at risk and undermines the government's effort on the COVID-19 response. Factual information is needed to avert the infodemic.
Plus - Suportahan ang FDA approved na bakuna	The vaccine for COVID-19 is an integral part of disease prevention and should be complemented by the observance of non-pharmaceutical interventions.

In line with this, the National Task Force Against COVID-19 Response Cluster requests your good office to fully adopt the BIDA Solusyon Plus sa COVID-19 Campaign in your policies and guidelines, especially on the Minimum Public Health Standards and other COVID-related policies.

Likewise, we would also like to request the widest dissemination in your respective office premises and other attached agencies using the following channels:

1. Social Media
2. Agency Website
3. LED/LCD Wall or Billboard, if available
4. Email or SMS Blasts to employees
5. Posters, floor/elevator/handwashing station decals within the premises
6. Campaign logo on agency merchandise, if available

We hope that your agency will align related initiatives with the **BIDA Solusyon Plus sa COVID-19 Messaging.** For questions or clarifications, you may contact TG Prevent at tgprevent.doh@gmail.com. We are hoping for your continued support in service towards the health of the Filipino people.

Thank you for your continued support.

CC: **SEC. CARLITO GALVEZ JR.**
Vaccine Czar, National Task Force Against COVID-19 Vaccine Cluster
Secretary, Office of the Presidential Adviser on the Peace Process

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Philippine News Agency
Philippine Overseas Employment Administration
Overseas Workers Welfare Administration
Technical Education and Skills Development Authority
Healthcare Professionals Association Against COVID-19
Trace-Test-Treat

ANNEX A. Relevant Links for BIDA Solusyon Plus sa COVID-19 Campaign

BIDA Brand Guide	http://bit.ly/BIDAbrandGuide
BIDA Assets	http://bit.ly/BIDAassets
Existing BIDA Materials	http://bit.ly/BIDAallFiles
BIDA Social Media Materials	http://bit.ly/BIDAsocmed
Existing BIDA Solusyon Videos	http://bit.ly/BIDAvideos
BIDA Solusyon AVP	http://bit.ly/BIDAavpV4
BIDA Brand Guide	http://bit.ly/BIDAbrandGuide
BIDA Solusyon Facebook Page	fb.com/BIDASolusyon

Republic of the Philippines
Department of Education
Bureau of Learner Support Services
DepEd Complex, Meralco Avenue, Pasig City

MEMORANDUM

FOR : **LEONOR MAGTOLIS BRIONES**
Secretary

THROUGH : **ALAIN DEL B. PASCUA**
Undersecretary for Administration

FROM : **LOPE B. SANTOS III**
OIC Director, Bureau of Learner Support Services

SUBJECT : **Participation in the AKAP Guro CONNECTed's COVID-19 Vaccines Education Campaign**

DATE : **February 17, 2021**

This refers to the communication of the Office of the Secretary (OSec) to the Bureau of Learner Support Services-School Health Division (BLSS-SHD) regarding the request from the Department of Health (DOH) for assistance in the **AKAP Guro CONNECTed's COVID-19 Vaccines Education Campaign.** This is an initiative of UNILAB that seeks to complement efforts to generate demand for COVID-19 vaccine.

As part of the campaign which will be launched on 20 February 2021, a webinar series will be conducted for teachers and principals all over the country. This will equip them with the correct and timely information about COVID-19 vaccines straight from the country's medical and scientific experts.

Kindly refer to the event schedule below:

Schedule	Target Participants
27 February 2021, 09:00-11:00 a.m.	NCR and Northern Luzon
06 March 2021, 09:00-11:00 a.m.	Southern Luzon
13 March 2021, 09:00-11:00 a.m.	Visayas
13 March 2021 02:00-04:00 p.m.	Mindanao

In relation to the preparatory meeting on 15 February 2021, and to address item nos. 1 and 2 of DOH's request, Dr. Dumlao provides the following updates:

Instruction/Concern	Updates/Recommendations
1. Attend the preparatory meeting	• The Secretary, together with the DILG Secretary and MMDA Chairman Benhur Abalos, is requested to deliver a Message of Solidarity at the opening of the campaign launch on 20 February 2021. • It was also agreed that for the webinar series—and for the launch, **if possible**—a representative from DepEd will provide a 15-minute talk contextualizing these activities in the overall plan of the Department in the implementation of the National Deployment and Vaccination Plan for COVID-19 Vaccines. **The Secretary is requested to designate the said representative.** The presentation is expected to provide guidance to the participants from the field regarding DepEd's role in the vaccination program, including arrangements with LGUs, aligned with the proposed recommendations of the DTFC in the aide memoire drafted for/submitted to the Secretary. • It was agreed during the meeting that all campaign activities (both the launch and the webinar series) will be promoted. The webinar series shall use DepEd's official logo, since it will be streamed live via the Department's social media accounts. The assistance of the Public Affairs Service will be sought for this purpose.
2. Issue a memorandum to Schools Division Offices inviting schools to the launch of the program on 20 February 2021	• Upon the approval of the Secretary, **the DTFC shall issue the attached draft memorandum to the field to officially invite concerned participants** to the launch of the campaign and its succeeding webinar series.
3. Provide a 3-minute video as introduction for the session	• This is the solidarity message that the Secretary is requested to deliver. The recording of the video message is requested to be submitted to the event organizer/Secretariat **during the technical run, on or before February 19, 2020, Thursday.**

For the certificates, the event organizer/Secretariat shall coordinate directly with the OSec for the format and the signature of the Secretary.

In addition to the previously mentioned updates, the webinar series is also recommended to be recorded and uploaded on DepEd's Professional Development-Learning Management System (PD-LMS) for it to reach more audience even after the event. This shall also grant participants access to the video materials for necessary review or refresher. LAC Session Guides and toolkits can also be developed based on the webinar.

These options can be explored, and can be made possible with the assistance of concerned offices such as the Information and Communications Technology Service, and the Curriculum and Instruction Strand.

For the Secretary's consideration and approval.

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DepEd Task Force COVID-19
MEMORANDUM No. 336
15 February 2021

For: **Secretary Leonor Magtolis Briones**
Undersecretaries and Assistant Secretaries
Bureau and Service Directors
Regional Directors and BARMM Minister of Education

Subject: **AKAP GURO CONNECTED'S COVID-19 VACCINES EDUCATION CAMPAIGN**

The Department of Education (DepEd), through the DepEd Task Force COVID-19, enjoins its officials and personnel to participate in the **AKAP Guro CONNECTed's COVID-19 Vaccines Education Campaign**.

The campaign is part of a series of activities organized by the government's Vaccine Cluster - Task Group on Demand Generation and Communications together with its partners, including UNILAB, to inform the general public about the national vaccine deployment plan.

In this connection, a webinar series will be conducted for teachers and principals from all over the country. This is to equip them with the correct and timely information about COVID-19 vaccines straight from the country's medical and scientific experts.

Kindly refer to the schedule of activities below:

Schedule	Activity
20 February 2021, 09:00-11:30 a.m.	Campaign Launch (Invited participants are selected officials and personnel from Central, Regional and Division offices, including BARMM)
27 February 2021, 09:00-11:00 a.m.	Webinar for school heads and teachers from NCR and Northern Luzon
06 March 2021, 09:00-11:00 a.m.	Webinar for school heads and teachers from Southern Luzon
13 March 2021, 09:00-11:00 a.m.	Webinar for school heads and teachers from Visayas
13 March 2021, 02:00-04:00 pm	Webinar for school heads and teachers from Mindanao

I. Campaign Launch

A. The campaign will be launched on 20 February 2021 (Saturday), 09:00–11:30 a.m., via Zoom. This is a **private virtual event exclusive to registered participants** and will not be streamed on social media.

B. Expected participants are the following:

Central Office	Bureau and Service Directors or their designated representatives
Regional Offices (5 participants per RO)	1. Regional Director 2. Education Support Services Division Chief 3. Medical Officer IV or another SHN personnel leading the regional COVID-19 response 4. Regional DRRM Coordinator 5. Regional Human Resource Management Officer For BARMM-MBHTE (5 participants) 6. Minister of Education 7. Regional officers/personnel in charge of COVID-19 response, school health, DRRM, and HRM
Schools Division Offices, including BARMM (5 participants per SDO)	1. Schools Division Superintendent 2. School Governance and Operations Division Chief 3. Medical Officer III or Nurse-in-Charge or another SHN personnel leading the division COVID-19 response 4. Division DRRM Coordinator 5. Division Human Resource Management Officer

C. Identified participants shall register via http://bit.ly/20210220ugnayanbakuna .

D. Participants will receive Certificates of Participation through email.

II. Webinar Series

A. The objectives of the webinar series are the following:
1. educate teachers about COVID-19 and its vaccines,
2. provide information about the plans of the LGUs involving teachers, and
3. provide a venue for the teachers to engage in in-depth discussions with experts on COVID-19.

B. The webinar series is open to all school heads and teachers. It will be streamed via Facebook live on the pages of AKAP Guro Connected (https://www.facebook.com/akapguroconnected) and DepEd Philippines (https://www.facebook.com/DepartmentOfEducation.PH).

C. All school heads and teachers are enjoined to attend the webinar on the date and timeslot scheduled for their respective region.

D. Certificates may be generated for a limited period at the Professional Development-Learning Management System (PD-LMS). Details shall be announced during the webinar.

Regional Directors and Schools Division Superintendents are requested to take the lead in the dissemination of information to all concerned personnel, school heads, and teachers to ensure their active participation in the campaign activities.

For queries on this matter, please contact **Dr. Maria Corazon C. Dumlao** of the Bureau of Learner Support Services - School Health Division (BLSS-SHD) and DTFC Secretariat, through (+632) 8632-9935 and email at maria.dumlao@deped.gov.ph or blss.shd@deped.gov.ph .

For immediate and appropriate action.

ALAIN DEL B. PASCUA
Undersecretary
Chairperson, DepEd Task Force COVID-19

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Republika ng Pilipinas
Kagawaran ng Edukasyon
Tanggapan ng Pangalawang Kalihim

DepEd Task Force COVID-19
MEMORANDUM No. 244
05 November 2020

For: **Minister of Basic, Higher, and Technical Education, BARMM**
Regional Directors
Schools Division Superintendents
Public School Heads
All Others Concerned

Subject: **GUIDELINES ON THE USE OF SCHOOLS AS EVACUATION CENTERS IN CONSIDERATION OF THE COVID-19 PANDEMIC**

The Department of Education (DepEd) Task Force COVID-19 reminds all concerned that **the use of DepEd schools as evacuation centers for families and individuals affected by natural and human-induced disasters shall continue to be guided by the *Children's Emergency Relief and Protection Act* (RA 10821) and COVID-19 minimum health standards.**

The following are specifically reiterated:

1. RA 10821 emphasizes that the establishment of evacuation centers which are safe, inclusive, child-friendly, and provide for gender-sensitive and responsive amenities is the responsibility of Local Government Units (LGUs). **A school may only be used as an evacuation center only as a last resort, or only in cases where there is no other available place or structure which can be used for the said purpose.** In cases where schools shall be used, the following shall be observed pursuant to RA 10821:

    a. LGUs shall coordinate with the School Heads and respective Schools Division Superintendents (SDS) before schools may be used as temporary evacuation centers, and shall **execute a Memorandum of Agreement**.

    b. Should the school be used, the LGU shall coordinate with the School Head and ensure that gymnasiums, learning and activity centers, auditoriums and other open spaces shall be utilized first; **classrooms shall only be used as a last resort**.

c. School personnel shall focus on providing education services, particularly education continuity for children in affected communities; **they shall not be assigned as camp managers**.

   Following DepEd policy, school personnel and members of the DRRM Teams in schools designated as evacuation centers may be requested to render service even when classes and/or work are suspended only for the purpose of monitoring the school facilities and resources, subject to strict compliance to COVID-19 health measures.

   In view of the emergency response services rendered during the period of work cancellation/suspension, concerned personnel shall be entitled to service credits pursuant to DepEd Order No. 53, s. 2003, and/or overtime payment subject to policy and guidelines set by the Civil Service Commission and the Department of Budget and Management.

d. When necessary, **the use of school premises shall be as brief as possible**. It shall only be up to three (3) days for short-term displacement, fifteen days for medium and long-term displacement, or until such time that the respective LGUs are able to establish alternative transitional sites.

e. **If the use is predicted to exceed fifteen days, the affected LGU shall provide written documentation** to the DepEd and the Department of the Interior and Local Government (DILG) on the following:
   i. The name and location of the school;
   ii. All alternative evacuation centers, transitional relocation sites, and/or permanent relocation sites for final selection;
   iii. Measures being implemented to prevent interference or disruption to the school and educational activities of children;
   iv. Timeline for the relocation of and plan of action for internally displaced persons to sites outside of schools shall be approved by DepEd.

f. The Regional or Division Office of DepEd, assisted by the Department of Public Works and Highways (DPWH), the Local Engineering Office, and the Bureau of Fire Protection (BFP) shall **conduct regular site inspection of public schools to ensure the stability of structures for the safety of children and their environment**. A report on the inspection shall be submitted to the Secretary of DepEd, copy furnished the Local Chief Executive, for the purpose of repair of the damaged school being used as an evacuation center.

g. **The LGU is responsible for facilitating general cleaning, fumigation, payment of utilities, and repair of schools used as evacuation centers**. Damages incurred by schools used as evacuation

centers shall be immediately reported by their respective School Heads to the LGU for appropriate action. Repairs and/or replacement of damaged facilities and materials of damages to schools used as evacuation centers shall be immediately undertaken to ensure the safety and well-being of internally displaced persons. Such repairs and replacement shall be monitored by the School Head and SDS in coordination with the LGU. LGUs shall also provide clean-up kits.

2. In consideration of the COVID-19 Pandemic, a school may only be considered for use as an evacuation enter if:

    a. The **school is not currently being used as a COVID-19 quarantine or isolation facility**, following OM-OSEC-2020-002, -003, -004, and -005.

    b. The **disinfection of the school has been completed** after its use as a quarantine or isolation facility.

    c. The LGU concerned is able to ensure that **all applicable and required health standards are adhered to in the set-up and operation of the school to be used as an evacuation center of last resort**, as evidenced by a certification from the local Inter-Agency Task Force on Emerging Infectious Diseases (IATF).

3. Finally, the findings of the Office of the Undersecretary for Administration first released through an Aide Memoire dated 04 May 2020 *(please see attached)* that **the design specifications of the ceilings of school buildings constructed from 2014 to 2019 were apparently not followed in actual construction** is reiterated. DepEd is currently in the direction of replacing the existing ceilings of school buildings, specifically those that were constructed from 2014 onwards.

    As a preventive measure against any untoward incident, all are advised to **refrain from using single-story school buildings, and the top floors of multi-story school buildings for evacuation purposes.**

For all future correspondence and queries on this subject, please contact the Disaster Risk Reduction and Management Service (DRRMS) through telephone number (02) 8637-4933 and email at drrmo@deped.gov.ph ; or Mr. Jeonoah Kali Fornoles, Senior Technical Assistant II of the said office via email at jeonoah.fornoles@deped.gov.ph .

For immediate and appropriate action.

ALAIN DEL B. PASCUA
Undersecretary
Chairperson, DepEd Task Force COVID-19

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Republic of the Philippines
Department of Education

26 MAR 2020

OFFICE MEMORANDUM
OM-O S E C-2 0 2 0-002

GUIDANCE TO REGIONAL DIRECTORS FOR ACTION ON REQUESTS BY LOCAL GOVERNMENT UNITS TO USE DEPED SCHOOLS AS QUARANTINE OR ISOLATION AREAS FOR COVID-19

1. The President issued Proclamation No. 922 dated March 8, 2020, *Declaring a State of Public Health Emergency Throughout the Philippines*, in view of the COVID-19 public health situation. Section 2 of Proclamation No. 922, s. 2020, states that "(a)ll government agencies and LGUs are hereby enjoined to render full assistance and cooperation and mobilize the necessary resources to undertake critical, urgent, and appropriate response and measures in a timely manner to curtail and eliminate the Covid-19 threat".

2. The Department of Education (DepEd) has received a growing number of requests by various Local Government Units (LGUs) for the use of DepEd schools as places for quarantine or isolation as part of their response to COVID-19.

3. DepEd is fully cooperating with the Office of the President, the Inter-Agency Task Force for the Management of Emerging Infectious Diseases (IATF), and the Cabinet on decisions concerning COVID-19. DepEd is committed to render full assistance and cooperation, and to mobilize the necessary resources to undertake critical, urgent, and appropriate response and measures in a timely manner to curtail and eliminate the COVID-19 threat, as enjoined by the President's Proclamation 922.

4. The matter of utilization of schools as quarantine or isolation areas has been discussed in the IATF. The agreement was that any decision concerning public schools should be made in consultation with DepEd, and in cooperation with DepEd officials on the ground and in compliance with the Department of Health (DOH) guidelines, with due consideration to specific conditions.

5. Consistent with this agreement, one of the provisions of Memorandum Circular No. 2020-062 (March 21, 2020) issued by the Department of Interior and Local Government states:

> 5.1.10. LGUs shall not use DepEd schools as quarantine or isolation areas. As a general rule, LGUs must refrain from using schools as quarantine or isolation areas unless explicitly allowed by the Department of Education and strictly following the guidelines it may set.

6. DOH also issued Department Memorandum No. 2020-0123 (March 16, 2020) on *Interim Guidelines on the Management of Surge Capacity through the Conversion of Public Spaces to Operate as Temporary Treatment and Monitoring Facilities for the Management of Persons Under Investigation and Mild Cases of Coronavirus Disease*

2019 (COVID-19). Among the public spaces it identified are auditoriums, gymnasiums, classrooms, vacant hotels, courts, open fields with tents.

7. I hereby delegate to Regional Directors the responsibility to approve or deny requests by LGUs to use DepEd schools for quarantine and isolation purposes within their respective jurisdiction, based on evaluation of the request by the Schools Division Superintendent in consultation with the school heads and with the Department of Health.

8. In adherence to DOH Department Memorandum No. 2020-0123 and other applicable DOH and World Health Organization (WHO) guidelines, the evaluation of the request shall be guided by the following:

a. The LGU must state in its request the specific intended purpose or use for the school, and identify the particular facility in the school that will be used as well as the duration of their use, subject to extension, if necessary;

b. The LGU must show that all other facilities have been duly assessed and were found to be inadequate. Schools can be recommended only when no other facilities are available;

c. The LGU must present an assessment by the municipal, city, or provincial health officer that the facility within the school is suitable for the specific intended purpose;

d. The LGU must present the planned management of the facility, which shall be under the supervision of the City/Municipal Health Officer, as stated in DOH Department Memorandum No. 2020-0123, and must conform to existing DOH standards and guidelines, including, but not limited to, patient management, safety standards within the facility and immediate community, waste management/disposal, and other similar/related health requirements; and

e. The LGU request must include an undertaking: for the safekeeping of all property and valuables in the school premises during the operation of the facility; payment of utilities for the period; the conduct of the general cleaning and fumigation, and repair and/or replacement of damaged school facilities as a result of the use of the school; and, payment of expenses related to the setting-up, operation and clearing of the areas used.

9. When a request is granted by the Regional Director based on the recommendation by the concerned Schools Division Superintendent, the school heads must coordinate with the LGU on the following preparations before actual use of the facility for the intended purpose:

a. Designation and vacating of the approved school spaces/structures to be used by the LGU as quarantine or isolation areas, including removal of all chairs, tables, furniture, equipment and other school properties. Such approved school spaces/structures to be used as quarantine or isolation areas shall be cordoned off from the rest of the school;

b. Designation of sufficient number of comfort rooms and handwashing facilities to be used;

c. Safekeeping and/or proper storage of all learning and education materials, resources, equipment, and school records;

d. Documentation of the condition of school facilities and resources before use of the facility;

e. Signing of the minimum Terms and Conditions (TAC) for the Use of DepEd Schools as Quarantine or Isolations Areas, as provided by the Regional Director; and

f. All DepEd personnel involved in the preparation of the school premises shall strictly observe all existing health precautions and social distancing protocols of DepEd.

10. The LGU shall sign the TAC provided by the Regional Director. Should there be other terms to be agreed upon between the Schools Division Office (SDO) and the LGU, the SDO shall draft a Memorandum of Agreement (MOA) between the SDO and LGU, detailing the roles and responsibilities of the parties, among others. The TAC shall be attached to the MOA as an Annex and shall form an integral part of the MOA. In case of conflict between the MOA and the TAC, the TAC shall prevail.

11. The following documents are hereto enclosed as reference to evaluate the health-related undertaking by the LGUs:

Enclosure No. 1 - *Interim Guidelines on the Management of PUMs suspected with COVID-19 for Home Quarantine* issued as DOH Memorandum No. 2020-0090

Enclosure No. 2 - *Interim Guidelines on the Management of Surge Capacity through the Conversion of Public Spaces to Operate as Temporary Treatment and Monitoring Facilities for the Management if PUIs and Mild Cases of COVID-19* issued by the Department of Health (DOH) as DOH Memorandum No. 2020-0123

Enclosure No. 3 - *Decontamination, Disinfection, and Sterilization practices issued by the DOH* (Annex A4 of DOH Memorandum DOH Memorandum No. 2020-0072; which is also Annex A4 of DOH Memorandum No. 2020-0123)

Enclosure No. 4 - *Considerations for quarantine of individuals in the context of containment for coronavirus disease (COVID-19)* by the World Health Organization

Enclosure No. 5 - *Minimum Standards for Social Distancing/Baseline Protocols to be observed in the workplace, travel, and home and private space and time of deployed personnel during the enhanced community quarantine* by DepEd Task Force COVID-19

12. The Regional Directors shall devise an appropriate system for monitoring the use of schools within their jurisdiction as quarantine or isolation areas. For this purpose, DRRM coordinators shall provide support to the School Health and Nutrition personnel in monitoring the use of school facilities. In light of precautionary and social

distancing measures, offsite monitoring through close coordination with LGUs is encouraged; physical monitoring shall be done when deemed feasible.

13. For clarifications and concerns, contact the **DepEd Task Force COVID-19 Quick Response and Recovery Team** (DTF COVID-19 QRRT) at the Bureau of Learner Support Services through email at blss.shd@deped.gov.ph or at telephone number (02) 8632-9935.

14. For immediate dissemination and implementation.

LEONOR MAGTOLIS BRIONES
Secretary

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

17 February 2020

DEPARTMENT MEMORANDUM
No. 2020 - 0090

TO: **ALL UNDERSECRETARIES AND ASSISTANT SECRETARIES; DIRECTORS OF BUREAUS AND CENTERS FOR HEALTH DEVELOPMENT; MINISTER OF HEALTH – BANGSAMORO AUTONOMOUS REGION IN MUSLIM MINDANAO); EXECUTIVE DIRECTORS OF SPECIALTY HOSPITALS AND NATIONAL NUTRITION COUNCIL; CHIEFS OF MEDICAL CENTERS, HOSPITALS, SANITARIA AND INSTITUTES; PRESIDENT OF THE PHILIPPINE HEALTH INSURANCE CORPORATION; DIRECTORS OF PHILIPPINE NATIONAL AIDS COUNCIL AND TREATMENT AND REHABILITATION CENTERS AND ALL OTHERS CONCERNED**

SUBJECT: **Interim Guidelines on the Management of Persons Under Monitoring (PUMs) suspected with Coronavirus Disease 2019 (COVID-19) for Home Quarantine**

I. BACKGROUND

After a cluster of pneumonia cases of unknown etiology was reported in Wuhan City, Hubei Province of China last December 31, 2019, Chinese health authorities preliminarily identified the cause of this viral pneumonia as a new or novel type of coronavirus.

With an increasing number of cases spreading to various territories and confirmed human-to-human transmission, the World Health Organization declared the outbreak as a Public Health Emergency of International Concern (PHEIC) last January 30, 2020.

The Department of Health (DOH) hereby issues interim guidelines on the management of persons under monitoring (PUMs) suspected with Coronavirus Disease 2019 (COVID-19) for home quarantine.

II. GENERAL GUIDELINES

A. Any person, regardless of nationality, race and age, who does not exhibit any sign nor symptom, has history of travel to other areas of China and/or history of exposure to a confirmed case of COVID-19, within the past 14 days, shall be required to undergo monitored home quarantine.
B. Any person, regardless of nationality, race and age, who exhibits fever or any symptom of lower respiratory illness, and has a history of travel to other countries with a confirmed case of COVID-19 but without any history of exposure, shall be advised to undergo monitored home quarantine.
C. Those undergoing home quarantine shall be prohibited to leave their rooms/homes where they are quarantined until they have been certified by the local health official to have finished the 14-day requirement for quarantine procedures.

D. Initial coordination should be done with the Local Government Epidemiologic Surveillance Unit on the logistical, administrative and clinical parameters to be standardized in any attempt to refer a PUM for transfer or consultation.

III. IMPLEMENTING GUIDELINES

A. Room Isolation and Contacts of Persons Under Monitoring (PUM)

1. Place the PUM alone in a well-ventilated room, preferably with toilet and bathroom. If this is not possible, maintain a distance of at least 1 meter from the PUM (e.g. sleep in a separate bed).
2. Assign one person who is in good health as caretaker of the PUM.
3. Visitors, family members and even caregivers are not allowed in the PUM's room, if possible.
4. Confine activities of the PUM in his/her room only. If this is not possible, ensure that shared spaces (e.g. kitchen, bathroom) are well ventilated (e.g. keep windows open).

B. Use of Disposable Surgical Mask

1. The PUM should wear a surgical mask fitted tightly to the nose, mouth, and chin when in the same room with another household member or when talking to other people. The use of masks is not required for the person/s the PUM is/are interacting with.
2. If alone, the PUM is not required to wear a mask.
3. Masks should not be touched or handled during use. If the mask gets wet or dirty with secretions, it must be changed immediately and disposed properly.
4. Discard the used mask after a maximum use of 8 hours. Masks are not reusable and should not be washed. After removal of mask, wash hands using water and soap, or rub hands with 70% alcohol or any hand disinfectant.

C. Hand Hygiene Practice for ALL

1. All PUMs and household members should perform hand hygiene following contact with PUM or if in contact with their immediate environment.
2. Perform hand hygiene by washing hands with soap and water. If hands are not visibly soiled, 70% alcohol or any alcohol-based hand rub can be used.
3. When using soap and water, disposable paper towels to dry hands is desirable. If not available, use dedicated cloth towels and replace them when they become wet.
4. Hand hygiene should also be performed before and after preparing food, before eating, after using the toilet, and whenever hands look dirty.
5. Address safety concerns (e.g. accidental ingestion by children and fire hazards) on the use of alcohol-based hand rubs.

D. Respiratory Hygiene and Standard Precaution for ALL

1. Respiratory hygiene/cough etiquette should be practiced by all at all times. Respiratory hygiene refers to covering the mouth and nose during coughing or sneezing using surgical masks, tissues, flexed elbow, sleeves of clothes, or inside the neckline of shirts, followed by hand hygiene.
2. Avoid direct contact with body fluids, particularly oral or respiratory secretions, and feces. Use disposable gloves to provide oral or respiratory care and when handling feces, urine and waste. Wash hands before putting on and after removing gloves.

3. Avoid other types of possible exposure to PUM or contaminated items in their immediate environment (e.g. avoid sharing toothbrushes, cigarettes, towels, washcloths, bed linen).

E. Food Handling of PUM on Home Quarantine

1. The assigned caretaker of the PUM shall serve their plates/meal trays only up to the room door.
2. After eating, plates/meal trays should be picked up at the room door by the caretaker using disposable gloves to avoid contamination. Perform hand hygiene afterwards.
3. Eating utensils and dishes should be cleaned with soap or detergent and water after use and may be re-used instead of being discarded.
4. Do not share eating utensils, dishes, and drinks with PUM.

F. Disposal of Used Gloves, Tissues Papers, and Masks

1. Immediately discard materials used to cover the mouth or nose into the trash or clean reusable items appropriately after use (e.g. wash handkerchiefs using regular soap or detergent and water).
2. Gloves, tissues, masks and other waste generated by PUM should be placed in a container in PUM's room before disposal with other household waste.

G. Cleaning and Disinfection

1. PUMs are encouraged to clean and disinfect frequently touched surfaces such as bedside tables, doorknobs, bedframes, and other bedroom furniture daily with regular household disinfectant containing a diluted bleach solution (1-part bleach to 99 parts water).
2. Clean and disinfect bathroom and toilet at least once daily with regular household disinfectant containing diluted bleach solution (1-part bleach to 99-parts water).
3. Clean clothes, bedclothes, bath and hand towels, etc. of PUM using regular laundry soap and water or machine wash at 60–90 °C with common household detergent, and sun-dry. Place used linen into a laundry bag. Do not shake soiled laundry. Additional measures may be needed to prevent unhygienic reuse of gloves, masks, avoid direct contact of the skin and clothes with the contaminated materials.
4. Use disposable gloves and protective clothing (e.g. plastic aprons) when cleaning or handling surfaces, clothing or linen soiled with body fluids. Perform hand hygiene before and after removing gloves.

H. Reporting

1. PUM who developed symptoms should be reported immediately to Regional Epidemiology and Surveillance Unit (RESU) or Local Surveillance Officer for transport to nearest health facility.
2. All household members of PUM should be advised to seek immediate medical care when signs and symptoms developed.

For strict compliance of all concerned.

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

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

March 16, 2020

DEPARTMENT MEMORANDUM
No. 2020 - 0123

FOR: **ALL UNDERSECRETARIES AND ASSISTANT SECRETARIES; DIRECTORS OF BUREAUS, SERVICES, AND CENTERS FOR HEALTH DEVELOPMENT(CHD); MINISTER OF HEALTH – BANGSAMORO AUTONOMOUS REGION IN MUSLIM MINDANAO (MOH-BARMM); EXECUTIVE DIRECTORS OF SPECIALTY HOSPITALS; CHIEFS OF MEDICAL CENTERS, HOSPITALS AND SANITARIA; AND ALL OTHERS CONCERNED**

SUBJECT: **Interim Guidelines on the Management of Surge Capacity through the Conversion of Public Spaces to Operate as Temporary Treatment and Monitoring Facilities for the Management of Persons Under Investigation and Mild Cases of Coronavirus Disease 2019 (COVID-19)**

I. BACKGROUND

On March 10, 2020, the Philippines was declared to be under Alert Level 4, Code Red Sublevel 2. Over the succeeding days, with the number of COVID-19 cases observed to rise, the capacities of all our health facilities are expected to be fully utilized.

In order to reduce the exposure of the general population to COVID-19 patients and enhance the surge capacity of our existing health facilities, the Department of Health (DOH) hereby issues these interim guidelines to provide guidance for health managers and among Local Government Units (LGU) to improve the surge capacity of the local health system by identifying and converting viable public spaces such as auditoriums, gymnasium, classrooms, vacant hotels, courts, open fields with tents, and the like as temporary treatment and monitoring facilities to manage COVID-19 PUIs and confirmed cases of mild COVID-19.

II. OBJECTIVE

This shall provide guidance in managing the potential surge of COVID-19 patients in different health facilities through the identification, assessment and conversion of viable public spaces into temporary treatment and monitoring facilities.

III. SCOPE AND COVERAGE

These interim guidelines shall cover all LGUs and health managers who require temporary treatment and monitoring facilities

IV. GENERAL GUIDELINES

A. Urban health centers and rural health units are enjoined to provide services for 24 hours, 7 days a week, or operate on an on call basis after office hours.

B. The health manager or LGU may identify and consider converting public spaces into temporary treatment and monitoring facilities when necessary, to cater to the increasing number of Persons Under Investigation (PUI) and cases of COVID-19 patients with mild symptoms in the following conditions:

1. Municipality, City, or Province has declared an enhanced community quarantine;
2. Current health facilities are operating nearing its maximum surge capacity.

C. Possible areas that may be converted include auditoriums, gymnasium, classrooms, vacant hotels, courts, and open fields with tents. They may consider partnership with Non-Government Agencies and Private Sector for the use of these public spaces.

D. Operations of these temporary treatment and monitoring facilities shall be under the supervision of the City/Municipal Health Officer who shall assign a facility manager when necessary, and shall serve as an extension of their Urban Health Centers/Rural Health Units.

E. These treatment facilities shall provide the following services:

1.Outpatient Services

a) Consultation for patients experiencing mild respiratory symptoms (fever, cough, colds, etc.);
b) Provision of supportive treatment and psychosocial service;

2.Treatment and monitoring services for PUIs who do not have optimal isolation space in their homes, and confirmed COVID-19 patients with mild symptoms, which includes vital signs monitoring, appropriate clinical management;

3.Timely referral to appropriate health facilities as needed.

F. The health manager or LGU may develop mechanisms to ensure coordination with Urban Health Centers/Rural Health Units and access to higher centers or health facilities that provide intensive care services and for proper and timely referral of patients as indicated in Department Memorandum No. 2020-0072, "Interim Guidelines for 2019 Novel Coronavirus Acute Respiratory Disease (2019-nCOV ARD) Response in Hospitals and Other Health Facilities (ANNEX A).

G. Conversion of public spaces into temporary treatment and monitoring facilities shall follow principles and protocols related to Infection Prevention and Control. Confirmed COVID-19 patients may be placed in shared space or rooms. PUIs shall be separated in a different space/tent/room provided with individual enclosed spaces and separate entrance.

H. The health manager or LGU shall ensure the provision of basic needs for patients, such as food, water, sanitation, and communication.

I. The temporary treatment and monitoring facility shall be limited only to health workers and patients. No visitors shall be allowed in the area.

J. The temporary treatment and monitoring facility shall provide for infection control measures, water, sanitation and hygiene facilities including but not limited to availability of toilets, solid waste management/disposal, vector control and other similar /related health requirements.

V. SPECIFIC GUIDELINES

A. Patient Management

1.Patients classified as Persons Under Investigation (PUI)

a) May be accommodated in temporary treatment and monitoring facilities provided they are in separate isolation rooms that meet the standards on converted private rooms detailed in Department Memorandum No. 2020-0062, "Guidelines on the Standards of Airborne Infection Isolation Room and Conversion of Private Rooms and/or Wards into Temporary Isolation Rooms for the Management of Patients Under Investigation (PUI) for 2019 Novel Coronavirus (nCOV)" (ANNEX B).

b) In compliance with Infection Prevention and Control standards, PUI cannot be cohorted together.

2. Confirmed COVID-19 with mild symptoms, no comorbidities, and aged 18-60 years may be accommodated and managed in the converted treatment and monitoring facilities.

3.Confirmed COVID-19 with severe symptoms, with comorbidities, aged 0-18 or 60 years and above may be referred to the nearest Level 2 or Level 3 hospital accepting PUI or confirmed COVID-19 patients for appropriate management.

B. Location Features

Identified space should:

1. Be accessible within a maximum of two (2) hours to a Level 2 or Level 3 hospital accepting PUI or confirmed COVID-19 patients;

2. Have uninterrupted access to electricity, potable water source, and sewer line;

C. Minimum Infrastructure Requirement

1.Temporary treatment and monitoring facilities must be fully enclosed with adequate lighting;

2.There should be at least fan ventilation to be provided;

3.There should be a separate entrance and exit for the patients and healthcare workers;

4.The facility should be divided into three (3) zones namely: contaminated, buffer and sterile zones.

a) Contaminated Zone: serve as the area where patients are admitted/ contained.
b) Buffer Zone: serves as an area for doffing of PPE, decontamination, and hand hygiene.
c) Sterile Zones: serves as holding area and entrance for healthcare workers, and the area for Personal Protective Equipment (PPE) donning of health workers.

5.Distance between patient beds should be maintained at least 3 feet apart on all sides;

6.Temporary partitions should be provided to ensure patient privacy (i.e. drapes or low walls) for COVID-19 patients placed in a shared space or room.

7.A backup supply of electricity and free-flowing water for at least 72 hours must be ensured, in case of water and power interruption;

8.The provision of fixed or temporary plumbing fixture per person must follow the following requirements:

a) Ratio requirements:
   (1)One (1) water closet per 25 males and one (1) per 20 females
   (2)One (1) urinal per 10-50 males, adding one (1) fixture for each additional 50 males
   (3)One (1) lavatory for every 10 males and one (1) for every 10 females
   (4)One (1) shower per 8 persons

b) Confirmed cases of COVID-19 may share toilets and showers. Regular disinfection should be practiced in accordance with DM 2020-0072 (see ANNEX A).

c) A dedicated toilet and shower for each PUI should be provided when possible. In cases where this arrangement is not feasible, the toilet/shower facilities must be disinfected after every use.

9.There may be provision or access to laundry services.

D. Minimum Medicines, Medical Supplies, and Equipment Requirement:

1. The LGU must ensure the availability of necessary medicines and medical supplies for supportive treatment and emergency care (Annex C);

2. The temporary treatment and monitoring facilities must have access to at least a secondary clinical laboratory and basic radiologic services such as X-ray.

E. Minimum Human Resources Requirements:

1. The LGU may source from its health network or private sector partners the necessary human resources needed to operationalize the temporary treatment and monitoring facility to ensure a 24/7 operation.

2. Each temporary and treatment monitoring may have the following minimum human resource:

   a) At least one (1) Physician per shift
   b) At least three (3) Nurses per shift (1 Nurses: 12 Patients)
   c) Support Staff
      (1)At least two (2) security personnel per shift (1 for each entrance).
      (2)At least one (1) maintenance staff per shift

3. The LGU may likewise provide the following additional human resources as the need arises:
   a) At least one (1) pharmacist per shift (1 pharmacist:100 patients)
   b) At least one (1) nutritionist-dietitian (1 ND:50 patients)
   c) At least one (1) medical social worker per shift (1 MSW:25 patients)
   d) At least five (5) food handlers: (10:100 patients)

4. The LGU should also ensure the availability of psychosocial interventions for healthcare workers deployed in these temporary treatment and monitoring facilities.

F. Minimum Requirements for the Adherence to Infection Prevention and Control

1. Adequate Personal Protective Equipment (PPE) must be provided to both patients and all healthcare workers and deployed in these facilities, which may include:
   a) For healthcare workers
      (1)Surgical masks
      (2)Gowns
      (3)Goggles/face shields
      (4)N95 respirators
   b) For patients
      (1)Surgical masks

2. Rational use of the provided PPE must be ensured.

G. Minimum Requirements for Healthcare Waste Management

1. Segregation, collection, and handling of all waste generated from these temporary treatment and monitoring health facilities may abide by the principles of healthcare waste management.

2. LGUs may refer to DM No. 2020-0072 in Annex A for a more detailed guide on healthcare waste management for highly infectious waste and the appropriate treatment of soiled linens and clothes.

H. Availability of Transport and Referral Protocols

1. All temporary treatment and monitoring facilities shall have access to at least a Type I Basic Life Support (BLS) Ambulance as defined in the Administrative Order No. 2018-0001, "Revised Rules and Regulations Governing the Licensure of Land Ambulances and Ambulance Service Providers."

2. All patients whose symptoms progressed may be referred to a facility with intensive care services. Referral to these health facilities may be in accordance with Department Memorandum No. 2020-0108, "Guidelines for Management of Patients with Possible and Confirmed COVID-19" and its amendments.

For guidance and strict compliance.

By Authority of the Secretary of Health

LILIBETH C. DAVID, MD, MPH, MPM, CESO I
Undersecretary of Health
Health Facilities Infrastructure and Development Team

ANNEX A

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

February 3, 2020

DEPARTMENT MEMORANDUM
No. 2020 - 0072

TO: **ALL UNDERSECRETARIES AND ASSISTANT SECRETARIES; DIRECTORS OF BUREAUS AND CENTERS FOR HEALTH DEVELOPMENT; MINISTER OF HEALTH – BANGSAMORO AUTONOMOUS REGION IN MUSLIM MINDANAO); EXECUTIVE DIRECTORS OF SPECIALTY HOSPITALS AND NATIONAL NUTRITION COUNCIL; CHIEFS OF MEDICAL CENTERS, HOSPITALS, SANITARIA AND INSTITUTES; PRESIDENT OF THE PHILIPPINE HEALTH INSURANCE CORPORATION; DIRECTORS OF PHILIPPINE NATIONAL AIDS COUNCIL AND TREATMENT AND REHABILITATION CENTERS AND OTHERS CONCERNED**

SUBJECT: **Interim Guidelines for 2019 Novel Coronavirus Acute Respiratory Disease (2019-nCoV ARD) Response in Hospitals and Other Health Facilities**

I. BACKGROUND

After a cluster of pneumonia cases of unknown etiology was reported in Wuhan City, Hubei Province of China last December 31, 2019, Chinese health authorities preliminarily identified the cause of this viral pneumonia as a new or novel type of coronavirus (2019-nCoV).

With an increasing number of cases spreading to various territories and confirmed human-to-human transmission, the World Health Organization declared the outbreak as a Public Health Emergency of International Concern (PHEIC) last January 30, 2020.

The Department of Health (DOH) hereby issues these interim guidelines for all health facilities and institutions whether public or private on the necessary precautions, preparations of the health facilities, and management of persons under investigation (PUI) and confirmed cases of the 2019-nCoV ARD.

II. GENERAL GUIDELINES

1. All Level 2 and Level 3 hospitals shall attend to all PUIs.
2. All hospitals and health facilities shall establish and maintain an Infection Prevention and Control Committee (IPCP) in the health facility, headed by an infection control physician and infection control nurse. The IPCP shall be responsible for the formulation, implementation, and monitoring of policies, guidelines, and procedures related to infection control. *(Refer to the National Standards in Infection Control for Healthcare Facilities, 2009 Edition)*

3. All hospitals and health facilities shall ensure that all hospital personnel are familiar with and adhere to infection prevention policies, guidelines, and procedures of the hospital, and shall be protected at all times since they are the first in line for exposure.
4. All hospitals and health facilities shall ensure that all resources and contingencies needed for the implementation of infection prevention and control measures are adequately available.
5. All hospitals and health facilities shall ensure that appropriate personal protective equipment (PPE) are appropriately used by patients and hospital personnel, according to existing protocols.

III. SPECIFIC GUIDELINES

A. Infection Prevention and Control

Universal precautionary measures are implemented in all health facilities. However, for an emerging infectious disease event such as the 2019-nCoV ARD, standard prevention and control strategies must be employed.

IPC strategies to prevent or limit infection transmission in health-care settings are summarized in ***Annex A.***

B. Case Definition

1. Patient under Investigation (PUI)

Clinical features and epidemiological risk should be considered in identifying persons as PUI for 2019-nCoV ARD. A person meeting the following criteria should be evaluated as a PUI in association with the outbreak of 2019-nCoV ARD:

a) A person with Severe Acute Respiratory Infection (SARI), with history of fever and cough requiring admission to hospital, with no other etiology that fully explains the clinical presentation (clinicians should also be alert to the possibility of atypical presentations in patients who are immunocompromised), and ANY of the following:
   (1) A history of travel to China and other 2019-nCoV ARD affected areas in the 14 days prior to symptom onset.
   (2) The disease occurs in a health care worker who has been working in an environment where patients with severe acute respiratory infections are being cared for, without regard to place of residence or history of travel;
   (3) The person develops an unusual or unexpected clinical course, especially sudden deterioration despite appropriate treatment, without regard to place of residence or history of travel, even if another etiology has been identified that fully explains the clinical presentation.

OR

b) Individuals with acute respiratory illness of any degree of severity who, within 14 days before onset of illness, had ANY of the following exposures:
   (1) Close physical contact with a confirmed case of 2019-nCoV ARD infection, while that patient was symptomatic;

(2) A healthcare facility in a country where hospital associated 2019-nCoV ARD infections have been reported;
(3) Direct contact with animals (if animal source is identified) in countries where the 2019-nCoV ARD is known to be circulating in animal populations or where human infections have occurred as a result of presumed zoonotic transmission

PUIs may present a range of signs and symptoms from mild, moderate, or severe illness; the latter includes severe pneumonia, ARDS, sepsis and septic shock. (See page ***3*** of ***Annex B*** for clinical manifestation of 2019-nCoV ARD*)* The criteria and the DOH decision tool ***(Annex C)*** shall be used to guide evaluation.

2. **Close Contact**
Persons visiting patients or staying in the same close environment of a 2019-nCoV ARD confirmed case who are either:
a) Within approximately 6 feet (2 meters), or within the room or care area, of a confirmed case for a prolonged period of time while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection); **OR**
b) Having direct contact with infectious secretions of a novel coronavirus case (e.g., being coughed on) while not wearing recommended personal protective equipment.

Close contact can include caring for, living with, visiting, or sharing a health care waiting area or room with a confirmed case.

The epidemiological link may have occurred within a 14-day period before or after the onset of illness in the case under consideration.

C. Patient Screening

The objective of screening is to quickly identify people with a travel history to countries with ongoing transmission of 2019-nCoV ARD. All personnel in health facilities should be trained on the following 2019-nCoV ARD screening procedures:

1. Screen at all points of entry to the health facility (to catch every patient and visitor).
2. Use broad criteria to quickly identify all patients at risk (i.e. travel to China in the last 14 days).
3. Train screening staff on what to probe. e.g., Have you traveled overseas in the last 14 days? Did you travel to China? Have you visited any animal or seafood market? Did you visit any healthcare facility or sick person during your travel?
4. Train screening staff on what to do once a PUI is identified.
5. Identify holding and isolation areas and healthcare workers who will perform further assessment of patients.
6. Ensure that effective triage checklist and patient flow are in place.
7. Ensure that necessary precautions are observed:
   a) Designate a well-ventilated area.
   b) Maintain a minimum 1-meter distance from patients.
   c) Provide symptomatic patients with facemask for source control when possible.

d) Perform hand hygiene frequently.
e) Follow standard precautions and droplet precautions when evaluating patients with acute respiratory tract infections.

8. Once identified, immediately isolate PUIs in designated holding or isolation areas with full infection control precautions.
9. There should be prompt reporting of cases to surveillance units for immediate contact tracing and quarantine measures. Ensure that the relevant contact numbers are readily available.

D. Patient Triage

The objective of triage is to determine if patients have symptoms of 2019-nCoV ARD infection and if so, to promptly isolate them. Only health care personnel should perform triage.

1. Triage should ideally be conducted in an isolation room with negative pressure and/or adequate ventilation.
2. Other respiratory hygiene supplies (such as facial tissues), trash cans, and hand hygiene facilities should be available inside the room.
3. Triage officers should wear the appropriate PPE.
4. Triage officers shall conduct a complete history and physical examination, and decide whether a patient fulfills the case definition or criteria for the specific Respiratory Infection of Pandemic or Outbreak Potential (RIPOP) in consultation with surveillance officers and consultant(s) in charge of EREIDs.
5. If patients are in queue (surge of patients), separate the "sick" from the "well" patients by 6 feet (2 meters) , and ensure patients are at least 3 feet (1 meter) apart from each other.

E. Referral for Admission

1. Symptomatic contacts or PUIs should be considered for admission for close observation in a health facility.
2. Based on WHO guidelines, coordination with a health facility and/or health care provider should be done during the observation period. Medical personnel should be involved in reviewing the current health status of the contacts by phone and, ideally, by scheduled visits on a regular (e.g. daily) basis, performing specific diagnostic tests as necessary.
3. Doctors and other health care professionals should give advance instructions on where to seek care when a contact becomes ill, what should be the most appropriate mode of transportation, when and where to enter the designated health care facility, and what infection control precautions should be followed.
4. Once the receiving medical facility has been notified that a symptomatic contact will be referred to their facility, the facility should facilitate transport of patient to the facility.
5. The ill contact should be advised to perform respiratory hygiene and stand or sit as far away from others as possible or at least 3 feet (1 meter), when in transit and when in the health care facility.
6. Appropriate hand hygiene should be employed by the ill contact and caregivers. Any surfaces that become soiled with respiratory secretions or body fluids during transport should be cleaned with regular household cleaners or a diluted bleach solution, whichever is most appropriate.

F. Isolation Precautions

1. The duration of infectivity for 2019-nCoV ARD is unknown. While Standard Precautions should continue to be applied always, additional isolation precautions should be used during the duration of symptomatic illness and continued for 24 hours after the resolution of symptoms. ***(Annex A2)***
2. Given that little information is currently available on viral shedding and the potential for transmission of 2019-nCoV ARD, testing for viral shedding should assist the decision making when readily available.
3. Patient information (e.g. age, immune status and medication) should also be considered in situations where there is concern that a patient may be shedding the virus for a prolonged period.

G. Notification

1. Designated disease surveillance officers in hospitals and other facilities shall be responsible for doing the preliminary assessment of suspected cases in their respective health facility and report accordingly using the form in ***Annex D.***
2. Healthcare providers should immediately notify the infection control personnel at their healthcare facility and report any event of a possible case of 2019-nCoV ARD to the Municipal Health Officer (MHO) or City Health Officer (CHO) for verification and initial investigation. The MHO/CHO shall then report to the Regional Epidemiology Surveillance Unit (RESU) using the Event-Based Surveillance System (ESR) system of the Epidemiology Bureau (EB) of DOH.

H. Clinical Management

1. There is no current evidence from RCTs to recommend any specific anti-2019-nCoV ARD treatment for PUIs or confirmed cases.
2. All healthcare providers are advised to use the latest available clinical practice guidelines issued by local specialty societies and duly-endorsed by the DOH. In the interim, a separate issuance will be published by the DOH.

I. Discharge and Follow-up

Due to the evolving nature of the etiology of 2019-nCOV, guidance for discharge criteria and management during follow-up shall be regularly updated and published in a separate issuance. In the interim, the following shall apply.

1. Confirmed positive cases on admission SHOULD ONLY be discharged if ALL of the following conditions are fulfilled:
    a. Two negative RT-PCR tests for 2019-nCoV ARD done 48 hours apart.
    b. Afebrile and asymptomatic (including cough and respiratory symptoms) for 48 hours.
    c. Laboratory and radiologic tests done according to clinical case management (e.g. chest x-ray WBC, platelet count, CPK, liver functions tests, plasma sodium) previously abnormal returning to normal
2. PUIs admitted as per DOH Decision Tool (***Annex C***), shall be discharged upon NEGATIVE 2019-nCoV ARD test from RITM. Until then PUIs shall be admitted in isolation even if asymptomatic. Repeat testing for patients with an initial negative nCoV test result may be performed if a high index for suspicion

for 20191-nCoV ARD remains despite an initial negative test result. Such conditions include, but are not limited, to the following:

a. Clinical deterioration in the presence of an established disease etiology and with adequate treatment. A single negative test result, particularly if this is from an upper respiratory tract specimen, does not exclude infection. Repeat sampling and testing, preferably of lower respiratory specimen, is strongly recommended in severe or progressive disease. Consider a possible co-infection with 2019-nCoV.
b. No other etiology for the patient's signs and symptoms has been identified despite work-up.
c. Clinical specimen(s) initially sent was/were deemed to be unsatisfactory or insufficient (delay in transport and processing, only NPS or OPS was sent).

3. For mortalities of 2019-nCoV ARD, refer to guidelines for Disposal and Shipment of the Remains of confirmed cases of 2019-nCoV ARD.

4. Hospital Disease Surveillance Officer shall report to the RESU within 24 hours the patients that have been discharged. The RESU shall then report to the DOH Regional Director and the 2019-nCoV ARD Task Force
   a. One week after discharge, confirmed cases should submit to mandatory follow-up and retesting for chest x-ray, complete blood count, and other laboratory tests which previously yielded abnormal results.

H. Sources of 2019-nCoV ARD Information and Advisories

1. Everyone is advised to refrain from sharing unverified reports and/or false news to avoid undue stress and worry due to misinformation.
2. For announcements and public advisories, you may visit the following official DOH channels:
   - Website: https://www.doh.gov.ph/2019-nCoV
   - Facebook: https://www.facebook.com/OfficialDOHgov/
   - Twitter: https://twitter.com/DOHgov
3. DOH health promotion materials (e.g. infographics, social media cards among others) may be reproduced by hospitals and other health facilities for instructional use or to keep health workers and patients informed free of charge.

For strict compliance of all concerned.

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

Annex A. Infection Prevention and Control Practices

1. **HAND HYGIENE**
   a. Proper handwashing is the single most effective way to prevent infections in the hospital.
   b. Hand hygiene practices in the health facility must be emphasized using the WHO Multimodal Hand Hygiene Strategy: 5 Moments of Hand Hygiene ***(Annex A1)*** and proper handwashing technique.
   c. The availability of alcohol-based hand rubs at point-of-care and other areas of the facility must be ensured.

2. **ISOLATION PRECAUTION**
   To achieve effective interruption in the transmission of an infectious agent, it is essential to use two tiers of precautions (***Annex A2***)
   a. Standard Precautions for the care of all patients; AND
   b. Transmission-based precautions for patients with known or suspected disease spread by any of these routes: Airborne Precautions, Droplet Precautions or Contact Precautions

3. **PERSONAL PROTECTIVE EQUIPMENT**
   a. Appropriately wearing personal protective equipment (PPE), such as gloves, masks, and gowns, is also essential to protect healthcare workers from contact with infectious agents. The selection of PPE is based on the nature of the patient interaction and/or mode of transmission (***Annex A3***).
   b. Hand hygiene is always the first and the final step before wearing or after removing and disposing of PPE.

4. **DECONTAMINATION, DISINFECTION AND STERILIZATION**
   Proper cleaning, disinfection and sterilization is one of the most effective ways of disrupting the transmission and spread of microorganisms in the healthcare setting. Existing protocols need to be strictly implemented by healthcare personnel (***Annex A4***).

5. **SPECIMEN COLLECTION**
   a. All specimens collected for laboratory testing shall be regarded as potentially infectious.
   b. All Health Care Workers who will collect, handle or transport, perform testing any clinical specimens shall adhere rigorously to the standard precaution measures such as Personal Protective Equipment (i.e. gloves, laboratory gown, N95 Masks, face shield, etc.), and ensure biosafety practices are observed to minimize the possibility of exposure to pathogens.
   c. For further details of the guidelines kindly refer to the "Interim Laboratory Biosafety Guidelines for Handling and Processing Suspected 2019 Novel Coronavirus (2019 nCoV) Specimens" of Research Institute for Tropical Medicine.

6. **SPECIMEN HANDLING, PROCESSING, PACKAGING AND TRANSPORT**
   To ensure that proper handling, processing, packaging and transport of laboratory specimens from suspected Person Under Investigation (PUI) is observed, please refer to the DOH Manual on Packaging and Transport of Laboratory Specimen for Referral and Interim Laboratory Biosafety Guidelines for Handling and Processing Suspected 2019-nCoV Specimens (http://bit.ly/2tdLr4x)

7. FLOW OF PATIENTS SUSPECTED TO BE INFECTIOUS

Early detection and placement of patients to appropriate areas in the health facility is critical in the prevention of spread of infectious diseases. For guidelines on the management of patients suspected to be infectious, kindly refer to the Interim Guidelines on the Preparedness and Response to Novel Coronavirus (2019-nCoV) issued.

Health facilities should ensure that all resources and contingencies needed to support the management of patients and for the implementation of infection prevention and control measures are adequately available.

8. DISPOSAL OF INFECTIOUS BODY

For proper handling of infectious body, strict adherence to precautionary measures is a must. Kindly refer to the Guidelines on Disposal of Dead Persons from Dangerous Communicable Diseases for guidance.

9. HEALTHCARE WASTE MANAGEMENT

a. "Health Care Waste" (HCW) includes all the solid and liquid waste generated as a result of any of the following: (***Annex A5***)
   i. Diagnosis, treatment, or immunization of human beings;
   ii. Research pertaining to the above activities;
   iii. Research using laboratory animals for the improvement of human health;
   iv. Production or testing of biological products; and
   v. Other activities performed by health care facilities.

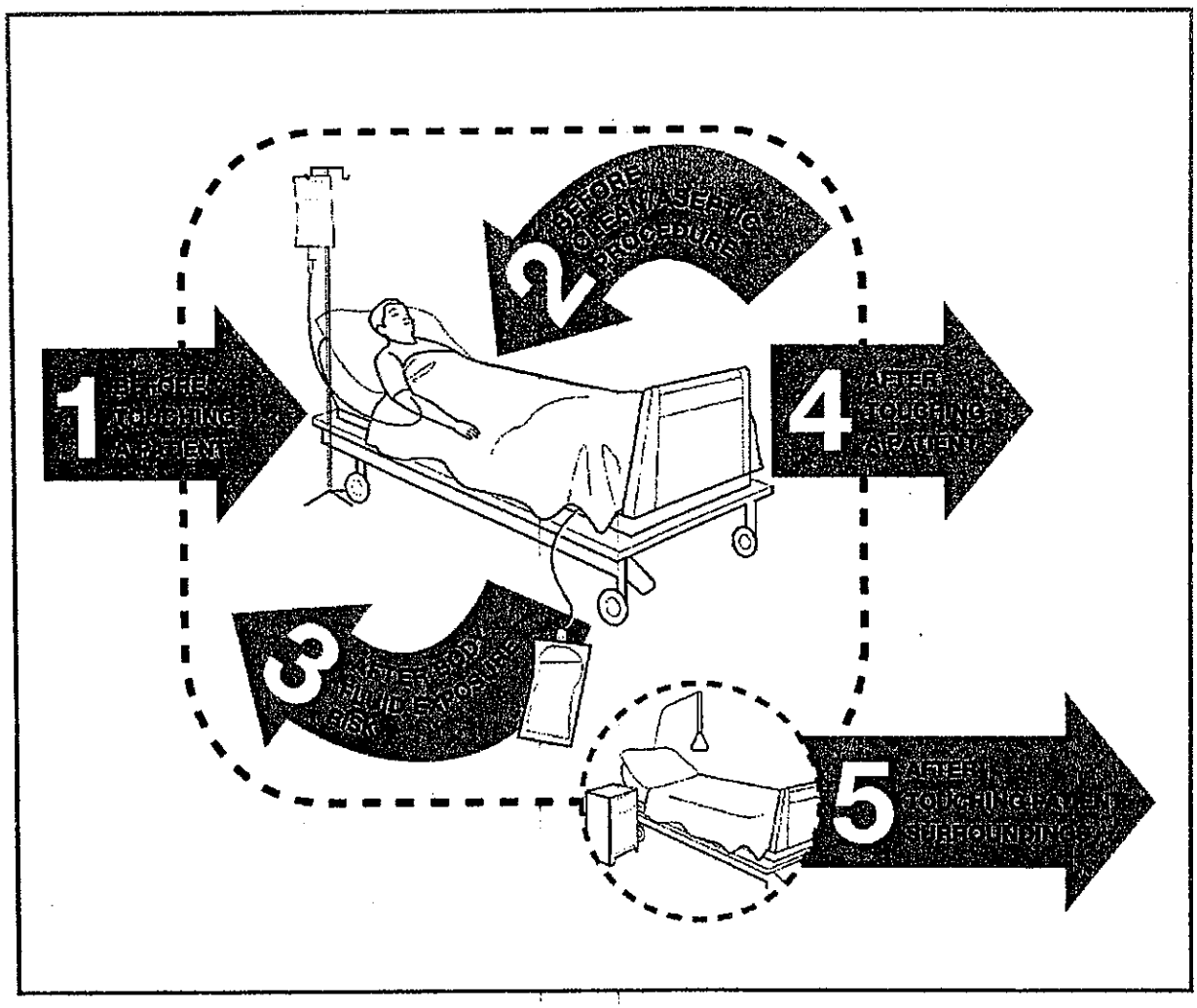
b. Management of health care waste, more specifically of the hazardous waste types (which include infectious waste) must be done through proper waste disposal to mitigate risks and potential health hazards to people exposed. Infectious waste should always be assumed to potentially contain a variety of pathogenic microorganisms that may enter the human body through the following routes:
   i. through a puncture, abrasion, or cut in the skin
   ii. through the mucous membrane
   iii. by inhalation
   iv. by ingestion

10. REFERENCES

Full WHO guidelines are available at Infection prevention and control of epidemic- and pandemic-prone acute respiratory infections in health care. Retrieved from the following:

- https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125; and
- https://www.who.int/publications-detail/advice-on-the-use-of-masks-the-community-during-home-care-and-in-health-care-settings-in-the-context-of-the-novel-coronavirus-(2019-ncov)-outbreak

Annex A1. Five Moments of Handwashing



Source:
The patient zone, health-care area, and critical sites with inserted time-space representation of "My five moments for hand hygiene" (Figure I.21.5b). Reprinted by the World Health Organization from Sax, 2007 with permission from Elsevier. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/44102/9789241597906_eng.pdf;jsessionid=F58881D16DB6861F4F387CFD85E3A998?sequence=1

Annex A2. Isolation Precautions

A. Standard Precautions

1. Standard precautions are recommended for all hospitalized patients should consist of hand hygiene and respiratory hygiene with cough etiquettes. This also includes safe disposal of instruments and soiled linens.
2. All healthcare workers should use appropriate barrier precautions to avoid skin and mucous membrane exposure when contact with blood or body fluids from any patient.
3. Gloves should be worn for contact with blood and body fluids, mucous membranes, or non-intact skin; when handling surfaces or items soiled with blood or body fluids; or for venipuncture or other procedures involving vascular access.
4. Gloves should be changed after each patient contact.
5. Masks and protective eyewear or face shields should be worn when procedures are likely to generate aerosols or droplets of blood or other body fluids.
6. Gowns should be worn for procedures that are likely to soil clothing.
7. Hands or skin contaminated with blood or body fluids should be washed immediately using soap and water. Hand hygiene should be done after removing gloves.
8. Precautions should be taken to prevent sharps or needlestick injuries. Needles should not be recapped, removed from disposable syringes, or manipulated by hand. After use, needles, disposable syringes, scalpels, and other disposable sharp instruments should immediately be placed in a designated puncture-resistant container.
9. Mouthpieces and resuscitation devices should be readily available for use in areas where resuscitation procedures may be anticipated.
10. All healthcare workers with exudative skin lesions should not be involved in direct patient care or should not handle patient-care equipment until the condition has resolved.

B. Transmission-based Precautions

1. When standard precautions are not able to completely interrupt the route of transmission of certain infections, transmission-based precautions are implemented.

C. Contact Precautions

1. Contact Precautions are intended to prevent transmission of pathogens which are spread by direct or indirect contact with the patient or the patient's environment. It applies when there is presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission.
2. A single-patient room is preferred for patients who require Contact Precautions.
3. When a single-patient room is not available, consultation with the ICC is recommended to assess the various risks associated with other patient placement options (e.g., cohorting, keeping the patient with an existing roommate).
4. In multi-patient rooms, ≥3 feet spatial separation between beds is advised to reduce the opportunities for inadvertent sharing of items between the infected/colonized patient and other patients.
5. Healthcare personnel caring for patients on Contact Precautions MUST wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment.

6. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination.

D. Droplet Precautions

1. Droplet Precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Because these pathogens do not remain infectious over long distances in a healthcare facility, special air handling and ventilation are not required to prevent droplet transmission.
2. A single patient room is preferred for patients who require Droplet Precautions.
3. When a single-patient room is not available, consultation with the ICC is recommended.
4. Spatial separation of ≥3 feet and drawing the curtain between patient beds is especially important for patients in multi-bed rooms with infections transmitted by the droplet route.
5. Healthcare personnel caring for patients on Droplet Precautions MUST wear a mask (a respirator is not necessary) for close contact with infectious patient; the mask is generally donned upon room entry.
6. Patients on Droplet Precautions who must be transported outside of the room should wear a mask if tolerated and follow Respiratory Hygiene and Cough etiquette.

E. Airborne Precautions

1. Airborne Precautions prevent transmission of infectious agents that remain infectious over long distances when suspended in the air (ie. rubeola virus [measles], varicella virus [chickenpox], M. tuberculosis, and SARS-CoV).
2. The preferred placement for patients who require Airborne Precautions is in an airborne infection isolation room (AIIR).
3. An AIIR is a single-patient room that is equipped with special air handling and ventilation capacity that meet international standards (i.e., monitored negative pressure relative to the surrounding area, 12 air exchanges per hour for new construction and renovation and 6 air exchanges per hour for existing facilities, air exhausted directly to the outside or recirculated through HEPA filtration before return)
4. It is best that isolation rooms are present in hospitals, emergency departments, and nursing homes that care for patients with M. tuberculosis.
5. In settings where Airborne Precautions cannot be implemented due to limited engineering resources (e.g., physician offices), masking the patient, placing the patient in a private room (e.g., office examination room) with the door closed, and providing N95 or higher level respirators or masks if respirators are not available for healthcare personnel will reduce the likelihood of airborne transmission until the patient is either transferred to a facility with an AIIR or returned to the home environment, as deemed medically appropriate.
6. Healthcare personnel caring for patients on Airborne Precautions MUST wear a mask or respirator, depending on the disease-specific recommendations that is donned prior to room entry.

Annex A3. Personal Protective Equipment (PPE)

A. Gloves

1. Gloves are used to prevent contamination of healthcare personnel hands when:
    a) anticipating direct contact with blood or body fluids, mucous membranes, non-intact skin and other potentially infectious material
    b) having direct contact with patients who are colonized or infected with pathogens transmitted by the contact route
    c) handling or touching visibly or potentially contaminated patient care equipment and environmental surfaces.
2. The healthcare personnel should use the following during specimen collection on a PUI: Double Gloves (preferably: Nitrile); Scrub suit; Disposable Laboratory Gown (impermeable/ breathable/ long sleeves/ back enclosure) ; Fit Tested N95 mask; Face shield / visor.
3. During patient care, transmission of infectious organisms can be reduced by adhering to the principles of working from "clean" to "dirty" and confining or limiting contamination to surfaces that are directly needed for patient care.
4. It may be necessary to change gloves during the care of a single patient to prevent cross-contamination of body sites.
5. It also may be necessary to change gloves if the patient interaction also involves touching portable computer keyboards or other mobile equipment that is transported from room to room.
6. Discarding gloves between patients is necessary to prevent transmission of infectious material.
7. Gloves must not be washed for subsequent reuse because microorganisms cannot be removed reliably from glove surfaces and continued glove integrity cannot be ensured.
8. When gloves are worn in combination with other PPE, they are put on last.
9. Hand hygiene following glove removal further ensures that the hands will not carry potentially infectious material that might have penetrated through unrecognized tears or that could contaminate the hands during glove removal.

B. Isolation Gowns

1. Isolation gowns are used as specified by Standard and Transmission-Based Precautions to protect the HCW's arms and exposed body areas; and to prevent contamination of clothing with blood, body fluids, and other potentially infectious material.
2. When applying Standard Precautions, an isolation gown is worn only if contact with blood or body fluid is anticipated.
3. When Contact Precautions are indicated, donning of both gown and gloves upon room entry is indicated to address unintentional contact with contaminated environmental surfaces.
4. Gowns are usually the first piece of PPE to be donned. Full coverage of the arms and body front, from neck to the mid-thigh or below will ensure that clothing and exposed upper body areas are protected.
5. Isolation gowns should be removed before leaving the patient care area to prevent possible contamination of the environment outside the patient's room.
6. Isolation gowns should be removed in a manner that prevents contamination of clothing or skin. The outer, "contaminated" side of the gown is turned inward and rolled into a bundle, and then discarded into a designated container for waste or linen to contain contamination.

C. Face Protection

a. Face Masks

1. Masks are used for three primary purposes:
    a. Placed on HCWs to protect them from contact with infectious material from patients, example, respiratory secretions and sprays of blood or body fluids, consistent with Standard Precautions and Droplet Precautions;
    b. Placed on HCWs when engaged in procedures requiring sterile technique to protect patients from exposure to infectious agents carried in a HCW's mouth or nose;
    c. Placed on coughing patients to limit potential dissemination of infectious respiratory secretions from the patient to others (Respiratory Hygiene/Cough Etiquette).
2. Masks may be used in combination with goggles to protect the mouth, nose and eyes, or a face shield may be used instead of a mask and goggles, to provide a more complete protection for the face

b. Goggles

1. The eye protection chosen for specific work situations depends upon the circumstances of exposure, other PPE used, and personal vision needs.
2. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
3. Even if Droplet Precautions are not recommended for a specific respiratory tract pathogen, protection for the eyes, nose and mouth by using a mask and goggles, or face shield alone, is necessary when it is likely that there will be a splash or spray of any respiratory secretions or other body fluids .

Annex A4. Decontamination, Disinfection and Sterilization

A. Decontamination and Disinfection Practices

The following must be observed in the decontamination and disinfection practices:

1. Use appropriate hand hygiene, PPE (e.g., gloves), and isolation precautions during cleaning and disinfecting procedures.
2. Have clear instructions and provide feedback to the personnel on how to properly wear PPE appropriate for a surface decontamination and cleaning task.
3. Discard used PPE by using routine disposal procedures or decontaminate reusable PPE as appropriate.
4. Use standard cleaning and disinfection protocols to control environmental contamination.
5. Pay close attention to cleaning and disinfection of high-touch surfaces in patient-care areas (e.g., bed rails, carts, charts, bedside commodes, bed rails, doorknobs, or faucet handles)
6. Ensure compliance by housekeeping staff with cleaning and disinfection procedures by putting up checklists.
7. When contact precautions are indicated for patient care, use disposable patient-care items wherever possible to minimize cross-contamination with multiple-resistant microorganisms.

B. Spaulding Classification for Disinfection & Sterilization of Healthcare Items

CLASSIFICATION	ITEM USE	GOAL	APPROPRIATE PROCESS
Critical Items	Items entering sterile tissue, the body cavity, the vascular system and non intact mucous membranes, e.g. surgical instruments	Objects will be sterile (free of all microorganisms including bacterial spores)	**Sterilization (or use of single use sterile product)** • Steam sterilization • Low temperature methods (ethylene oxide, peracetic acid, hydrogen peroxide plasma)
Semi-critical Items	Items that make contact, directly or indirectly, with intact mucous membranes or non intact skin, e.g. endoscopes, diagnostic probes (vaginal/rectal), anesthetic equipment	Objects will be free of all microorganisms, with the exception of high numbers of bacterial spores	**High level disinfection** • Thermal disinfection • Chemical disinfection (glutaraldehyde, OPA) *It is always preferable to sterilize semi-critical items

			whenever they are compatible with available sterilization processes
Non-critical Items	Objects that come into contact with intact skin but not mucous membranes, e.g. crutches, BP cuffs	Objects will be clean	**Low level disinfection** • Cleaning (manual or mechanical)

Annex A5. Healthcare Waste

A. Healthcare Waste Types

Healthcare waste (HCW) can be broadly categorized into "hazardous" and "non-hazardous" waste types, as listed below.

HAZARDOUS	NON-HAZARDOUS (General)
- Sharps - Infectious - Pathological - Anatomical - Pharmaceutical - Genotoxic - Chemical - Radioactive - Pressurized Containers	- Recyclable - Biodegradable - Residual

Hazardous HCW, which includes infectious wastes, refers to waste that may pose a variety of environmental and health risks. Infectious waste is most likely to contain pathogens (bacteria, viruses, parasites, or fungi) in sufficient concentration or quantity to cause disease in susceptible hosts.

B. Risks Associated with Health Care Waste

1. All individuals coming into proximity with hazardous HCW are potentially at risk, including those who generate hazardous HCW, as well as those who either handle such waste or are exposed to it as a consequence of improper management.
2. The main groups of people at risk to potential health hazards associated with HCW are the following:
    a. HCF staff, e.g., doctors, nurses, auxiliaries, and maintenance personnel
    b. Patients in the HCF or receiving home care
    c. Visitors to the HCF
    d. Workers providing support and allied services to the HCF, such as laundry
    e. Workers transporting hazardous HCW to treatment, storage, and disposal facilities
    f. Workers and operators of waste management facilities (e.g., sanitary landfill and Treatment, Storage, Disposal (TSD) facilities) including informal recyclers or scavenger.
3. The General Public could also be at risk whenever hazardous HCW is abandoned or disposed of improperly.

C. Health Care Waste Disposal

1. HCW that is properly treated with the applicable technology as stated in the Health Care Waste Management Manual can be disposed of in a sanitary landfill but must not be mixed with the municipal waste. Dedicated cells for the treated HCW must be provided in a sanitary landfill. To allow the disposal of HCW to the sanitary landfill, the following must be met:
    a. The waste treatment facility/system passed the standards for microbial inactivation test;
    b. The properly treated HCW passed the spore strip test;

c. The waste treatment facility/system has a valid CPR from the DOH-Bureau of Health ·Devices and Technology (BHDT), and;
d. The waste treatment facility is an EMB-registered TSD facility.

Clinical management of severe acute respiratory infection when novel coronavirus (2019-nCoV) infection is suspected

Interim guidance

28 January 2020

WHO/nCoV/Clinical/2020.2

World Health Organization

Introduction

This is the first edition of this document for novel coronavirus, an adaption of WHO Clinical management of severe acute respiratory infection when MERS-CoV infection is suspected publication (2019).

This document is intended for clinicians taking care of hospitalised adult and paediatric patients with severe acute respiratory infection (SARI) when 2019-nCoV infection is suspected. It is not meant to replace clinical judgment or specialist consultation but rather to strengthen clinical management of these patients and provide to up-to-date guidance. Best practices for SARI including IPC and optimized supportive care for severely ill patients are essential.

This document is organized into the following sections:

1. Triage: recognize and sort patients with SARI
2. Immediate implementation of appropriate infection prevention and control (IPC) measures
3. Early supportive therapy and monitoring
4. Collection of specimens for laboratory diagnosis
5. Management of hypoxemic respiratory failure and acute respiratory distress syndrome (ARDS)
6. Management of septic shock
7. Prevention of complications
8. Specific anti-nCoV treatments
9. Special considerations for pregnant patients

These symbols are used to flag interventions:

- ✔ Do: the intervention is beneficial (strong recommendation) **OR** the intervention is a best practice statement
- ✘ Don't: the intervention is known to be harmful.
- Consider: the intervention may be beneficial in selected patients (conditional recommendation) **OR** be careful when considering this intervention.

This document aims to provide clinicians with updated interim guidance on timely, effective, and safe supportive management of patients with 2019-nCoV and SARI, particularly those with critical illness.

The recommendations in this document are derived from WHO publications.[1-4] Where WHO guidance is not available, we refer to evidence-based guidelines. Members of a WHO global network of clinicians, and clinicians who have treated SARS, MERS or severe influenza patients have reviewed the recommendations (see Acknowledgements). For queries, please email outbreak@who.int with '2019-nCoV clinical question' in the subject line.

1. Triage: early recognition of patients with SARI associated with 2019-nCoV infection

✔ **Triage: recognize and sort all patients with SARI at first point of contact with health care system (such as the emergency department). Consider 2019-nCOV as a possible etiology of SARI under certain conditions (see Table 1). Triage patients and start emergency treatments based based on disease severity.**

Remarks: 2019-nCoV infection may present with mild, moderate, or severe illness; the latter includes severe pneumonia, ARDS, sepsis and septic shock. Early recognition of suspected patients allows for timely initiation of IPC (see Table 2). Early identification of those with severe manifestations (see Table 2) allows for immediate optimized supportive care treatments and safe, rapid admission (or referral) to intensive care unit according to institutional or national protocols. For those with mild illness, hospitalization may not be required unless there is concern for rapid deterioration. All patients discharged home should be instructed to return to hospital if they develop any worsening of illness.

Table 1. Definitions of patients with SARI, suspected of 2019-nCoV infection*

SARI	An ARI with history of fever or measured temperature ≥38 C° and cough; onset within the last ~10 days; and requiring hospitalization.[5] However, the absence of fever does NOT exclude viral infection.[6]
Surveillance case definitions for 2019-nCoV*	A. Patients with severe acute respiratory infection (fever, cough, and requiring admission to hospital), AND with no other etiology that fully explains the clinical presentation[1] AND at least one of the following: • a history of travel to or residence in the city of Wuhan, Hubei Province, China in the 14 days prior to symptom onset, or • patient is a health care worker who has been working in an environment where severe acute respiratory infections of unknown etiology are being cared for. B. Patients with any acute respiratory illness AND at least one of the following: • close contact[2] with a confirmed or probable case of 2019-nCoV in the 14 days prior to illness onset, or • visiting or working in a live animal market in Wuhan, Hubei Province, China in the 14 days prior to symptom onset, or • worked or attended a health care facility in the 14 days prior to onset of symptoms where patients with hospital-associated 2019-nCov infections have been reported.

*see https://www.who.int/health-topics/coronavirus for latest case definitions

[1] clinicians should also be alert to the possibility of atypical presentations in patients who are immunocompromised;

[2]: Close contact' is defined as:

- Health care associated exposure, including providing direct care for nCoV patients, working with health care workers infected with novel coronavirus, visiting patients or staying in the same close environment as a nCoV patient.
- Working together in close proximity or sharing the same classroom environment with a nCoV patient
- Traveling together with a nCoV patient in any kind of conveyance
- Living in the same household as a nCoV patient

The epidemiological link may have occurred within a 14-day period from onset of illness in the case under consideration.

Table 2. Clinical syndromes associated with 2019-nCoV infection

Uncomplicated illness	Patients with uncomplicated upper respiratory tract viral infection, may have non-specific symptoms such as fever, cough, sore throat, nasal congestion, malaise, headache, muscle pain or malaise. The elderly and immunosuppressed may present with atypical symptoms. These patients do not have any signs of dehydration, sepsis or shortness of breath.
Mild pneumonia	Patient with pneumonia and no signs of severe pneumonia. Child with non-severe pneumonia has cough or difficulty breathing + fast breathing: fast breathing (in breaths/min): <2 months, ≥60; 2–11 months, ≥50; 1–5 years, ≥40 and no signs of severe pneumonia.
Severe pneumonia	Adolescent or adult: fever or suspected respiratory infection, plus one of respiratory rate >30 breaths/min, severe respiratory distress, or SpO_2 <90% on room air (adapted from [1]). Child with cough or difficulty in breathing, plus at least one of the following: central cyanosis or SpO_2 <90%; severe respiratory distress (e.g. grunting, very severe chest indrawing); signs of pneumonia with a general danger sign: inability to breastfeed or drink, lethargy or unconsciousness, or convulsions. Other signs of pneumonia may be present: chest indrawing, fast breathing (in breaths/min): <2 months, ≥60; 2–11 months, ≥50; 1–5 years, ≥40.[2] The diagnosis is clinical; chest imaging can exclude complications.
Acute Respiratory Distress Syndrome[7-9]	**Onset:** new or worsening respiratory symptoms within one week of known clinical insult. **Chest imaging (radiograph, CT scan, or lung ultrasound):** bilateral opacities, not fully explained by effusions, lobar or lung collapse, or nodules. **Origin of oedema:** respiratory failure not fully explained by cardiac failure or fluid overload. Need objective assessment (e.g. echocardiography) to exclude hydrostatic cause of oedema if no risk factor present. **Oxygenation (adults):** • Mild ARDS: 200 mmHg < PaO_2/FiO_2 ≤ 300 mmHg (with PEEP or CPAP ≥5 cmH_2O,[7] or non-ventilated[8]) • Moderate ARDS: 100 mmHg < PaO_2/FiO_2 ≤200 mmHg with PEEP ≥5 cmH_2O,[7] or non-ventilated[8]) • Severe ARDS: PaO_2/FiO_2 ≤ 100 mmHg with PEEP ≥5 cmH_2O,[7] or non-ventilated[8]) • When PaO_2 is not available, SpO_2/FiO_2 ≤315 suggests ARDS (including in non-ventilated patients) **Oxygenation (children; note OI = Oxygenation Index and OSI = Oxygenation Index using SpO_2):** • Bilevel NIV or CPAP ≥5 cmH_2O via full face mask: PaO_2/FiO_2 ≤ 300 mmHg or SpO_2/FiO_2 ≤264 • Mild ARDS (invasively ventilated): 4 ≤ OI < 8 or 5 ≤ OSI < 7.5 • Moderate ARDS (invasively ventilated): 8 ≤ OI < 16 or 7.5 ≤ OSI < 12.3 • Severe ARDS (invasively ventilated): OI ≥ 16 or OSI ≥ 12.3
Sepsis[10,11]	Adults: life-threatening organ dysfunction caused by a dysregulated host response to suspected or proven infection, with organ dysfunction*. Signs of organ dysfunction include: altered mental status, difficult or fast breathing, low oxygen saturation, reduced urine output, fast heart rate, weak pulse, cold extremities or low blood pressure, skin mottling, or laboratory evidence of coagulopathy, thrombocytopenia, acidosis, high lactate or hyperbilirubinemia. Children: suspected or proven infection and ≥2 SIRS criteria, of which one must be abnormal temperature or white blood cell count.
Septic shock[10,12]	Adults: persisting hypotension despite volume resuscitation, requiring vasopressors to maintain MAP ≥65 mmHg and serum lactate level >2 mmol/L. Children (based on [12]): any hypotension (SBP <5th centile or >2 SD below normal for age) or 2-3 of the following: altered mental state; tachycardia or bradycardia (HR <90 bpm or >160 bpm in infants and HR <70 bpm or >150 bpm in children); prolonged capillary refill (>2 sec) or warm vasodilation with bounding pulses; tachypnea; mottled skin or petechial or purpuric rash; increased lactate; oliguria; hyperthermia or hypothermia.

Abbreviations: ARI, acute respiratory infection; BP, blood pressure; bpm, beats/minute; CPAP, continuous positive airway pressure; FIO_2, fraction of inspired oxygen; MAP, mean arterial pressure; NIV, noninvasive ventilation; OI, Oxygenation Index; OSI, Oxygenation Index using SpO_2; PaO_2, partial pressure of oxygen; PEEP, positive end-expiratory pressure; SBP, systolic blood pressure; SD, standard deviation; SIRS, systemic inflammatory response syndrome; SpO_2, oxygen saturation. *If altitude is higher than 1000m, then correction factor should be calculated as follows: PaO_2/FiO_2 x Barometric pressure/760.

* The SOFA score ranges from 0 to 24 and includes points related to 6 organ systems: respiratory (hypoxemia defined by low PaO_2/FiO_2), coagulation (low platelets), liver (high bilirubin), cardiovascular (hypotension), central nervous system (low level of consciousness defined by Glasgow Coma Scale), and renal (low urine output or high creatinine). Sepsis is defined by an increase in the Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score[13] of ≥2 points. Assume the baseline score is zero if data are not available

2. Immediate implementation of appropriate IPC measures

IPC is a critical and integral part of clinical management of patients and should be initiated at the point of entry of the patient to hospital (typically the Emergency Department). Standard precautions should always be routinely applied in all areas of health care facilities. Standard precautions include hand hygiene; use of PPE to avoid direct contact with patients' blood, body fluids, secretions (including respiratory secretions) and non-intact skin. Standard precautions also include prevention of needle-stick or sharps injury; safe waste management; cleaning and disinfection of equipment; and cleaning of the environment.

Table 2. How to implement infection prevention and control measures for patients with suspected or confirmed 2019-nCoV infection [14,15]

At triage	Give suspect patient a medical mask and direct patient to separate area, an isolation room if available. Keep at least 1meter distance between suspected patients and other patients. Instruct all patients to cover nose and mouth during coughing or sneezing with tissue or flexed elbow for others. Perform hand hygiene after contact with respiratory secretions
Apply droplet precautions	Droplet precautions prevent large droplet transmission of respiratory viruses. Use a medical mask if working within 1-2 metre s of the patient. Place patients in single rooms, or group together those with the same etiological diagnosis. If an etiological diagnosis is not possible, group patients with similar clinical diagnosis and based on epidemiological risk factors, with a spatial separation. When providing care in close contact with a patient with respiratory symptoms (e.g. coughing or sneezing), use eye protection (face-mask or goggles), because sprays of secretions may occur. Limit patient movement within the institution and ensure that patients wear medical masks when outside their rooms.
Apply contact precautions	Droplet and contact precautions prevent direct or indirect transmission from contact with contaminated surfaces or equipment (i.e. contact with contaminated oxygen tubing/interfaces). Use PPE (medical mask, eye protection, gloves and gown) when entering room and remove PPE when leaving. If possible, use either disposable or dedicated equipment (e.g. stethoscopes, blood pressure cuffs and thermometers). If equipment needs to be shared among patients, clean and disinfect between each patient use. Ensure that health care workers refrain from touching their eyes, nose, and mouth with potentially contaminated gloved or ungloved hands. Avoid contaminating environmental surfaces that are not directly related to patient care (e.g. door handles and light switches). Ensure adequate room ventilation. Avoid movement of patients or transport. Perform hand hygiene.
Apply airborne precautions when performing an aerosol generating procedure	Ensure that healthcare workers performing aerosol-generating procedures **(i.e. open suctioning of respiratory tract, intubation, bronchoscopy, cardiopulmonary resuscitation)** use PPE, including gloves, long-sleeved gowns, eye protection, and fit-tested particulate respirators (N95 or equivalent, or higher level of protection). (The scheduled fit test should not be confused with user seal check before each use.) Whenever possible, use adequately ventilated single rooms when performing aerosol-generating procedures, meaning negative pressure rooms with minimum of 12 air changes per hour or at least 160 litres/second/patient in facilities with natural ventilation. Avoid the presence of unnecessary individuals in the room. Care for the patient in the same type of room after mechanical ventilation commences.

Abbreviations: ARI, acute respiratory infection; PPE, personal protective equipment

3. Early supportive therapy and monitoring

✔ **Give supplemental oxygen therapy immediately to patients with SARI and respiratory distress, hypoxaemia, or shock.**

Remarks: Initiate oxygen therapy at 5 L/min and titrate flow rates to reach target SpO_2 ≥90% in non-pregnant adults and SpO_2 ≥92-95 % in pregnant patients.[12] Children with emergency signs (obstructed or absent breathing, severe respiratory distress, central cyanosis, shock, coma or convulsions) should receive oxygen therapy during resuscitation to target SpO_2 ≥94%; otherwise, the target SpO_2 is ≥90%.[4] All areas where patients with SARI are cared for should be equipped with pulse oximeters, functioning oxygen systems and disposable, single-use, oxygen-delivering interfaces (nasal cannula, simple face mask, and mask with reservoir bag). Use contact precautions when handling contaminated oxygen interfaces of patients with nCoV infection.

✔ **Use conservative fluid management in patients with SARI when there is no evidence of shock.**

Remarks: Patients with SARI should be treated cautiously with intravenous fluids, because aggressive fluid resuscitation may worsen oxygenation, especially in settings where there is limited availability of mechanical ventilation.[16]

✔ **Give empiric antimicrobials to treat all likely pathogens causing SARI. Give antimicrobials within one hour of initial patient assessment for patients with sepsis.**

Remarks: Although the patient may be suspected to have nCoV, administer appropriate empiric antimicrobials within **ONE hour** of identification of sepsis.[17] Empiric antibiotic treatment should be based on the clinical diagnosis (community-acquired pneumonia, health care-associated pneumonia [if infection was acquired in healthcare setting], or sepsis), local epidemiology and susceptibility data, and treatment guidelines. Empiric therapy includes a neuraminidase inhibitor for treatment of influenza when there is local circulation or other risk factors, including travel history or exposure to animal influenza viruses.[18] Empiric therapy should be de-escalated on the basis of microbiology results and clinical judgment.

✘ **Do not routinely give systemic corticosteroids for treatment of viral pneumonia or ARDS outside of clinical trials unless they are indicated for another reason.**

Remarks: A systematic review of observational studies of corticosteroids administered to patients with SARS reported no survival benefit and possible harms (avascular necrosis, psychosis, diabetes, and delayed viral clearance).[19] A systematic review of observational studies in influenza found a higher risk of mortality and secondary infections with corticosteroids; the evidence was judged as very low to low quality due to confounding by indication.[20] A subsequent study that addressed this limitation by adjusting for time-varying confounders found no effect on mortality.[21] Finally, a recent study of patients receiving corticosteroids for MERS used a similar statistical approach and found no effect of corticosteroids on mortality but delayed lower respiratory

tract (LRT) clearance of MERS-CoV.[22] Given lack of effectiveness and possible harm, routine corticosteroids should be avoided unless they are indicated for another reason. See section 6 for the use of corticosteroids in sepsis.

✔ **Closely monitor patients with SARI for signs of clinical deterioration, such as rapidly progressive respiratory failure and sepsis, and apply supportive care interventions immediately.**

Remarks: Application of timely, effective, and safe supportive therapies is the cornerstone of therapy for patients that develop severe manifestations of 2019-nCoV.

✔ **Understand the patient's co-morbid condition(s) to tailor the management of critical illness and appreciate the prognosis. Communicate early with patient and family.**

Remarks: During intensive care management of SARI, determine which chronic therapies should be continued and which therapies should be stopped temporarily. Communicate proactively with patients and families and provide support and prognostic information. Understand the patient's values and preferences regarding life-sustaining interventions.

4. Collection of specimens for laboratory diagnosis

WHO guidance on specimen collection, processing, and laboratory testing, including related biosafety procedures, is available.[23]

✔ **Collect blood cultures for bacteria that cause pneumonia and sepsis, ideally before antimicrobial therapy. DO NOT delay antimicrobial therapy to collect blood cultures.**

✔ **Collect specimens from BOTH the upper respiratory tract (URT; nasopharyngeal and oropharyngeal) AND lower respiratory tract (LRT; expectorated sputum, endotracheal aspirate, or bronchoalveolar lavage) for 2019-nCoV testing by RT-PCR. Clinicians may elect to collect only LRT samples when these are readily available (for example, in mechanically ventilated patients).**

✔ **Serology for diagnostic purposes is recommended only when RT-PCR is not available.[23]**

Remarks: Use appropriate PPE for specimen collection (droplet and contact precautions for URT specimens; airborne precautions for LRT specimens). When collecting URT samples, use viral swabs (sterile Dacron or rayon, not cotton) and viral transport media. Do not sample the nostrils or tonsils. In a patient with suspected novel coronavirus, especially with pneumonia or severe illness, a single URT sample does not exclude the diagnosis, and additional URT and LRT samples are recommended.[23] LRT (vs. URT) samples are more likely to be positive and for a longer period.[23] Clinicians may elect to collect only LRT samples when these are readily available (for example, in mechanically ventilated patients). Sputum induction should be avoided due to increased risk of increasing aerosol transmission.

Remarks: Dual infections with other respiratory viral infections have been found in SARS and MERS cases. At this stage we need detailed microbiologic studies in all suspected cases. Both URT and LRT specimens can tested for other respiratory viruses, such as influenza A and B (including zoonotic influenza A), respiratory syncytial virus, parainfluenza viruses, rhinoviruses, adenoviruses, enteroviruses (e.g. EVD68), human metapneumovirus, and endemic human coronaviruses (i.e. HKU1, OC43, NL63, and 229E). LRT specimens can also be tested for bacterial pathogens, including *Legionella pneumophila*.

✔ **In hospitalized patients with confirmed 2019-nCoV infection, repeat URT and LRT samples should be collected to demonstrate viral clearance. The frequency of specimen collection will depend on local circumstances but should be at least every 2 to 4 days until there are two consecutive negative results (both URT and LRT samples if both are collected) in a clinically recovered patient at least 24 hours apart. If local infection control practice requires two negative results before removal of droplet precautions, specimens may be collected as often as daily.**

5. Management of hypoxemic respiratory failure and ARDS

✔ **Recognize severe hypoxemic respiratory failure when a patient with respiratory distress is failing standard oxygen therapy.**

Remarks: Patients may continue to have increased work of breathing or hypoxemia even when oxygen is delivered via a face mask with reservoir bag (flow rates of 10-15 L/min, which is typically the minimum flow required to maintain bag inflation; FiO_2 0.60-0.95). Hypoxemic respiratory failure in ARDS commonly results from intrapulmonary ventilation-perfusion mismatch or shunt and usually requires mechanical ventilation.

High-flow nasal oxygen (HFNO) or non-invasive ventilation (NIV) should only be used in selected patients with hypoxemic respiratory failure. The risk of treatment failure is high in patients with MERS treated with NIV, and patients treated with either HFNO or NIV should be closely monitored for clinical deterioration.

Remark 1: HFNO systems can deliver 60 L/min of gas flow and FiO_2 up to 1.0; paediatric circuits generally only handle up to 15 L/min, and many children will require an adult circuit to deliver adequate flow. Compared to standard oxygen therapy, HFNO reduces the need for intubation.[24] Patients with hypercapnia (exacerbation of obstructive lung disease, cardiogenic pulmonary oedema), hemodynamic instability, multi-organ failure, or abnormal mental status should generally not receive HFNO, although emerging data suggest that HFNO may be safe in patients with mild-moderate and non-worsening hypercapnia.[25] Patients receiving HFNO should be in a monitored setting and cared for by experienced personnel capable of endotracheal intubation in case the patient acutely deteriorates or does not improve after a short trial (about 1 hr). Evidence-based guidelines on HFNO do not exist, and reports on HFNO in MERS patients are limited.[26]

Remark 2: NIV guidelines make no recommendation on use in hypoxemic respiratory failure (apart from cardiogenic pulmonary oedema and post-operative respiratory failure) or pandemic viral illness (referring to studies of SARS and pandemic influenza).[27] Risks include delayed intubation, large tidal volumes, and injurious transpulmonary pressures. Limited data suggest a high failure rate when MERS patients receive NIV.[28] Patients receiving a trial of NIV should be in a monitored setting and cared for by experienced personnel capable of endotracheal intubation in case the patient acutely deteriorates or does not improve after a short trial (about 1 hr). Patients with hemodynamic instability, multiorgan failure, or abnormal mental status should not receive NIV.

Remark 3: Recent publications suggest that newer HFNO and NIV systems with good interface fitting do not create widespread dispersion of exhaled air and therefore should be associated with low risk of airborne transmission.[29-31]

✔ **Endotracheal intubation should be performed by a trained and experienced provider using airborne precautions.**
Remarks: Patients with ARDS, especially young children or those who are obese or pregnant, may desaturate quickly during intubation. Pre-oxygenate with 100% FiO_2 for 5 minutes, via a face mask with reservoir bag, bag-valve mask, HFNO, or NIV. Rapid sequence intubation is appropriate after an airway assessment that identifies no signs of difficult intubation[32].

The following recommendations in this section pertain to mechanically ventilated patients with ARDS.[17,33] *These focus on adults; consensus-based recommendations for children are available.*[34]

✔ **Implement mechanical ventilation using lower tidal volumes (4–8 ml/kg predicted body weight, PBW) and lower inspiratory pressures (plateau pressure <30 cmH_2O).**
Remarks: This is a strong recommendation from a clinical guideline for patients with ARDS,[33] and is suggested for patients with sepsis-induced respiratory failure who do not meet ARDS criteria.[17] The initial tidal volume is 6 ml/kg PBW; tidal volume up to 8 ml/kg PBW is allowed if undesirable side effects occur (e.g. dyssynchrony, pH <7.15). Hypercapnia is permitted if meeting the pH goal of 7.30-7.45. Ventilator protocols are available.[35] The use of deep sedation may be required to control respiratory drive and achieve tidal volume targets. Although high driving pressure (plateau pressure–PEEP) may more accurately predict increased mortality in ARDS compared to high tidal volume or plateau pressure,[36] RCTs of ventilation strategies that target driving pressure are not currently available.

✔ **In patients with severe ARDS, prone ventilation for >12 hours per day is recommended.**
Remarks: Application of prone ventilation is strongly recommended for adult and paediatric patients with severe ARDS[33] but requires sufficient human resources and expertise to be performed safely.[37,38]

✔ **Use a conservative fluid management strategy for ARDS patients without tissue hypoperfusion.**
Remarks: This is a strong guideline recommendation;[17] the main effect is to shorten the duration of ventilation. See reference [39] for details of a sample protocol.

◐ **In patients with moderate or severe ARDS, higher PEEP instead of lower PEEP is suggested.**
Remarks: PEEP titration requires consideration of benefits (reducing atelectrauma and improving alveolar recruitment) vs. risks (end-inspiratory overdistension leading to lung injury and higher pulmonary vascular resistance). Tables are available to guide PEEP titration based on the FiO_2 required to maintain SpO_2.[35] A related intervention of recruitment manoeuvres (RMs) is delivered as episodic periods of high continuous positive airway pressure [30–40 cm H_2O], progressive incremental increases in PEEP with constant driving pressure, or high driving pressure; considerations of benefits vs. risks are similar. Higher PEEP and RMs were both conditionally recommended in a clinical practice guideline.[33] For PEEP, the guideline considered an individual patient data meta-analysis[40] of 3 RCTs. However, a subsequent RCT of high PEEP and prolonged high-pressure RMs showed harm, suggesting that the protocol in this RCT should be avoided.[41] Monitoring of patients to identify those who respond to the initial application of higher PEEP or a different RM protocol, and stopping these interventions in non-responders, is suggested.[42]

◐ **In patients with moderate-severe ARDS (PaO_2/FiO_2 <150), neuromuscular blockade by continuous infusion should not be routinely used.**
Remarks: One trial found that this strategy improved survival in patients with severe ARDS (PaO_2/FiO_2 <150) without causing significant weakness,[43] but results of a recent larger trial found that use of neuromuscular blockage with high PEEP strategy was not associated with survival when compared to a light sedation strategy without neuromuscular blockade[44]. Continuous neuromuscular blockade may still be considered in patients with ARDS in certain situations: ventilator dyssnchony despite sedation, such that tidal volume limitation cannot be reliably achieved; or refractory hypoxemia or hypercapnia.

◐ **In settings with access to expertise in extracorporeal life support (ECLS), consider referral of patients with refractory hypoxemia despite lung protective ventilation.**
Remarks: A recent guideline made no recommendation about ECLS in patients with ARDS.[33] Since then, an RCT of ECLS for patients with ARDS was stopped early and found no statistically significant difference in the primary outcome of 60-day mortality between ECLS and standard medical management (including prone positioning and neuromuscular blockade).[45] However, ECLS was associated with a reduced risk of the composite outcome of mortality and crossover to ECLS,[45] and a *post hoc* Bayesian analysis of this RCT showed that ECLS is very likely to reduce mortality across a range of prior assumptions.[46] In patients with MERS-CoV infection, ECLS vs. conventional treatment was associated with reduced mortality in a cohort study.[47] ECLS should

only be offered in expert centres with a sufficient case volume to maintain expertise and that can apply the IPC measures required for 2019-nCoV patients.[48]

Avoid disconnecting the patient from the ventilator, which results in loss of PEEP and atelectasis. Use in-line catheters for airway suctioning and clamp endotracheal tube when disconnection is required (for example, transfer to a transport ventilator).

6. Management of septic shock

Recognize septic shock in adults when infection is suspected or confirmed AND vasopressors are needed to maintain mean arterial pressure (MAP) ≥65 mmHg AND lactate is ≥2 mmol/L, in absence of hypovolemia.
Recognize septic shock in children with any hypotension (systolic blood pressure [SBP] <5th centile or >2 SD below normal for age) or 2-3 of the following: altered mental state; tachycardia or bradycardia (HR <90 bpm or >160 bpm in infants and HR <70 bpm or >150 bpm in children); prolonged capillary refill (>2 sec) or warm vasodilation with bounding pulses; tachypnea; mottled skin or petechial or purpuric rash; increased lactate; oliguria; hyperthermia or hypothermia.

Remarks: In the absence of a lactate measurement, use MAP and clinical signs of perfusion to define shock. Standard care includes early recognition and the following treatments within 1 hour of recognition: antimicrobial therapy and fluid loading and vasopressors for hypotension.[49] The use of central venous and arterial catheters should be based on resource availability and individual patient needs. Detailed guidelines are available for the management of septic shock in adults[17] and children.[2,3,12]

In resuscitation from septic shock in adults, give at least 30 ml/kg of isotonic crystalloid in adults in the first 3 hours. In resuscitation from septic shock in children in well-resourced settings, give 20 ml/kg as a rapid bolus and up to 40-60 ml/kg in the first 1 hr.

Do not use hypotonic crystalloids, starches, or gelatins for resuscitation.

Fluid resuscitation may lead to volume overload, including respiratory failure. If there is no response to fluid loading and signs of volume overload appear (for example, jugular venous distension, crackles on lung auscultation, pulmonary oedema on imaging, or hepatomegaly in children), then reduce or discontinue fluid administration. This step is particularly important where mechanical ventilation is not available. Alternate fluid regimens are suggested when caring for children in resource-limited settings[50]

Remarks: Crystalloids include normal saline and Ringer's lactate. Determine need for additional fluid boluses (250-1000 ml in adults or 10-20 ml/kg in children) based on clinical response and improvement of perfusion targets. Perfusion targets include MAP (>65 mmHg or age-appropriate targets in children), urine output (>0.5 ml/kg/hr in adults, 1 ml/kg/hr in children), and improvement of skin mottling, capillary refill, level of consciousness, and lactate. Consider dynamic indices of volume responsiveness to guide volume administration beyond initial resuscitation based on local resources and experience.[17] These indices include passive leg raises, fluid challenges with serial stroke volume measurements, or variations in systolic pressure, pulse pressure, inferior vena cava size, or stroke volume in response to changes in intrathoracic pressure during mechanical ventilation.

Starches are associated with an increased risk of death and acute kidney injury vs. crystalloids. The effects of gelatins are less clear, but they are more expensive than cyrstalloids.[51,52] Hypotonic (vs. isotonic) solutions are less effective at increasing intravascular volume. Surviving Sepsis also suggests albumin for resuscitation when patients require substantial amounts of crystalloids, but this conditional recommendation is based on low-quality evidence.[17]

Administer vasopressors when shock persists during or after fluid resuscitation. The initial blood pressure target is MAP ≥65 mmHg in adults and age-appropriate targets in children.

If central venous catheters are not available, vasopressors can be given through a peripheral IV, but use a large vein and closely monitor for signs of extravasation and local tissue necrosis. If extravasation occurs, stop infusion. Vasopressors can also be administered through intraosseous needles.

If signs of poor perfusion and cardiac dysfunction persist despite achieving MAP target with fluids and vasopressors, consider an inotrope such as dobutamine.

Remarks: Vasopressors (i.e. norepinephrine, epinephrine, vasopressin, and dopamine) are most safely given through a central venous catheter at a strictly controlled rate, but it is also possible to safely administer them via peripheral vein[53] and intraosseous needle. Monitor blood pressure frequently and titrate the vasopressor to the minimum dose necessary to maintain perfusion and prevent side effects. Norepinephrine is considered first-line in adult patients; epinephrine or vasopressin can be added to achieve the MAP target. Because of the risk of tachyarrhythmia, reserve dopamine for selected patients with low risk of tachyarrhythmia or those with bradycardia. In children with cold shock (more common), epinephrine is considered first-line, while norepinephrine is used in patients with warm shock (less common).

No RCTs have compared dobutamine to placebo for clinical outcomes.[17]

7. Prevention of complications

Implement the following interventions (Table 3) to prevent complications associated with critical illness. These interventions are based on Surviving Sepsis[17] or other guidelines,[54-57] and are generally limited to feasible recommendations based on high quality evidence.

Table 3. Prevention of complications

Anticipated Outcome	Interventions
Reduce days of invasive mechanical ventilation	• Use weaning protocols that include daily assessment for readiness to breathe spontaneously • Minimize continuous or intermittent sedation, targeting specific titration endpoints (light sedation unless contraindicated) or with daily interruption of continuous sedative infusions
Reduce incidence of ventilator-associated pneumonia	• Oral intubation is preferable to nasal intubation in adolescents and adults • Keep patient in semi-recumbent position (head of bed elevation 30-45°) • Use a closed suctioning system; periodically drain and discard condensate in tubing • Use a new ventilator circuit for each patient; once patient is ventilated, change circuit if it is soiled or damaged but not routinely • Change heat moisture exchanger when it malfunctions, when soiled, or every 5–7 days
Reduce incidence of venous thromboembolism	• Use pharmacological prophylaxis (low molecular-weight heparin [preferred if available] or heparin 5000 units subcutaneously twice daily) in adolescents and adults without contraindications. For those with contraindications, use mechanical prophylaxis (intermittent pneumatic compression devices).
Reduce incidence of catheter-related bloodstream infection	• Use a checklist with completion verified by a real-time observer as reminder of each step needed for sterile insertion and as a daily reminder to remove catheter if no longer needed
Reduce incidence of pressure ulcers	• Turn patient every two hours
Reduce incidence of stress ulcers and gastrointestinal bleeding	• Give early enteral nutrition (within 24–48 hours of admission) • Administer histamine-2 receptor blockers or proton-pump inhibitors in patients with risk factors for GI bleeding. Risk factors for gastrointestinal bleeding include mechanical ventilation for ≥48 hours, coagulopathy, renal replacement therapy, liver disease, multiple comorbidities, and higher organ failure score
Reduce incidence of ICU-related weakness	• Actively mobilize the patient early in the course of illness when safe to do so

8. Specific anti-Novel-CoV treatments and clinical research

There is no current evidence from RCTs to recommend any specific anti-nCoV treatment for patients with suspected or confirmed 2019-nCoV infection.

Unlicensed treatments should be administered only in the context of ethically-approved clinical trials or the Monitored Emergency Use of Unregistered Interventions Framework (MEURI), with strict monitoring.
https://www.who.int/ethics/publications/infectious-disease-outbreaks/en/

Clinical characterization protocols are available, at the WHO 2019 nCoV website:
https://www.who.int/emergencies/diseases/novel-coronavirus-2019. WHO has established Global 2019-nCoV Clinical Data Platform, for member countries to contribute. Contact EDCARN@who.int for additional questions.

9. Special considerations for pregnant patients

Pregnant women with suspected or confirmed 2019-nCoV infection should be treated with supportive therapies as described above, taking into account the physiologic adaptations of pregnancy.

The use of investigational therapeutic agents outside of a research study should be guided by individual risk-benefit analysis based on potential benefit for mother and safety to fetus, with consultation from an obstetric specialist and ethics committee.

Emergency delivery and pregnancy termination decisions are challenging and based on many factors: gestational age, maternal condition, and fetal stability. Consultations with obstetric, neonatal, and intensive care specialists (depending on the condition of the mother) are essential.

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References

1. Rosjo H, Varpula M, Hagve TA, et al. Circulating high sensitivity troponin T in severe sepsis and septic shock: distribution, associated factors, and relation to outcome. Intensive Care Med 2011;37:77-85.
2. Pocket book of hospital care for children: Guidelines for the management of common childhood illnesses [http://www.who.int/maternal_child_adolescent/documents/child_hospital_care/en/]. 2nd ed. Geneva: WHO; 2013.
3. Gunnerson KJ, Shaw AD, Chawla LS, et al. TIMP2*IGFBP7 biomarker panel accurately predicts acute kidney injury in high-risk surgical patients. J Trauma Acute Care Surg 2016;80:243-9.
4. Oxygen therapy for children: a manual for health workers [http://www.who.int/maternal_child_adolescent/documents/child-oxygen-therapy/en/]. Geneva: WHO; 2016.
5. Global Epidemiological Surveillance Standards for Influenza [http://www.who.int/influenza/resources/documents/influenza_surveillance_manual/en/]. Geneva: WHO; 2014.
6. Shalhoub S, Farahat F, Al-Jiffri A, et al. IFN-alpha2a or IFN-beta1a in combination with ribavirin to treat Middle East respiratory syndrome coronavirus pneumonia: a retrospective study. J Antimicrob Chemother 2015;70:2129-32.
7. ARDS Definition Task Force, Ranieri VM, Rubenfeld GD, et al. Acute respiratory distress syndrome: the Berlin Definition. JAMA 2012;307:2526-33.
8. Riviello ED, Kiviri W, Twagirumugabe T, et al. Hospital Incidence and Outcomes of the Acute Respiratory Distress Syndrome Using the Kigali Modification of the Berlin Definition. Am J Respir Crit Care Med 2016;193:52-9.
9. Khemani RG, Smith LS, Zimmerman JJ, Erickson S, Pediatric Acute Lung Injury Consensus Conference Group. Pediatric acute respiratory distress syndrome: definition, incidence, and epidemiology: proceedings from the Pediatric Acute Lung Injury Consensus Conference. Pediatr Crit Care Med 2015;16:S23-40.
10. Singer M, Deutschman CS, Seymour CW, et al. The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3). JAMA 2016;315:801-10.
11. Goldstein B, Giroir B, Randolph A, International Consensus Conference on Pediatric Sepsis. International pediatric sepsis consensus conference: definitions for sepsis and organ dysfunction in pediatrics. Pediatr Crit Care Med 2005;6:2-8.
12. Davis AL, Carcillo JA, Aneja RK, et al. American College of Critical Care Medicine Clinical Practice Parameters for Hemodynamic Support of Pediatric and Neonatal Septic Shock. Crit Care Med 2017;45:1061-93.
13. Vincent JL, Moreno R, Takala J, et al. The SOFA (Sepsis-related Organ Failure Assessment) score to describe organ dysfunction/failure. On behalf of the Working Group on Sepsis-Related Problems of the European Society of Intensive Care Medicine. Intensive Care Med 1996;22:707-10.
14. Infection prevention and control of epidemic-and pandemic prone acute respiratory infections in health care [http://www.who.int/csr/bioriskreduction/infection_control/publication/en/]. Geneva: WHO; 2014.
15. Infection prevention and control during health care for probable or confirmed cases of Middle East respiratory syndrome coronavirus (MERS-CoV) infection: Interim guidance. Geneva: WHO; 2015.
16. Schultz MJ, Dunser MW, Dondorp AM, et al. Current challenges in the management of sepsis in ICUs in resource-poor settings and suggestions for the future. Intensive Care Med 2017;43:612-24.
17. Rhodes A, Evans LE, Alhazzani W, et al. Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock: 2016. Intensive Care Med 2017;43:304-77.
18. Clinical management of human infection with pandemic (H1N1) 2009: revised guidance [http://www.who.int/csr/resources/publications/swineflu/clinical_management/en/]. Geneva: WHO; 2009.
19. Stockman LJ, Bellamy R, Garner P. SARS: systematic review of treatment effects. PLoS Med 2006;3:e343.
20. Rodrigo C, Leonardi-Bee J, Nguyen-Van-Tam J, Lim WS. Corticosteroids as adjunctive therapy in the treatment of influenza. Cochrane Database Syst Rev 2016;3:CD010406.
21. Delaney JW, Pinto R, Long J, et al. The influence of corticosteroid treatment on the outcome of influenza A(H1N1pdm09)-related critical illness. Crit Care 2016;20:75.
22. Arabi YM, Mandourah Y, Al-Hameed F, et al. Corticosteroid Therapy for Critically Ill Patients with Middle East Respiratory Syndrome. Am J Respir Crit Care Med 2018;197:757-67.
23. Laboratory testing for Middle East Respiratory Syndrome Coronavirus: Interim guidance [http://www.who.int/csr/disease/coronavirus_infections/mers-laboratory-testing/en/]. Geneva: WHO; 2018.
24. Ou X, Hua Y, Liu J, Gong C, Zhao W. Effect of high-flow nasal cannula oxygen therapy in adults with acute hypoxemic respiratory failure: a meta-analysis of randomized controlled trials. CMAJ 2017;189:E260-E7.
25. Lee MK, Choi J, Park B, et al. High flow nasal cannulae oxygen therapy in acute-moderate hypercapnic respiratory failure. Clin Respir J 2018;12:2046-56.
26. Luo Y, Ou R, Ling Y, Qin T. The therapeutic effect of high flow nasal cannula oxygen therapy for the first imported case of Middle East respiratory syndrome to China [Chinese]. Zhonghua Wei Zhong Bing Ji Jiu Yi Xue 2015;27:841-4.

27. Rochwerg B, Brochard L, Elliott MW, et al. Official ERS/ATS clinical practice guidelines: noninvasive ventilation for acute respiratory failure. Eur Respir J 2017;50.
28. Arabi YM, Arifi AA, Balkhy HH, et al. Clinical course and outcomes of critically ill patients with Middle East respiratory syndrome coronavirus infection. Ann Intern Med 2014;160:389-97.
29. Leung CCH, Joynt GM, Gomersall CD, et al. Comparison of high-flow nasal cannula versus oxygen face mask for environmental bacterial contamination in critically ill pneumonia patients: a randomized controlled crossover trial. J Hosp Infect 2019;101:84-7.
30. Hui DS, Chow BK, Lo T, et al. Exhaled air dispersion during high-flow nasal cannula therapy versus CPAP via different masks. Eur Respir J 2019;53.
31. Hui DS, Chow BK, Lo T, et al. Exhaled air dispersion during noninvasive ventilation via helmets and a total facemask. Chest 2015;147:1336-43.
32. Detsky ME, Jivraj N, Adhikari NK, et al. Will This Patient Be Difficult to Intubate?: The Rational Clinical Examination Systematic Review. JAMA 2019;321:493-503.
33. Fan E, Del Sorbo L, Goligher EC, et al. An Official American Thoracic Society/European Society of Intensive Care Medicine/Society of Critical Care Medicine Clinical Practice Guideline: Mechanical Ventilation in Adult Patients with Acute Respiratory Distress Syndrome. Am J Respir Crit Care Med 2017;195:1253-63.
34. Rimensberger PC, Cheifetz IM, Pediatric Acute Lung Injury Consensus Conference G. Ventilatory support in children with pediatric acute respiratory distress syndrome: proceedings from the Pediatric Acute Lung Injury Consensus Conference. Pediatr Crit Care Med 2015;16:S51-60.
35. ARDS Network Tools. 2014. (Accessed 25 July, 2018, at http://www.ardsnet.org/tools.shtml.)
36. Amato MB, Meade MO, Slutsky AS, et al. Driving pressure and survival in the acute respiratory distress syndrome. N Engl J Med 2015;372:747-55.
37. Messerole E, Peine P, Wittkopp S, Marini JJ, Albert RK. The pragmatics of prone positioning. Am J Respir Crit Care Med 2002;165:1359-63.
38. Guerin C, Reignier J, Richard JC, et al. Prone positioning in severe acute respiratory distress syndrome. N Engl J Med 2013;368:2159-68.
39. National Heart L, and Blood Institute Acute Respiratory Distress Syndrome Clinical Trials Network,, Wiedemann HP, Wheeler AP, et al. Comparison of two fluid-management strategies in acute lung injury. N Engl J Med 2006;354:2564-75.
40. Briel M, Meade M, Mercat A, et al. Higher vs lower positive end-expiratory pressure in patients with acute lung injury and acute respiratory distress syndrome: systematic review and meta-analysis. JAMA 2010;303:865-73.
41. Writing Group for the Alveolar Recruitment for Acute Respiratory Distress Syndrome Trial Investigators, Cavalcanti AB, Suzumura EA, et al. Effect of Lung Recruitment and Titrated Positive End-Expiratory Pressure (PEEP) vs Low PEEP on Mortality in Patients With Acute Respiratory Distress Syndrome: A Randomized Clinical Trial. JAMA 2017;318:1335-45.
42. Goligher EC, Kavanagh BP, Rubenfeld GD, et al. Oxygenation response to positive end-expiratory pressure predicts mortality in acute respiratory distress syndrome. A secondary analysis of the LOVS and ExPress trials. Am J Respir Crit Care Med 2014;190:70-6.
43. Papazian L, Forel JM, Gacouin A, et al. Neuromuscular blockers in early acute respiratory distress syndrome. N Engl J Med 2010;363:1107-16.
44. National Heart L, Blood Institute PCTN, Moss M, et al. Early Neuromuscular Blockade in the Acute Respiratory Distress Syndrome. N Engl J Med 2019;380:1997-2008.
45. Combes A, Hajage D, Capellier G, et al. Extracorporeal Membrane Oxygenation for Severe Acute Respiratory Distress Syndrome. N Engl J Med 2018;378:1965-75.
46. Goligher EC, Tomlinson G, Hajage D, et al. Extracorporeal Membrane Oxygenation for Severe Acute Respiratory Distress Syndrome and Posterior Probability of Mortality Benefit in a Post Hoc Bayesian Analysis of a Randomized Clinical Trial. JAMA 2018;320:2251-9.
47. Alshahrani MS, Sindi A, Alshamsi F, et al. Extracorporeal membrane oxygenation for severe Middle East respiratory syndrome coronavirus. Ann Intensive Care 2018;8:3.
48. Combes A, Brodie D, Bartlett R, et al. Position paper for the organization of extracorporeal membrane oxygenation programs for acute respiratory failure in adult patients. Am J Respir Crit Care Med 2014;190:488-96.
49. Levy MM, Evans LE, Rhodes A. The Surviving Sepsis Campaign Bundle: 2018 update. Intensive Care Med 2018;44:925-8.
50. Lamontagne F, Meade MO, Hebert PC, et al. Higher versus lower blood pressure targets for vasopressor therapy in shock: a multicentre pilot randomized controlled trial. Intensive Care Med 2016;42:542-50.
51. Rochwerg B, Alhazzani W, Gibson A, et al. Fluid type and the use of renal replacement therapy in sepsis: a systematic review and network meta-analysis. Intensive Care Med 2015;41:1561-71.
52. Rochwerg B, Alhazzani W, Sindi A, et al. Fluid resuscitation in sepsis: a systematic review and network meta-analysis. Ann Intern Med 2014;161:347-55.
53. Loubani OM, Green RS. A systematic review of extravasation and local tissue injury from administration of vasopressors through peripheral intravenous catheters and central venous catheters. J Crit Care 2015;30:653 e9-17.
54. Schmidt GA, Girard TD, Kress JP, et al. Official Executive Summary of an American Thoracic Society/American College of Chest Physicians Clinical Practice Guideline: Liberation from Mechanical Ventilation in Critically Ill Adults. Am J Respir Crit Care Med 2017;195:115-9.
55. Muscedere J, Dodek P, Keenan S, et al. Comprehensive evidence-based clinical practice guidelines for ventilator-associated pneumonia: prevention. J Crit Care 2008;23:126-37.
56. Klompas M, Branson R, Eichenwald EC, et al. Strategies to prevent ventilator-associated pneumonia in acute care hospitals: 2014 update. Infect Control Hosp Epidemiol 2014;35:915-36.
57. Marschall J, Mermel LA, Fakih M, et al. Strategies to prevent central line-associated bloodstream infections in acute care hospitals: 2014 update. Infect Control Hosp Epidemiol 2014;35:753-71.

Annex C. Decision Tool for Novel Coronavirus Assessment for Bureau of Quarantine and Hospitals
(Version as of January 30, 2020)

Fever ≥38°C (current fever or with history of fever)	Respiratory Infection (cough AND/OR colds)	Travel History for the past 14 days in China	History of Exposure[1]	Case Category/ Intervention
+	+	+	+	**Category: Patient Under Investigation (PUI)** **Bureau of Quarantine (BoQ)** • Gives mask and isolate PUI • Collects and evaluates the BoQ Health Declaration Card • Endorses patient for admission in a hospital. • Arranges transportation of PUI to hospital **Hospitals** • Completes the case investigation form (CIF) • Trained hospital staff collects specimens (nasopharyngeal swab [NPS] and oral pharyngeal swab [OPS]) and sends to RITM. (NPS/OPS must be collected upon admission and after 24 to 48 hours) • Coordinates with RESU for reporting and transport of specimens • Manages PUI accordingly
+	+	+	-	
+	+	-	+	
+	-	+	+	
-	+	+	+	
+	-	+	-	
-	+	+	-	
+	-	-	+	
-	+	-	+	
-	-	+	+	**Category: Person under Monitoring*** **Bureau of Quarantine** • Collects and evaluates the BoQ Health Declaration Card • Advises person to go on self-quarantine for 14 days, monitor body temperature daily, and observe any signs and symptoms of respiratory infection • If symptoms worsen, immediately notify the nearest hospital for consultation and provide travel history **Centers for Health Development** • Monitor strictly those who are self-quarantined *Anyone who came from other parts of the world with confirmed 2019-nCoV ARD infection except China, has no history of exposure, but with fever and/or cough, is considered **Person under Monitoring** and is advised to go on self-quarantine for 14 days
-	-	+	-	
-	-	-	+	

[1] History of exposure Include:
a. close contact who took care, handled specimens and/or lived with a confirmed case of 2019-nCoV infection; or
- Close contact is defined as:
  - o Health care associated exposure, including providing direct care for nCoV patients, working with health care workers infected with novel coronavirus, visiting patients or staying in the same close environment as a nCoV patient
  - o Working together in close proximity or sharing the same classroom environment with a nCoV patient
  - o Traveling together with a nCoV patient in any kind of conveyance
  - o Living in the same household as a nCoV patient

b. visiting/working in a live animal market in China
c. direct contact with animals in China with circulating 2019-nCoV in human and animals

Annex D. Interim Case Reporting Form for 2019 Novel Coronavirus (2019-nCoV) of Confirmed And Probable Cases

World Health Organization

WHO Case ID (International): _____

Interim case reporting form for 2019 Novel Coronavirus (2019-nCoV) of confirmed and probable cases

WHO Minimum Data Set Report Form

Date of reporting to national health authority: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Reporting institution: _____

Reporting country: _____

Case classification: ◻ Confirmed ◻ Probable

Detected at point of entry ◻ No ◻ Yes ◻ Unknown If yes, date [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Section 1: Patient information

Unique Case Identifier (used in country): _____

Date of Birth: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] or estimated age: [__][__][__] in years

if < 1 year old, [__][__] in months or if < 1 month, [__][__] in days

Sex at birth: ◻ Male ◻ Female

Place where the case was diagnosed: Country: _____

Admin Level 1 (province): _____ Admin Level 2 (district): _____

Patient usual place of residency: Country: _____

Admin Level 1 (province): _____ Admin Level 2 (district): _____

Section 2: Clinical information

Patient clinical course

Date of onset of symptoms: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] ◻ Asymptomatic ◻ Unknown

Admission to hospital: ◻ No ◻ Yes ◻ Unknown

First date of admission to hospital: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Name of hospital: _____

Date of isolation: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Was the patient ventilated: ◻ No ◻ Yes ◻ Unknown

Health status (circle) at time of reporting: recovered / not recovered / death / unknown

Date of death, if applicable: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Patient symptoms (check all reported symptoms):

◻ History of fever / chills
◻ General weakness
◻ Cough
◻ Sore throat
◻ Runny nose
◻ Shortness of breath
◻ Diarrhoea
◻ Nausea/vomiting
◻ Headache
◻ Irritability/Confusion
◻ Pain (check all that apply)
( ) Muscular ( ) Chest
( ) Abdominal ( ) Joint
◻ Other, specify _____

Patient signs:

Temperature: [__][__][__] ◻°C / ◻ F

Check all observed signs:

◻ Pharyngea exudate
◻ Conjunctival injection
◻ Seizure
◻ Coma
◻ Dyspnea / tachypnea
◻ Abnormal lung auscultation
◻ Abnormal lung X-Ray findings
◻ Other, specify: _____

Underlying conditions and comorbidity (check all that apply):

- ◻ Pregnancy (trimester: _____)
- ◻ Post-partum (< 6 weeks)
- ◻ Cardiovascular disease, including hypertension
- ◻ Immunodeficiency, including HIV
- ◻ Diabetes
- ◻ Renal disease
- ◻ Liver disease
- ◻ Chronic lung disease
- ◻ Chronic neurological or neuromuscular disease
- ◻ Malignancy
- ◻ Other, specify: _____

Section 3: Exposure and travel information in the 14 days prior to symptom onset (prior to reporting if asymptomatic)

Occupation: (tick any that apply)

◻ Student ◻ Health care worker ◻ Other, specify: _____

◻ Working with animals ◻ Health laboratory worker

Has the patient **travelled** in the 14 days prior to symptom onset? ◻ No ◻ Yes ◻ Unknown

If yes, please specify the places the patient travelled:

	Country	City
1.	_____	_____
2.	_____	_____
3.	_____	_____

Has the patient **visited any health care facility(ies)** in the 14 days prior to symptom onset? ◻ No ◻ Yes ◻ Unknown

Has the patient had **close contact**[1] with a person with acute respiratory infection in the 14 days prior to symptom onset?

◻ No ◻ Yes ◻ Unknown

If yes, contact setting (check all that apply):

◻ Health care setting ◻ Family setting ◻ Work place ◻ Unknown ◻ Other, specify: _____

Has the patient **had contact with a probable or confirmed case** in the 14 days prior to symptom onset? :

◻ No ◻ Yes ◻ Unknown

If yes, please list unique case identifiers of all probable or confirmed cases:

Case 1 identifier. _____ Case 2 identifier. _____ Case 3 identifier. _____

If yes, contact setting (check all that apply):

◻ Health care setting ◻ Family setting ◻ Work place ◻ Unknown ◻ Other, specify: _____

If yes, location/city/country for exposure: _____

Have you visited any **live animal markets** in the 14 days prior to symptom onset? ◻ No ◻ Yes ◻ Unknown

If yes, location/city/country for exposure: _____

Section 4: Laboratory Information

Name of confirming laboratory: : _____

Please specify which assay was used: _____ Sequencing done?: ◻ Yes ◻ No ◻ Unknown

Date of laboratory confirmation: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

[1] Close contact' is defined as: 1. Health care associated exposure, including providing direct care for nCoV patients, working with health care workers infected with novel coronavirus, visiting patients or staying in the same close environment of a nCoV patient. 2. Working together in close proximity or sharing the same classroom environment with a with nCoV patient. 3. Traveling together with nCoV patient in any kind of conveyance. 4. Living in the same household as a nCoV patient

ANNEX B

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

February 4, 2020

DEPARTMENT MEMORANDUM
No. 2020 - 0062

TO: **ALL UNDERSECRETARIES AND ASSISTANT SECRETARIES; MINISTER OF HEALTH – BANGSAMORO AUTONOMOUS REGION IN MUSLIM MINDANAO (MOH-BARMM); CENTERS FOR HEALTH DEVELOPMENT (CHD), BUREAU AND SERVICE DIRECTORS; EXECUTIVE DIRECTORS OF SPECIALTY HOSPITALS; CHIEFS OF MEDICAL CENTERS, HOSPITALS AND SANITARIA; AND OTHERS CONCERNED**

SUBJECT: **Guidelines on the Standards of Airborne Infection Isolation Room and Conversion of Private Rooms and/or Wards into Temporary Isolation Rooms for the Management of Patients Under Investigation (PUI) for 2019 Novel Coronavirus (nCoV)**

In response to the current or potential influx of Patients Under Investigation (PUI) for 2019 Novel Coronavirus (nCoV) in our health facilities, all DOH Hospitals are hereby urged to comply with the patient placement guidelines and isolation standards adopted from the CDC Guidelines and Standards for Transmission-based Precautions. This shall facilitate the management of PUIs and prevent the transmission of the virus within the health facility.

I. For health facilities with Airborne Infection Isolation Room (AIIR), the following standards shall be followed:

A. Isolation of Patients Under Investigation for nCoV Patients

1. Place patient with known or suspected nCoV
2. Airborne Infection Isolation Room (AIIR).
3. While transfer to AIIR or discharge from the facility is pending, put face mask on the patient and isolate in an examination room with the door closed. The patient must not be placed in any room where room exhaust is re-circulated within the building without high-efficiency particulate air (HEPA) filtration.
4. Follow CDC guidelines on placement of patient with known or suspected nCoV infection and adhere to standard, contact, and airborne precautions (ANNEX A).

B. Standards of Airborne Infection Isolation Room (AIIR)

1. AIIR must be single-occupancy rooms with negative pressure relative to the surrounding areas.
2. There must be at least six (6) air changes per hour, or twelve (12) air changes per hour for newly constructed or renovated rooms.

3. Air exhaust should be directed away from people and air intakes. If this is not possible, air must be filtered through a HEPA filter before recirculation.
4. Doors must be kept closed except when entering or leaving the room. Minimize unnecessary entry and exit.
5. Air pressure must be monitored daily with visual indicators (e.g smoke tubes, flutter strips), regardless of the presence of differential pressure sensing devices (e.g. manometers).
6. For the standard floor plan for AIIR, refer to ANNEX B.

II. For facilities with limited Airborne Infection Isolation Rooms, private rooms may be utilized for the management of PUIs.

A. Conversion of Single Private Room

For the conversion of private rooms to isolation rooms, the following guidelines must be followed:

1. Use private rooms at the end of the hallway for conversion into a temporary isolation room. It must be away from the stairs and nurses' station.
2. Keep doors closed except when entering or leaving the room. Entry and exit should be minimized.
3. Keep the windows in the converted isolation rooms open regardless of use and non-use of air conditioning. Windows connecting to hallways should not be opened.
4. The use of air conditioning in the isolation room is allowed provided it is not part of the general air conditioning system of the facility.
5. Use temporary portable solutions, such as exhaust fans or unidirectional fans, to create a negative pressure environment in the converted area. Discharge air directly outside, away from people and air intakes, or through HEPA filters before introducing to other air spaces.
6. All healthcare personnel shall strictly adhere to hand hygiene following the World Health Organization's *Multimodal Hand Hygiene Strategy: 5 Moments of Hand Hygiene*.
7. Place wall-mounted alcohol-based hand rubs at point of care and outside the isolation room.
8. Medical supplies needed for patient care shall be made readily available at point of care.
9. Ensure that the relatives or carers of minors and elderly patients are provided with Personal Protective Equipment (PPEs). Instructions on the appropriate use and disposal of PPEs must be provided.
10. Refer to ANNEX C for the Proposed Floor Plan for Converted Private Room. If access to a lavatory in the ante room is not feasible, wall mounted alcohol-based hand rubs are recommended.

B. Conversion of Ward

Wards may also be utilized for the management of PUIs. For the conversion of wards into isolation rooms, the following guidelines must be followed:

1. Follow the same guidelines for conversion of private rooms.
2. Place cohorted PUIs in a converted ward room provided that they have the same test results. Do not include patients with pending confirmatory test results in the cohort.

3. General ward rooms must have adequate ventilation with at least 60 L/s of air flow per patient.
4. All patient beds should be placed at least three (3) feet apart with a curtain separator for privacy.

III. Exclusive Use of Converted Private Rooms and Wards

Private rooms and wards converted into isolation rooms must not be used for the management and treatment of patients other than PUIs until after appropriate environmental cleaning and disinfection procedures are undertaken.

IV. Additional Information on Isolation Rooms

Additional reference materials on establishment and types of isolation rooms are listed on ANNEX D.

For guidance and strict compliance.

By Authority of the Secretary of Health:

LILIBETH C. DAVID, MD, MPH, MPM, CESO I
Undersecretary of Health
Health Facilities Infrastructure and Development Team

ANNEX A

CDC STANDARD, CONTACT, AND AIRBORNE INFECTION PRECAUTIONS FOR PATIENT WITH KNOWN OR SUSPECTED 2019-nCoV

(Source: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html)

1. Once in an Airborne Infection Isolation Room (AIIR), the patient's facemask may be removed. Transport and movement of the patient outside of the AIIR must be limited to medically-essential purposes. When not in an AIIR (e.g. during transport), patients must wear a facemask to contain secretions.
2. Personnel entering the room must use PPEs, including respiratory protection (i.e. fit-tested disposable N95 mask).
3. Only essential personnel must enter the room. Staffing policies must be strictly observed to minimize the number of healthcare professionals (HCP) who enter the room.
4. Facilities must take precautions to minimize the risk of transmission and exposure to other patients and other HCP.
5. Facilities must keep a log of all persons who provide care and enter the room or care areas of these patients.
6. Dedicated or disposable noncritical patient-care equipment must be used (e.g., blood pressure cuffs). If equipment will be used for more than one patient, clean and disinfect such equipment before use on another patient according to manufacturer's instructions.
7. HCP entering the room after a patient vacates the room must use respiratory protection. Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles. Currently, there is no data on how long 2019-nCoV remains infectious in the air. In the interim, apply a similar time period before entering the room without respiratory protection as used for pathogens spread by the airborne route (e.g., measles, tuberculosis). In addition, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.
8. HCP must perform hand hygiene before and after contacts with patients, potentially infectious material and PPE, including gloves.
9. Healthcare facilities must ensure that hand hygiene supplies are readily available in every care location.

ANNEX B

STANDARDS AND FLOOR PLAN FOR AIRBORNE INFECTION ISOLATION ROOM

Hospital: 250-Bed (Level 3)	ROOM DATA SHEET		Department of Health HEALTH FACILITY DEVELOPMENT BUREAU
Updated Reference: April 2016	Department: NURSING WARDS	Room Title: ISOLATION ROOM (TYPICAL)	Reference Sheet Number: 250B-NU-RDS-07A

FUNCTIONAL DESIGN REQUIREMENTS:

This activity space provides facilities needed for the following activities:

a. Patient arrives on foot, in wheelchair or on a stretcher trolley
b. Transfer of patient to a hospital bed from a wheelchair or a stretcher trolley and vice versa
c. Patient undresses/dresses in the vicinity of hospital bed, with or without assistance
d. Patient takes meal in bed or in sitting area
e. Patient receives visitors
f. Patient stores clothing and other personal belongings
g. Patient requires privacy
h. Patient uses toilet and bath
i. Patient uses monitoring/diagnostic equipment
j. Physicians and nurses check on patients
k. Handwashing and other clean up activities
l. Nurse gives medication to patient
m. Nurse may feed or wash patient, in the absence of a relative or watcher

People involved:

1 x Patient
2 x Visitors
1 x Resident Physician/ Medical Specialist
1 x Nurse or Nursing Aide

Planning Relationships:

a. Acessible to Nurse Station
b. Located at end portion of Nursing Ward
c. Close to medical/surgical services

EQUIPMENT AND ACCESSORY CHECKLIST	QUANTITY	REMARKS
Television	1	
Waste bin w/ yellow lining	1	infectious
Waste bin w/ black lining	1	general
Water Heater	1	
Console, bedhead	1	

FURNITURE AND FIXTURE CHECKLIST	QUANTITY	REMARKS
Hospital bed, adjustable; with adjustable side rails	1	
Chair, upright; stacking	1	
Footstool	1	
Bench, cushioned	1	
Table, side; with cabinet	1	
Table, overbed	1	
Closet, wardrobe	1	
Lavatory, wall-hung	1	
Concealed floor drain	1	
Cabinet, PPE	1	
Water closet	1	
Lavatory	1	
Shower set	1	

ADDITIONAL EQUIPMENT & ENGINEERING TERMINALS	QUANTITY	REMARKS
Window curtain rail	1	
Bedhead light w/ night lamp	1	fluorescent, 20W
Outlet, 10A,2P,240V, duplex	7	grounding type, universal
Outlet, 10A,2P,240V, single	1	for emergency light
Nurse call station, emergency	1	w/ pendant switch
Outlet, antenna/Cable	1	
Smoke Detector	1	

Hospital: 250-Bed (Level 3)	ROOM DATA SHEET		Department of Health HEALTH FACILITY DEVELOPMENT BUREAU
Updated Reference: April 2016	Department: NURSING WARDS	Room Title: ISOLATION ROOM (TYPICAL)	Reference Sheet Number: 250B-NU-RDS-07B

TECHNICAL DESIGN DATA:

ENVIRONMENTAL CONDITIONS	DESIGN DATA	ENVIRONMENTAL CONDITIONS	DESIGN DATA
AIR		**LIGHTING AND VISUAL**	
Outdoor air temperature (°C)	ave. local station temp. reading	General illumination (LUX)	250
Room temperature (°C)	23	Night illumination (LUX)	50
Mechanical ventilation		Task illumination (LUX)	500
Volume (cu.m./hr.-person)	25	Color rendering	essential:DESIRABLE:unnecessary
Velocity (m./min.)	30	Standby light	ESSENTIAL:desirable:unnecessary
Pressure Differential:		Emergency light	ESSENTIAL:desirable:unnecessary
Negative Pressure (Pa)	10	Daylight	essential:DESIRABLE:unnecessary
Positive Pressure (Pa)	NA	View out	essential:DESIRABLE:unnecessary
% Dust filtration	93%-99%@ 1 micron	Privacy	ESSENTIAL:desirable:unnecessary
Humidity (%RH)	50	Black out	essential:desirable:UNNECESSARY
Cooling load (TR)	0.75		
SOUND		**SAFETY**	
Acceptable sound level (db)	40	Accessible hot surface:	NA
Speech privacy	essential:DESIRABLE:unnecessary	Maximum temperature (°C)	NA
Quality which cannot be	tonal Impact	Domestic hot water:	at lavatory
tolerated		Maximum temperature (°C)	70
		Access limit	medical staff, relatives/watcher & patient
		Fire risk	LOW: medium: high
		Other risks	NA

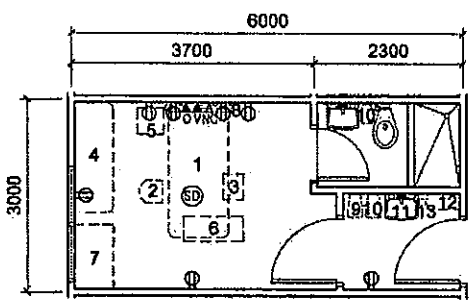
Hospital: 250-Bed (Level 3)	ROOM DATA SHEET	Department of Health HEALTH FACILITY DEVELOPMENT BUREAU

Updated Reference:	Department:	Room Title:	Reference Sheet Number:
April 2016	NURSING WARDS	ISOLATION ROOM (TYPICAL)	250B-NU-RDS-07C

TECHNICAL DESIGN DATA:

DIRECT SERVICES	DESIGN DATA
Disposal	hospital solid waste type: A & G
Hot Water	required at shower
Cold Water	req'd at lav & toilet fixtures
Drainage	req'd at lav, toilet fixt. & floor
Medical Oxygen	30 lpm @ 4.0 Bar
Medical Vacuum	40 lpm @ 450mm Hg
Compressed Air	NA
Steam	NA
Others	suction outlet required
DIRECT DEMANDS ON FLOOR AND WALL	
Loading	NA
Spillage	SLIGHT:occasional:frequent
Foot Traffic	light:MEDIUM:heavy
Wheel Traffic	light:MEDIUM:heavy
Impacts	NA
Abrasion	NA
Easy Maintenance	ESSENTIAL:desirable:unnecessary
Vibration Free	ESSENTIAL:desirable:unnecessary
Door Set	bed, wheelchair, &
	stretcher trolley access
Windows	clear, solar control,
	privacy control
Internal Glazing	none

LAYOUT OF ROOM AND SPACE COMPONENTS:



KEY

SCALE 1:100 M

1 Hospital bed, adjustable; with adjustable side rails
2 Chair, upright; stacking
3 Footstool
4 Bench, cushioned
5 Table, side; with cabinet
6 Table, overbed
7 Closet, wardrobe
8 Console, bedhead; for nurse call medical gas outlets, power outlets, lamp, etc.
9 Waste bin, infectious
10 Waste bin, general

ANTE ROOM:
11 Lavatory, wall-hung
12 Concealed floor drain
13 Cabinet, PPE

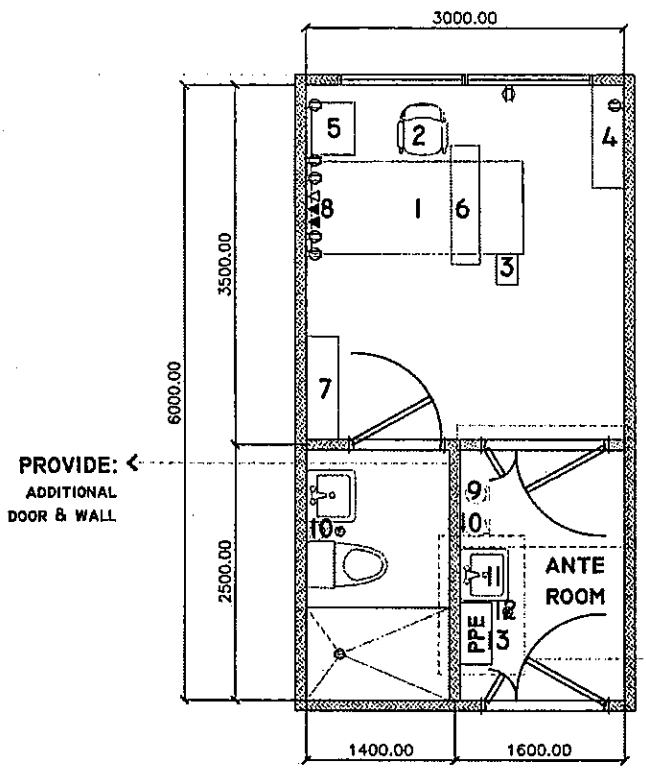
SPACE DEMANDS (Total Minimum Space Required in sq.m.) :

Space Components	Minimum Space Required/Component (sq.m.)

REGULATIONS AND NOTES:

ANNEX C

PROPOSED FLOOR PLAN FOR CONVERTED PRIVATE ROOM



KEY:

1. HOSPITAL BED, ADJUSTABLE; WITH ADJUSTABLE SIDE RAILS
2. CHAIR, UPRIGHT; STACKING
3. FOOTSTOOL
4. BENCH, CUSHIONED
5. TABLE, SIDE; WITH CABINET
6. TABLE, OVERBED
7. CLOSET, WARDROBE
8. CONSOLE, BEDHEAD; FOR NURSE CALL, MEDICAL GAS OUTLETS, POWER OUTLETS, LAMP, ETC.
9. WASTE BIN; INFECTIOUS
10. WASTE BIN; GENERAL

ANTE ROOM:

11. LAVATORY; WALL-HUNG
12. CONCEALED FLOOR DRAIN
13. CABINET; PPE

CONVERTED PRIVATE ROOM

ANNEX D

ADDITIONAL REFERENCE MATERIALS ON ISOLATION ROOMS

1. Administrative Order No. 2012-0012, "Rules and Regulations Governing the New Classification of Hospitals and Other Health Facilities in the Philippines," as amended.

   Refer to A.O. No. 2012-0012-A, "Amendment to Administrative Order (A.O.) No. 2012-0012 entitled "Rules and Regulations Governing the New Classification of Hospitals and Other Health Facilities in the Philippines"

2. Administrative Order No. 2016-0042, "Guidelines in the Application for Department of Health Permit to Construct (DOH-PTC)"

   Refer to the following documents:
   - Annex H-6A, "Checklist for Review of Floor Plans, Level 1 Hospital"
   - Annex H-6B, "Checklist for Review of Floor Plans, Level 2 Hospital"
   - Annex H-6C, "Checklist for Review of Floor Plans, Level 3 Hospital"

3. Total Alliance Health Partners International (TAHPI), "International Health Facility Guidelines"

   Refer to Chapter IV, "Isolation Rooms" (Visit: https://bit.ly/3bbu45L)

4. Centers for Disease Control and Prevention (2007). "2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Setting", updated July 2019. https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

ANNEX C
(List of Medicines and Medical Supplies)

Medicine	Medical Supplies and Equipment
Antipyretic	**Monitoring**
Paracetamol 500mg tablets Paracetamol 200mg/ ampule	Thermometer (Thermal scanner or digital)
	Sphygmomanometer
Respiratory Medications:	Pulse Oximeters
Lagundi 300mg tor 600mg tablets 300mg/ 5mL, 60mL Syrup	Stethoscopes
Ipratropium + Salbutamol 500mcg + 2.5mg x2.5mL (unit dose) Respiratory	**Airway**
Salbutamol 1mg/mL 2.5mL nebule	Oxygen Tanks
Butamirate Citrate 50mg tablet	Oxygen Cannula (Adult and Pediatric)
Anti-Inflammatory Medications:	Bag Valve- Mask (Adult and Pediatric)
Hydrocortisone 100mg, 200mg or 500mg powder vial	Laryngoscope and Blade (Adult and Pediatric)
Antidiarrheal Medications	Nebulizer
Oral Rehydration Salts	Nebulizing kits
Loperamide 2mg Capsule	ET Tubes of varying sizes
Others	**Circulation**
Clonidine 75mcg/ tab Clonidine 150 mcg/mL, 1mL ampule	Intravenous Set (IV Cannula, Macro/Microset) Soluset
IV Fluids (PLR, PNSS, D5LR, D5IMB) Sterile water for IV meds preparation	Syringes (1cc, 3cc, 5cc, 10cc and 30 syringe)
Epinephrine ampule	Sterile needles (varied gauges)

	Others Supplies and Equipment
	Surgical tapes of different sizes (for IV insertion and intubation)
	Cotton balls
	Sterile gauze
	Surgical gloves (sterile & non-sterile)
	Tongue Depressor
	Sterile cotton swab
	Tourniquet
	Isopropyl alcohol
	Povidone Iodine
	Disinfectant solutions
	Surgical Masks
	Gowns
	Goggles/ Face shields
	N95 Respirators
	Liquid antibacterial hand soap
	Bed linens, pillows and cases
	Color coded solid wastes disposal bins and plastic bags
	Wheel chair
	IV Stand

Considerations for quarantine of individuals in the context of containment for coronavirus disease (COVID-19)

Interim guidance
19 March 2020

World Health Organization

On 30 January 2020, the WHO Director-General determined that the outbreak of coronavirus disease (COVID-19) constitutes a Public Health Emergency of International Concern.[1] As the outbreak continues to evolve, Member States are considering options to prevent introduction of the disease to new areas or to reduce human-to-human transmission in areas where the virus that causes COVID-19 is already circulating.

Public health measures to achieve these goals may include quarantine, which involves the restriction of movement, or separation from the rest of the population, of healthy persons who may have been exposed to the virus, with the objective of monitoring their symptoms and ensuring early detection of cases. Many countries have the legal authority to impose quarantine. Quarantine should be implemented only as part of a comprehensive package of public health response and containment measures and, in accordance with Article 3 of the International Health Regulations (2005), be fully respectful of the dignity, human rights and fundamental freedoms of persons.[2]

The purpose of this document is to offer guidance to Member States on implementing quarantine measures for individuals in the context of the current COVID-19 outbreak. It is intended for those who are responsible for establishing local or national policy for the quarantine of individuals and for ensuring adherence to infection prevention and control (IPC) measures.

This document is informed by current knowledge of the COVID-19 outbreak and by considerations undertaken in response to other respiratory pathogens, including the severe acute respiratory syndrome coronavirus (SARS-CoV), the Middle East respiratory syndrome (MERS)-CoV and influenza viruses. WHO will continue to update these recommendations as new information becomes available.

Quarantine of persons

The quarantine of persons is the restriction of activities of or the separation of persons who are not ill but who may been exposed to an infectious agent or disease, with the objective of monitoring their symptoms and ensuring the early detection of cases. Quarantine is different from isolation, which is the separation of ill or infected persons from others to prevent the spread of infection or contamination.

Quarantine is included within the legal framework of the International Health Regulations (2005), specifically:

- Article 30 – Travellers under public health observation;
- Article 31 – Health measures relating to entry of travellers;
- Article 32 – Treatment of travellers.[2]

Member States have, in accordance with the Charter of the United Nations and the principles of international law, the sovereign right to legislate and to implement legislation, in pursuit of their health policies, even if this involves the restriction of movement of individuals.

Before implementing quarantine, countries should properly communicate such measures to reduce panic and improve compliance.[1]

- Authorities must provide people with clear, up-to-date, transparent and consistent guidelines, and with reliable information about quarantine measures.
- Constructive engagement with communities is essential if quarantine measures are to be accepted.
- Persons who are quarantined need to be provided with health care; financial, social and psychosocial support; and basic needs, including food, water, and other essentials. The needs of vulnerable populations should be prioritized.
- Cultural, geographic and economic factors affect the effectiveness of quarantine. Rapid assessment of the local context should evaluate both the drivers of success and the potential barriers to quarantine, and they should be used to inform plans for the most appropriate and culturally accepted measures.

When to use quarantine

Introducing quarantine measures early in an outbreak may delay the introduction of the disease to a country or area or may delay the peak of an epidemic in an area where local transmission is ongoing, or both. However, if not implemented properly, quarantine may also create additional sources of contamination and dissemination of the disease.

In the context of the current COVID-19 outbreak, the global containment strategy includes the rapid identification of laboratory-confirmed cases and their isolation and management either in a medical facility[3] or at home.[4]

WHO recommends that contacts of patients with laboratory-confirmed COVID-19 be quarantined for 14 days from the last time they were exposed to the patient.

For the purpose of implementing quarantine, a contact is a person who is involved in any of the following from 2 days before and up to 14 days after the onset of symptoms in the patient:

- Having face-to-face contact with a COVID-19 patient within 1 meter and for >15 minutes;
- Providing direct care for patients with COVID-19 disease without using proper personal protective equipment;
- Staying in the same close environment as a COVID-19 patient (including sharing a workplace, classroom or household or being at the same gathering) for any amount of time;
- Travelling in close proximity with (that is, within 1 m separation from) a COVID-19 patient in any kind of conveyance;
- and other situations, as indicated by local risk assessments.[5]

Recommendations for implementing quarantine

If a decision to implement quarantine is taken, the authorities should ensure that:

- the quarantine setting is appropriate and that adequate food, water, and hygiene provisions can be made for the quarantine period;
- minimum IPC measures can be implemented;
- minimum requirements for monitoring the health of quarantined persons can be met during the quarantine period.

Ensuring an appropriate setting and adequate provisions.

The implementation of quarantine implies the use or creation of appropriate facilities in which a person or persons are physically separated from the community while being cared for.

Appropriate quarantine arrangements include the following measures.

- Those who are in quarantine must be placed in adequately ventilated, spacious single rooms with en suite facilities (that is, hand hygiene and toilet facilities). If single rooms are not available, beds should be placed at least 1 metre apart.
- Suitable environmental infection controls must be used, such as ensuring are adequate air ventilation, air filtration systems, and waste-management protocols.
- Social distance must be maintained (that is, distance of at least 1 metre) between all persons who are quarantined.
- Accommodation must provide an appropriate level of comfort, including:
  - provision of food, water, and hygiene facilities;
  - protection for baggage and other possessions;
  - appropriate medical treatment for existing conditions;
  - communication in a language that those who are quarantined can understand, with an explanation of their rights, services that will be made available, how long they will need to stay and what will happen if they get sick; additionally, contact information for their local embassy or consular support should be provided.
- Medical assistance must be provided for quarantined travellers who are isolated or subject to medical examinations or other procedures for public health purposes.
- Those who are in quarantine must be able to communicate with family members who are outside the quarantine facility.
- If possible, access to the internet, news, and entertainment should be provided.
- Psychosocial support must be available.
- Older persons and those with comorbid conditions require special attention because of their increased risk for severe COVID-19.

Possible settings for quarantine include hotels, dormitories, other facilities catering to groups, or the contact's home. Regardless of the setting, an assessment must ensure that the appropriate conditions for safe and effective quarantine are being met.

When home quarantine is chosen, the person should occupy a well-ventilated single room, or if a single room is not available, maintain a distance of at least 1 metre from other household members, minimize the use of shared spaces and cutlery, and ensure that shared spaces (such as the kitchen and bathroom) are well ventilated.

Minimum infection prevention and control measures.

The following IPC measures should be used to ensure a safe environment for quarantined persons.

1. Early recognition and control

- Any person in quarantine who develops febrile illness or respiratory symptoms at any point during the quarantine period should be treated and managed as a suspected case of COVID-19.
- Standard precautions apply to all persons who are quarantined and to quarantine personnel:
  - Perform hand hygiene frequently, particularly after contact with respiratory secretions, before eating, and after using the toilet. Hand hygiene includes either cleaning hands with soap and water or with an alcohol-based hand rub. Alcohol-based hand rubs are preferred if hands are not visibly dirty; hands should be washed with soap and water when they are visibly dirty.

  - Ensure that all persons in quarantine are practicing respiratory hygiene and are aware of the importance of covering their nose and mouth with a bent elbow or paper tissue when coughing or sneezing and then immediately disposing of the tissue in a wastebasket with a lid and then performing hand hygiene.
  - Refrain from touching the eyes, nose and mouth.
- A medical mask is not required for persons with no symptoms. There is no evidence that wearing a mask of any type protects people who are not sick.

2. Administrative controls

Administrative controls and policies for IPC within quarantine facilities include but may not be limited to:

- establishing sustainable IPC infrastructure (for example, by designing appropriate facilities) and activities;
- educating persons who are quarantined and quarantine personnel about IPC measures. All personnel working in the quarantine facility need to have training on standard precautions before the quarantine measures are implemented. The same advice on standard precautions should be given to all quarantined persons on arrival. Both personnel and quarantined persons should understand the importance of promptly seeking medical care if they develop symptoms;
- developing policies to ensure the early recognition and referral of a suspected COVID-19 case.

3. Environmental controls

Environmental cleaning and disinfection procedures must be followed consistently and correctly. Cleaning personnel need to be educated about and protected from COVID-19 and ensure that environmental surfaces are regularly and thoroughly cleaned throughout the quarantine period.

- Clean and disinfect frequently touched surfaces − such as bedside tables, bed frames and other bedroom furniture − daily with regular household disinfectant containing a diluted bleach solution (that is, 1-part bleach to 99 parts water). For surfaces that cannot be cleaned with bleach, 70% ethanol can be used.
- Clean and disinfect bathroom and toilet surfaces at least once daily with regular household disinfectant containing a diluted bleach solution (that is, 1-part bleach to 99 parts water).
- Clean clothes, bed linens, and bath and hand towels using regular laundry soap and water or machine wash at 60-90 °C (140–194 °F) with common laundry detergent, and dry thoroughly.
- Countries should consider implementing measures to ensure that waste is disposed of in a sanitary landfill and not in an unmonitored open area.
- Cleaning personnel should wear disposable gloves when cleaning surfaces or handling clothing or linen soiled with body fluids, and they should perform hand hygiene before putting on and after removing their gloves.

Minimum requirements for monitoring the health of quarantined persons.

Daily follow up of persons who are quarantined should be conducted within the facility for the duration of the quarantine period and should include screening for body temperature and symptoms. Groups of persons at higher risk of infection and severe disease may require additional surveillance owing to chronic conditions or they may require specific medical treatments.

Consideration should be given to the resources and personnel needed and rest periods for staff at quarantine facilities. This is particularly important in the context of an ongoing outbreak, during which limited public health resources may be better prioritized for health care facilities and case-detection activities.

Respiratory samples from quarantined persons, irrespective of whether they have symptoms, should be sent for laboratory testing at the end of the quarantine period.

References

1. Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV). In: World Health Organization/Newsroom [website]. Geneva: World Health Organization; 2020 (https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov), accessed 29 February 2020).

2. Key considerations: quarantine in the context of COVID-19. In: Social Science in Humanitarian Action: A Communication for Development Platform [website]. New York: UNICEF, Institute of Development Studies; 2020 (https://www.socialscienceinaction.org/resources/february-2020-social-science-humanitarian-action-platform/, accessed 29 February 2020).

3. World Health Organization. Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected. (accessed 16 March 2020).

4. World Health Organization. Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts: interim guidance, 17 March 2020. Geneva: World Health Organization; 2020 (accessed 17 March 2020).

5. World Health Organization. Global Surveillance for human infection with coronavirus disease (COVID-19): interim guidance,

6. World Health Organization. Advice on the use of masks in the community, during home care and in health care settings in the context of COVID-19: interim guidance, 29 January 2020. Geneva: World Health Organization; 2020 (accessed 16 March 2020).

WHO continues to monitor the situation closely for any changes that may affect this interim guidance. Should any factors change, WHO will issue a further update. Otherwise, this interim guidance document will expire 2 years after the date of publication.

WHO reference number: WHO/2019-nCoV/IHR_Quarantine/2020.2

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Republika ng Pilipinas
Kagawaran ng Edukasyon
Tanggapan ng Pangalawang Kalihim

DepEd Task Force COVID-19
MEMORANDUM No. 025
25 March 2020

For: **Execom and Mancom Members**
SDS and All Others Concerned

Subject: **MINIMUM STANDARDS FOR SOCIAL DISTANCING/ BASELINE PROTOCOLS TO BE OBSERVED IN THE WORKPLACE, TRAVEL, AND HOME AND PRIVATE SPACE AND TIME OF DEPLOYED PERSONNEL DURING THE ENHANCED COMMUNITY QUARANTINE**

This memorandum is being issued pursuant to the directive of the Secretary to the DepEd Task Force COVID-19 to "prepare for the baseline protocols to be observed in the workplace, travel, and home and private space and time of the deployed personnel, and the coordination mechanism for the effective implementation of these," per Office Memorandum OO-OSEC-2020-001, titled **Authorization of Office and Field Work for Identified Critical Services in Areas Covered by the Enhanced Community Quarantine**, or "to issue the uniform and minimum standards for social distancing within the workplace, during travel, and in private premises and activities," per DM 43, s. 2020, titled **Guidelines on the Alternative Work Arrangements in the Department of Education in Light of the Covid-19 Stringent Social Distancing Measures**.

1. **Guidelines on work arrangement**

   a. **Personnel on work-from-home**

      i. The following factors shall be considered when identifying the personnel that will make up the skeletal workforce:

         (1) The overall health of the personnel. Personnel considered as **high-risk individuals** shall be prioritized for home-from-work arrangement. "Persons who are at high risk of being infected" are elaborated as "those **sixty (60) years old and above**, those who are **immunocompromised** or **with co-morbidities**, and **pregnant** women," based on the Memorandum from the Executive Secretary, IATF-MEID and DOH.

(2) **Distance between the residence of the personnel and the office** (workstation) (e.g., those who reside outside the National Capital Region and require daily travel shall be prioritized for home-from-work arrangement, if a service cannot be provided)

ii. All personnel who are on work-from-home arrangement are advised to observe applicable preventive measures contained in this memorandum (Item No. 2).

b. **Personnel on skeletal workforce**

i. Those part of the skeletal workforce shall be provided with a **door-to-door vehicle service** where applicable preventive measures (as enumerated in Item No. 2 of this memorandum), including social distancing, shall be strictly observed. The vehicle used for transportation shall be cleaned and disinfected after every trip.

ii. Proper orientation on safety and precautionary measures including social distancing of passengers shall be provided to the drivers.

iii. The skeletal workforce shall report only during their assigned schedule or as necessary.

iv. The skeletal workforce shall adhere to the preventive measures enumerated in Items No. 2 and No. 3 of this memorandum.

v. The Central Office Task Force COVID-19 and similar task forces at the Regional Offices, Division Offices and Schools are enjoined to formulate implementing rules on the above items.

2. General preventive measures for the skeletal workforce (Based on DOH Circular No. 2020-0039)

a. **Respiratory etiquette**

i. Cough and sneeze into tissue or into shirt sleeve if tissue is not available. Dispose used tissues properly and disinfect hands immediately after a cough o sneeze.

ii. Avoid touching the mouth, eyes, and nose to help slow the spread of the virus.

iii. The use of masks, which provides a physical barrier from COVID-19 by blocking large-particle respiratory droplets propelled by coughing or sneezing, is **only** recommended for:

(1) Persons caring for the sick
(2) Healthcare workers attending to patients with respiratory infections/symptoms (cough/cold)
(3) Persons with respiratory infection/symptoms

iv. People in good health do not need to use face masks, except in crowded places where social distancing is not feasible.

b. **Hand hygiene.** Perform regular and thorough handwashing with soap and water. Use alcohol-based hand sanitizers containing at least 60 ethanol or isopropanol when soap and water are not available.

c. **Social distancing measures**

i. Whenever possible, keep a distance of at least 3 feet or 1 meter away from other people to reduce the possibility of person-to-person transmission. This distance should be observed even as to apparently healthy persons without symptoms.

ii. Offer telecommuting and replace in-person meetings in the workplace with video or telephone conferences.

d. **Environmental measures**

i. Clean frequently-touched surfaces and objects, including tables, doorknobs, desks, and keyboards.

ii. Maintaining the environment clean, especially common-use areas and those with touchpoints such as elevators, railings, staircases, light switches and the like.

iii. Make dispensers with alcohol-based hand rub available in public areas.

3. **Practical measures for the offices at the DepEd Central, Regional, Division, Facilities and/or Schools while on skeletal workforce**

a. One major consideration when determining the skeletal workforce to report to the office is the workspace. The number of personnel to report each day shall permit strict observance of social distancing within the office.

b. All personnel who are reporting as part of the skeletal workforce shall always have the "mindset" and be conscious to behave as if they may be possibly be infected with the virus, albeit asymptomatic, and may be potentially exposing their colleagues to the virus.

c. All reporting staff must as much as possible stay only in their respective workstations, and avoid moving around the office.

d. Talking closely between personnel during reporting hours is highly discouraged. Talking is also discouraged in common areas such as near the water dispenser or the photocopier.

e. All personnel are advised to always carry their own pens with them so that they use it when filling-out log-sheets at the entrance.

f. All personnel are advised to wash their hands with soap upon arrival at the

DepEd Complex before entering their respective offices.

g. Doors may be slightly opened so that feet or elbows may be used when opening and closing them, instead of opening them through the doorknobs.

h. Social distancing—keeping a distance of at least 3 feet or 1 meter away from other people—shall be strictly observed at all times in the entire DepEd complex.

i. Personnel who manifests symptoms of respiratory infection shall be immediately provided with appropriate health care and automatically removed of the skeletal workforce. Likewise, personnel who will have exposure to a confirmed case, or whose household members will be eventually categorized as Person Under Monitoring or Person Under Investigation shall immediately disclose such information to their immediate supervisor for appropriate referral and intervention.

The DepEd Task Force COVID-19 welcomes suggestions and ideas on how social distancing and other preventive measures can be further practiced in the workplace. Such feedback and other concerns may be e-mailed at medical.nursing@deped.gov.ph.

For proper guidance.

ALAIN DEL B. PASCUA
Undersecretary
Chairperson, DepEd Task Force COVID-19

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Republic of the Philippines
Department of Education

26 MAR 2020

OFFICE MEMORANDUM
OM-O S E C-2 0 2 0-003

TEMPLATE TERMS AND CONDITIONS FOR THE USE OF DEPED SCHOOLS AS QUARANTINE OR ISOLATIONS AREAS

To: Regional Directors
Schools Division Superintendents
Public Elementary and Secondary School Heads
All Others Concerned

1. The Department of Education (DepEd), through Office Memorandum OM-OSEC-2020-002, issued its **Guidance to Regional Directors for Action on Requests by Local Government Units (LGUs) to Use Deped Schools as Quarantine or Isolation Areas For COVID-19.**

2. Paragraph 9 (e) of the said memorandum requires signing of the minimum Terms and Conditions (TAC) for the Use of DepEd Schools as Quarantine or Isolation Areas before actual use of the facility for the intended purpose. Furthermore, paragraph 10states that:

> 10. The LGU shall sign the TAC provided by the Regional Director. Should there be other terms to be agreed upon between the Schools Division Office (SDO) and the LGU, the SDO shall draft a Memorandum of Agreement (MOA) between the SDO and LGU, detailing the roles and responsibilities of the parties, among others. The TAC shall be attached to the MOA as an Annex and shall form an integral part of the MOA. In case of conflict between the MOA and the TAC, the TAC shall prevail.

3. In view of the foregoing, the following enclosed templates shall be accomplished:

Enclosure No. 1 - Letter of the School Head to the LGU communicating the Approval by the Regional Director of the request for the use of school as temporary quarantine or isolation facility

Enclosure No. 2 - Terms and Conditions for the Use of DepEd School by the Local Government Unit as a Temporary Quarantine or Isolation Facility of Last Resort with School Inventory

4. For strict compliance.

LEONOR MAGTOLIS BRIONES
Secretary

(Enclosure No. 1 to Office Memorandum OM-OSEC-2020-003)

Date

NAME
Designation
Office
Address

Re: Approval by the Regional Office of _____

Dear _____,

This has reference to your request for the use of the school, (NAME OF SCHOOL), as temporary quarantine or isolation facility, in relation to the COVID-19 public health situation.

The Department of Education Regional Office of _____ has approved the request, subject to the attached minimum "Terms and Conditions for the Use of DepEd School by the Local Government Unit as A Quarantine or Isolation Facility of Last Resort" with annexed School Inventory indicating the facilities of the school relative to the request.

Kindly sign the Terms and Conditions and the School Inventory to signify your conformity.

Sincerely,

_____
(School Head)

(Enclosure No. 2 to Office Memorandum OM-OSEC-2020-003)

TERMS AND CONDITIONS
FOR THE USE OF DEPED SCHOOL BY THE LOCAL GOVERNMENT UNIT
AS A TEMPORARY QUARANTINE OR ISOLATION FACILITY
OF LAST RESORT

The Local Government Unit of the City/Municipality of _____, with office address at _____, and represented by _____, Mayor, hereinafter referred to as the "LGU", has requested from the DepEd-Regional Office of _____, as represented by _____, Regional Director, hereinafter referred to as the "RO", the use of ___(Name of School)___, with address at _____ and School Head, (Name of School Head), as a temporary quarantine or isolation facility relative to the COVID-19 public health situation.

The request is made under the following premises:

The President issued Proclamation No. 922 dated March 8, 2020, "Declaring a State of Public Health Emergency Throughout the Philippines", in view of the COVID-19 public health situation;

Section 2 of Proclamation No. 922, s. 2020, states that "(a)ll government agencies and LGUs are hereby enjoined to render full assistance and cooperation and mobilize the necessary resources to undertake critical, urgent, and appropriate response and measures in a timely manner to curtail and eliminate the Covid-19 threat";

The LGU needs a temporary quarantine or isolation facility relative to its response to the COVID-19 public health situation and it has no other available place or structure for use, thus it submitted a request to the RO for the use of the (Name of School), hereinafter referred to as the "School", as a quarantine or isolation facility of the LGU, subject to OFFICE MEMORANDUM OM-OSEC-2020-002;

The RO, acting on the recommendation of the Schools Division Office, approved the request, in adherence to applicable guidelines of the Department of Health (DOH) and the World Health Organization (WHO), and other pertinent laws and rules, and upon a clear showing by the LGU of the need to use the School as a temporary quarantine or isolation facility due to absence of other available facility as certified by the provincial/city/municipal health officer, as well as a presentation by the LGU of its planned management of the facility under the supervision of the city/municipal health officer, subject to DOH and other relevant guidelines;

The approval of the RO was conditioned upon the undertaking of the LGU for the safekeeping of all property and valuables in the school premises during the

operation of the facility, payment of all expenses including utilities in relation to its use of the School as a temporary quarantine or isolation facility, the conduct of the general cleaning and fumigation, and repair and/or replacement of damaged or lost school facilities as a result of, and incidental to, the use of the school by the LGU.

Foregoing premises considered, the LGU commits and binds itself to the following terms and conditions set by the DepEd in its use of the School as a temporary quarantine or isolation facility of last resort:

I. SCOPE

This Terms and Conditions (TAC) pertains to the use of (NAME OF THE SCHOOL) as a temporary quarantine or isolation facility of the LGU in relation to the COVID-19 outbreak during the period of Public Health Emergency under Proclamation No. 922, s. 2020. The School may only be used by the LGU for this purpose if classes are not being conducted therein.

Quarantine of persons is defined as the separation of persons who are not ill, but who may be exposed to an infectious agent or disease, with the objective of monitoring symptoms and early detection of COVID-19 cases.

Isolation refers to the separation of ill or infected persons from others, so as to prevent the spread of infection or contamination.

II. ROLES AND RESPONSIBILITIES

A. **The LGU shall:**

1. Prepare the areas approved by the RO to be used as temporary quarantine or isolation facility in the School, and shall not require students/pupils and DepEd personnel to be engaged in the preparation of the School for this purpose. The LGU shall vacate the designated areas and remove education equipment and resources therefrom, under the supervision and guidance of the School.

2. Use only the specified School area and facilities approved by the RO to be used as quarantine or isolation facility.

3. Take charge of the management and maintenance of the School used as a quarantine or isolation facility, under the supervision of the city/municipal health officer, and in accordance with the applicable guidelines of the DOH and the WHO, cited in OFFICE MEMORANDUM OM-OSEC-2020-002, and other applicable laws, rules and guidelines.

4. Cordon off the identified quarantine or isolation facility from the rest of the School premises or facilities.

5. Provide measures to ensure the safety and security of the School.

6. Provide all resources and equipment required for the use of the School as a quarantine or isolation facility.

7. Ensure that water supply will be sufficient and there will be no cooking in the School during its use as a quarantine or isolation facility.

8. Ensure compliance with the sanitation and health standards applicable to the School before, during and after its use by the LGU as a quarantine or isolation facility, including disinfecting the premises used and ensuring the use of personal protective equipment (PPE).

9. Facilitate and provide for the general cleaning, maintenance and upkeep of School premises, structures, facilities, equipment, and resources, and repair and replace them if damaged, destroyed or lost as a result of their use by the LGU as a quarantine or isolation facility. Such repair and replacement shall be completed prior to the return of the use of the School to the School Head.

10. Clean up and fumigate the School within a maximum period of one week after its use by the LGU as a quarantine or isolation facility during the public health emergency. The proper health authorities shall certify whether the School is fit for education use subsequent to the fumigation, in accordance with pertinent guidelines of the DOH and other applicable rules and issuances.

11. Pay for utilities during its use of the School as a quarantine or isolation facility, and until it has returned the use of the School to its School Head for education use and the School Head has accepted the same.

12. Ensure that the School and facilities be restored to their original or better state, compared to their condition upon commencement of their use as quarantine or isolation facility by the LGU.

13. Prior to return by the LGU of the use of the School to the School Head, secure clearance from the School with respect to the LGU's compliance with the TAC.

B. The School shall:

1. Identify the School spaces/structures/comfort rooms and handwashing facilities approved by the RO to be used as temporary quarantine or isolation facility. School areas beyond those approved by the RO shall be off limits to the LGU and users of the quarantine or isolation facility.

2. In preparation for the use of the School as temporary quarantine or isolation facility, ensure proper storage and safekeeping of all learning and education equipment, resources, materials and school records. The School shall provide supervision and guidance to the LGU in the vacating of designated School spaces/structures and removal of education equipment and resources therefrom by the LGU, provided that all DepEd personnel involved in the preparation of the school premises shall strictly observe all existing health precautions and social distancing protocols of DOH and WHO.

3. Prepare and implement work protocols that would not require DepEd personnel to report to the School for the performance of regular functions during the period the School is used as quarantine or isolation facility.

4. Inform the LGU of any damage, destruction, or loss of School facilities and resources due to, or incidental to, the use of the School, if any, to serve as basis for repair, maintenance, and/or replacement by the LGU after use of the School as quarantine or isolation facility.

5. Have the authority to monitor and access the School, subject to strict observance of safety and health requirements applicable to the quarantine or isolation facility.

C. **The LGU and the School**

1. The School shall make a School Inventory and record the condition of school premises, structures, facilities, equipment and resources immediately prior to use, and after the use and fumigation of the School as a quarantine or isolation facility by the LGU. The Inventory prior to use shall be signed by both the School Head and Mayor and shall form an integral part of this TAC (*See* Annex A).

2. Any and all expenses relative to the preparation and operation of the School as a temporary quarantine or isolation facility as well as the clearing, fumigation and restoration of the School to its educational use shall be shouldered by the LGU.

3. The School and LGU shall each designate focal person/s who shall be responsible for coordination between the Parties to ensure compliance with this TAC.

III. GENERAL PROVISIONS

1. The LGU shall use the School as a temporary quarantine or isolation facility only upon its showing to the RO that there is no other available space or structure which can be used for that purpose. The use of the School as a temporary quarantine or isolation facility of last resort is a continuing requirement. Should a place or structure which can be used for this purpose become available, the LGU shall terminate its use of the School as a quarantine or isolation facility.

2. This TAC shall take effect upon its execution, and shall be in full force and effect for a period of (Indicate number of days approved by the RO) days during the period of Public Health Emergency under Proclamation No. 922, s. 2020, unless mutually extended by the LGU and the RO in writing, or sooner terminated by either the LGU or the RO upon fifteen-day written notice for valid reasons.

   Notwithstanding the lifting of the said Public Health Emergency, the responsibilities and obligations of the LGU under this TAC shall subsist until fully complied with.

3. When warranted by compelling circumstances, the RO may amend, modify or supplement this TAC for valid reasons, upon prior written notice to the LGU.

4. The LGU represents and warrants that it has the requisite power and authority to make, deliver, and comply with the provisions of this TAC, and has taken all the necessary action to duly and validly authorize the execution, delivery and performance of this TAC.

5. Should there be any conflict between the provisions of this TAC and other Agreements between the LGU and the DepEd through the Regional Office, Schools Division Office or the School, this TAC shall prevail.

LOCAL GOVERNMENT UNIT OF THE CITY/MUNICIPALITY OF:

_____

By:

_____

Signature over Printed Name
City/Municipal Mayor

Date:

_____

REPUBLIC OF THE PHILIPPINES)
CITY/MUNICIPALITY OF _____) s.s.

Before me, a notary public for and in the City of _____, this _____, personally appeared the following:

Name	Competent Evidence of Identity	Date/Place Issued
School Head		
Mayor		

known to me to be the same persons who executed the foregoing document on the Terms and Conditions for the Use of DepEd School by the Local Government Unit as A Quarantine or Isolation Facility with School Inventory consisting of _____ (___) pages, including Annex A-School Inventory and the page on which this Acknowledgment is written, and they acknowledged to me that the same are their free and voluntary act and deed.

WITNESS MY HAND AND SEAL, on the date and in the place first above written.

NOTARY PUBLIC

Doc. No. _____;
Page No. _____;
Book No. _____;
Series of 2020.

ANNEX A

INVENTORY OF FACILITIES OF
(NAME OF SCHOOL)
FOR USE AS TEMPORARY QUARANTINE OR ISOLATION FACILITY

Designated Facilities for Use as Temporary Quarantine or Isolation Facility**:**

1. E.g. Gymnasium
2. Room _____
3. Room _____
4. _____

Facility (Gymnasium, Room, etc.)	Item (Furniture and Fixture, Equipment, etc)	Quantity	Condition

Other Remarks on Premises/Structures/Facilities

_____
_____

Prepared by:

_____
Signature over Printed Name
School Head

Date _____

Conforme:

_____
Signature over Printed Name
Mayor

Date_____

Republic of the Philippines
Department of Education

30 MAR 2020

OFFICE MEMORANDUM
OM-O S E C-2 0 2 0-004

GUIDANCE TO REGIONAL DIRECTORS FOR ACTION ON REQUESTS BY LOCAL GOVERNMENT UNITS TO USE DEPED SCHOOLS AND ENGAGE DEPED PERSONNEL IN ACTIVITIES RELATED TO COVID-19

1. The President issued Proclamation No. 922, dated March 8, 2020, *Declaring a State of Public Health Emergency Throughout the Philippines*, due to the COVID-19 outbreak, and enjoined "(a)ll government agencies and LGUs…to render full assistance and cooperation and mobilize the necessary resources to undertake critical, urgent, and appropriate response and measures in a timely manner to curtail and eliminate the Covid-19 threat."

2. Republic Act No. (RA) 11469, otherwise known as the *Bayanihan to Heal As One Act*, then took effect on March 24, 2020, authorizing the President to exercise powers to adopt temporary emergency measures to respond to the COVID-19 pandemic. The powers include "ensur(ing) that all Local Government Units (LGUs) are acting within the letter and spirit of all rules, regulations and directives issued by the National Government pursuant to this Act; are implementing standards of Community Quarantine consistent with what the National Government has laid down for the subject area, while allowing LGUs to continue exercising their autonomy in matters undefined by the National Government or are within the parameters it has set; and are fully cooperating towards a unified, cohesive and orderly implementation of the national policy to address COVID-19."

3. To implement RA 11469, Executive Secretary Salvador C. Medialdea issued a Memorandum dated March 28, 2020, on the *Implementation of Temporary Emergency Measures under Republic Act (RA) No. 11469, Otherwise Known as the Bayanihan to Heal As One Act.* The Memorandum, addressed to Heads of Departments, Agencies and Local Government Units, among others, mandates the Secretary of the Department of Interior and Local Government (DILG) to exercise the power of the President under RA 11469 to "(e)nsure that all LGUs are…fully cooperating towards a unified, cohesive and orderly implementation of the national policy to address COVID-19".

4. The DepEd reiterates its full cooperation with the Office of the President, the Inter-Agency Task Force for the Management of Emerging Infectious Diseases (IATF) and the Cabinet on decisions and measures concerning COVID-19, including the mobilization of necessary resources to eliminate the COVID-19 threat.

5. Hence, on March 26, 2020, I issued OM-OSEC-2020-002, titled *Guidance to Regional Directors for Action on Requests by Local Government Units to Use DepEd*

Schools as Quarantine or Isolation Areas for COVID-19, in view of the growing number of requests by LGUs for the use of DepEd schools as places for quarantine or isolation as part of their response to COVID-19.

6. DepEd has also been receiving requests from LGUs for the use of DepEd schools for various other purposes (e.g., venue for mobile market, food packing for distribution, facility for showering and changing of clothes of health workers before proceeding home, etc.) and the participation of DepEd teaching and nonteaching personnel to help LGUs conduct activities in response to the COVID-19 outbreak such as the distribution of food stubs to families of public school pupils and students.

7. In light of the various requests by LGUs for the use of DepEd schools and/or participation of DepEd personnel in LGU activities related to their response to the COVID-19 outbreak, this Memorandum is issued to provide guidance for action on these requests.

Use of DepEd Schools and Facilities

8. This guidance recognizes that under RA 9155, otherwise known as the *Governance of Basic Education Act of 2001,* DepEd is vested with authority, accountability and responsibility for ensuring access to, promoting equity in, and improving the quality of basic education. The law provides that the "Secretary of the Department of Education shall exercise overall authority and supervision over the operations of the Department" including all its officials, personnel and schools throughout the country.

9. The school, as also provided by RA 9155, is the heart of the formal education system; it is where children learn. Its single aim, as the law emphasizes, is to provide the best possible basic education for all learners. Consistent with this role of the school, and the principles embodied in RA 10821, otherwise known as the *Children's Emergency Relief and Protection Act*, school facilities may be used for other purposes such as an evacuation center only when there is no other available place or structure which can be used for that purpose.

10. RA 9155 further provides that, in accordance with national policies and plans, the school head is responsible for the administrative and instructional supervision of the school or cluster of schools; the Schools Division Superintendent is mandated to plan and manage the effective and efficient use of all personnel, physical and fiscal resources of the division, as well as to supervise the operations of all public and private elementary, secondary and integrated schools, and learning centers; and the Regional Director has the authority, accountability and responsibility to define a regional educational policy framework which reflects the values, needs and expectations of communities they serve.

11. This guideline further recognizes that RA 7160, otherwise known as the *Local Government Code of 1991*, provides for Local School Boards in every province, city or municipality composed of, among others, the Governor and Schools Division Superintendent as co-chairpersons, the City Mayor and City Schools Division Superintendent as co-chairpersons, and the Municipal Mayor and the Public Schools District Supervisor as co-chairpersons, respectively. The functions of the

Local School Boards, as specifically provided in the Code, pertain to the budgetary needs for the operation and maintenance of public schools, disbursements from the Special Education Fund, advising the Sanggunian concerned on educational matters, recommendations for changes in names of public schools, and providing inputs on the appointment of certain personnel of DepEd.

12. In sum, DepEd schools are established and designed to function as basic education institutions and facilities, under the control and supervision of DepEd, as provided under RA 9155. In a particular manner, LGUs participate in the provision of basic education mainly through the Local School Boards co-headed by the Governor/Mayor and the Schools Division Superintendent/Public Schools District Supervisor, which are mandated to perform specified education-related functions pursuant to RA 7160. Under the circumstances of the COVID-19 pandemic, however, LGUs request DepEd for the use of schools in their response to the public health situation and not necessarily for education-related purposes. With the declaration of a state of public health emergency in the Philippines through Proclamation No. 922 and the enactment of the *Bayanihan to Heal As One Act*, DepEd is enjoined to mobilize the necessary resources to contribute to the elimination of the COVID-19 threat in accordance with law and applicable national policies or directives.

13. In light of the foregoing and consistent with OM-OSEC-2020-002, I hereby delegate to the Regional Directors the responsibility to approve or deny requests by LGUs to use DepEd schools for activities related to the COVID-19 outbreak within their respective jurisdictions, based on evaluation of the request by the Schools Division Superintendent in consultation with the school heads.

14. In adherence to applicable laws, rules and guidelines, the evaluation of the request shall be guided by the following:

a. The LGU must state in its request the specific intended purpose or use for the school, and identify the particular facility in the school that will be used as well as the duration of their use, subject to extension, if necessary;

b. The LGU must show that the Regional Director of the DILG or the head of the Regional Task Force COVID-19, has assessed that the activity intended to be conducted by the LGU in the school is within the parameters of rules, regulations and directives issued by the National Government, and in full cooperation towards a unified, cohesive and orderly implementation of the national policy to address the COVID-19 outbreak. The document showing such assessment must be attached to the request of the LGU;

c. The LGU must show that all other facilities have been duly assessed and were found to be inadequate. Schools can be recommended for use only when no other facilities are available.

d. The LGU must present an assessment by the concerned local official that the facility within the school is suitable for the specific intended

purpose, e.g. the local health officer if the use is health-related, the local social worker if the use is welfare-related, etc.

e. The LGU must present the planned management of the facility, and must conform to relevant government rules, standards and requirements; and

f. The LGU request must include an undertaking for the management of the school area or structure, safekeeping of all property and valuables in the school premises during the operation of the facility, payment of all expenses including utilities in relation to the use of the school, conduct of general cleaning and fumigation, and repair and/or replacement of damaged or lost school facilities as a result of the use of the school, as well as compliance with the safety regulations and precautionary measures enforced during the public health emergency by the proper authorities. (See Enclosure No. 1: *Minimum standards for social distancing/baseline protocols to be observed in the workplace, travel, and home and private space and time of deployed personnel during the enhanced community quarantine by DepEd Task Force COVID-19 [DTFC Memorandum No. 25]*)

15. When a request is granted by the Regional Director based on the recommendation by the concerned Schools Division Superintendent, the school heads must coordinate with the LGU on the following preparations before actual use of the facility for the intended purpose:

a. Designation, as well as vacating if necessary, of approved school spaces/structures to be used by the LGU, including removal of all chairs, tables, furniture, equipment and other school properties;

b. Designation of sufficient number of comfort rooms and handwashing facilities to be used, if any;

c. Safekeeping and/or proper storage of all learning and education materials, resources, equipment, and school records;

d. Documentation of the condition of school facilities and resources before use of the facility;

e. Signing of the minimum Terms and Conditions (TAC) for the intended use/purpose of DepEd School, as provided by the Regional Director (See Enclosure No. 2: *Minimum Terms and Conditions for Use of DepEd Schools by LGUs for Various Purposes [Other than Quarantine or Isolation Areas]*); and

f. All DepEd personnel involved in the preparation of the school premises shall strictly observe all existing health precautions and social distancing protocols of the Department of Health and DepEd.

16. The LGU shall sign the TAC provided by the Regional Director. Should there be other terms to be agreed upon between the Schools Division Office (SDO) and the LGU, the SDO shall draft a Memorandum of Agreement (MOA) between the SDO and LGU, detailing the roles and responsibilities of the parties, among others. The TAC shall be attached to the MOA as an Annex and shall form an integral part of the MOA. In case of conflict between the MOA and the TAC, the TAC shall prevail. Attached hereto is a template TAC, setting forth the minimum terms and conditions for the use of school.

17. The Regional Directors shall devise an appropriate system for monitoring the use of schools by LGUs for purposes related to the COVID-19 outbreak in their respective jurisdictions.

Participation of DepEd Personnel in LGU activities

18. The activities of LGUs in response to the COVID-19 outbreak, for which they request human resources, are numerous and varied. The number of DepEd personnel requested to participate in an activity may be one or many, and the duration of participation of one person may be different from that of another person.

19. Given this nature of the LGU activities and possible participation in them, DepEd teaching and nonteaching personnel may participate in these activities under the supervision of the LGU, in a voluntary and personal capacity, subject to applicable laws and rules, including the rules and directives of the national government to address the COVID-19 public health emergency such as the Enhanced Community Quarantine.

20. Should DepEd personnel participate in the LGU activities, the LGU must provide proper trainings; ensure the safety and health of the DepEd personnel by providing the necessary personal protective equipment (PPE), alcohol, sanitizers and other disinfectants, and implementing stringent social distancing measures; and pay remuneration or allowances, as may be warranted by law.

21. Participation of DepEd personnel in said activities of the LGU should not prejudice work in the DepEd and should thus be consistent with alternative work-from-home and skeletal work force arrangements, as provided in the Memorandum of Executive Secretary Salvador C. Medialdea, dated March 16, 2020, with subject *Community Quarantine over the Entire Luzon and Further Guidelines for the Management of the Coronavirus Disease 2019 (COVID-19) Situation*, DepEd Memorandum No. 43, s. 2020, DepEd Office Memorandum OM-OSEC-2020-001, and other applicable laws and rules.

22. For purposes of monitoring activities under this Guidance, DepEd Disaster Risk Reduction and Management (DRRM) coordinators shall provide support to school heads and School Health and Nutrition personnel in monitoring the use of schools by LGUs and the voluntary participation of DepEd personnel in activities of the LGUs in addressing the COVID-19 outbreak. Offsite monitoring shall be

undertaken in view of social distancing precautionary measures, unless physical monitoring is necessary and feasible.

23. The Regional Director shall submit to the Office of the Secretary, through the Offices of the Undersecretaries for Field Operations, a consolidated report of all requests received by the Regional Office from LGUs and the actions taken thereon.

24. This Guidance may also be used by school heads, Schools Division Superintendents and Regional Directors to act on similar requests from other government agencies, unless another guidance is subsequently issued by the Secretary pertaining to such requests.

25. For clarifications and concerns, contact the **DepEd Task Force COVID-19 Quick Response and Recovery Team** (DTFC-QRRT-COVID-19) at the Bureau of Learner Support Services-School Health Division through email at blss.shd@deped.gov.ph or at telephone number (02) 8632-9935.

26. For immediate dissemination and implementation.

LEONOR MAGTOLIS BRIONES
Secretary

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Republika ng Pilipinas
Kagawaran ng Edukasyon
Tanggapan ng Pangalawang Kalihim

DepEd Task Force COVID-19
MEMORANDUM No. 025
25 March 2020

For: **Execom and Mancom Members**
SDS and All Others Concerned

Subject: **MINIMUM STANDARDS FOR SOCIAL DISTANCING/ BASELINE PROTOCOLS TO BE OBSERVED IN THE WORKPLACE, TRAVEL, AND HOME AND PRIVATE SPACE AND TIME OF DEPLOYED PERSONNEL DURING THE ENHANCED COMMUNITY QUARANTINE**

This memorandum is being issued pursuant to the directive of the Secretary to the DepEd Task Force COVID-19 to "prepare for the baseline protocols to be observed in the workplace, travel, and home and private space and time of the deployed personnel, and the coordination mechanism for the effective implementation of these," per Office Memorandum OO-OSEC-2020-001, titled **Authorization of Office and Field Work for Identified Critical Services in Areas Covered by the Enhanced Community Quarantine**, or "to issue the uniform and minimum standards for social distancing within the workplace, during travel, and in private premises and activities," per DM 43, s. 2020, titled **Guidelines on the Alternative Work Arrangements in the Department of Education in Light of the Covid-19 Stringent Social Distancing Measures**.

1. **Guidelines on work arrangement**

   a. **Personnel on work-from-home**

      i. The following factors shall be considered when identifying the personnel that will make up the skeletal workforce:

         (1) The overall health of the personnel. Personnel considered as **high-risk individuals** shall be prioritized for home-from-work arrangement. "Persons who are at high risk of being infected" are elaborated as "those **sixty (60) years old and above**, those who are **immunocompromised** or **with co-morbidities**, and **pregnant** women," based on the Memorandum from the Executive Secretary, IATF-MEID and DOH.

(2) **Distance between the residence of the personnel and the office** (workstation) (e.g., those who reside outside the National Capital Region and require daily travel shall be prioritized for home-from-work arrangement, if a service cannot be provided)

ii. All personnel who are on work-from-home arrangement are advised to observe applicable preventive measures contained in this memorandum (Item No. 2).

b. **Personnel on skeletal workforce**

i. Those part of the skeletal workforce shall be provided with a **door-to-door vehicle service** where applicable preventive measures (as enumerated in Item No. 2 of this memorandum), including social distancing, shall be strictly observed. The vehicle used for transportation shall be cleaned and disinfected after every trip.

ii. Proper orientation on safety and precautionary measures including social distancing of passengers shall be provided to the drivers.

iii. The skeletal workforce shall report only during their assigned schedule or as necessary.

iv. The skeletal workforce shall adhere to the preventive measures enumerated in Items No. 2 and No. 3 of this memorandum.

v. The Central Office Task Force COVID-19 and similar task forces at the Regional Offices, Division Offices and Schools are enjoined to formulate implementing rules on the above items.

2. General preventive measures for the skeletal workforce (Based on DOH Circular No. 2020-0039)

a. **Respiratory etiquette**

i. Cough and sneeze into tissue or into shirt sleeve if tissue is not available. Dispose used tissues properly and disinfect hands immediately after a cough o sneeze.

ii. Avoid touching the mouth, eyes, and nose to help slow the spread of the virus.

iii. The use of masks, which provides a physical barrier from COVID-19 by blocking large-particle respiratory droplets propelled by coughing or sneezing, is **only** recommended for:

(1) Persons caring for the sick
(2) Healthcare workers attending to patients with respiratory infections/symptoms (cough/cold)
(3) Persons with respiratory infection/symptoms

iv. People in good health do not need to use face masks, except in crowded places where social distancing is not feasible.

b. **Hand hygiene.** Perform regular and thorough handwashing with soap and water. Use alcohol-based hand sanitizers containing at least 60 ethanol or isopropanol when soap and water are not available.

c. **Social distancing measures**

i. Whenever possible, keep a distance of at least 3 feet or 1 meter away from other people to reduce the possibility of person-to-person transmission. This distance should be observed even as to apparently healthy persons without symptoms.

ii. Offer telecommuting and replace in-person meetings in the workplace with video or telephone conferences.

d. **Environmental measures**

i. Clean frequently-touched surfaces and objects, including tables, doorknobs, desks, and keyboards.

ii. Maintaining the environment clean, especially common-use areas and those with touchpoints such as elevators, railings, staircases, light switches and the like.

iii. Make dispensers with alcohol-based hand rub available in public areas.

3. **Practical measures for the offices at the DepEd Central, Regional, Division, Facilities and/or Schools while on skeletal workforce**

a. One major consideration when determining the skeletal workforce to report to the office is the workspace. The number of personnel to report each day shall permit strict observance of social distancing within the office.

b. All personnel who are reporting as part of the skeletal workforce shall always have the "mindset" and be conscious to behave as if they may be possibly be infected with the virus, albeit asymptomatic, and may be potentially exposing their colleagues to the virus.

c. All reporting staff must as much as possible stay only in their respective workstations, and avoid moving around the office.

d. Talking closely between personnel during reporting hours is highly discouraged. Talking is also discouraged in common areas such as near the water dispenser or the photocopier.

e. All personnel are advised to always carry their own pens with them so that they use it when filling-out log-sheets at the entrance.

f. All personnel are advised to wash their hands with soap upon arrival at the

DepEd Complex before entering their respective offices.

g. Doors may be slightly opened so that feet or elbows may be used when opening and closing them, instead of opening them through the doorknobs.

h. Social distancing—keeping a distance of at least 3 feet or 1 meter away from other people—shall be strictly observed at all times in the entire DepEd complex.

i. Personnel who manifests symptoms of respiratory infection shall be immediately provided with appropriate health care and automatically removed of the skeletal workforce. Likewise, personnel who will have exposure to a confirmed case, or whose household members will be eventually categorized as Person Under Monitoring or Person Under Investigation shall immediately disclose such information to their immediate supervisor for appropriate referral and intervention.

The DepEd Task Force COVID-19 welcomes suggestions and ideas on how social distancing and other preventive measures can be further practiced in the workplace. Such feedback and other concerns may be e-mailed at medical.nursing@deped.gov.ph.

For proper guidance.

ALAIN DEL B. PASCUA
Undersecretary
Chairperson, DepEd Task Force COVID-19

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Date

NAME
Designation
Office
Address

Re: Approval by the Regional Office of _____

Dear _____,

This has reference to your request for the use of the school, (Name of School), for (Purpose of Use), in relation to the COVID-19 public health emergency.

The Department of Education Regional Office of _____ has approved the request, subject to the attached minimum "Terms and Conditions for the Use of DepEd School by the Local Government Unit as (Intended use/purpose)" with annexed School Inventory indicating the facilities of the school relative to the request.

Kindly sign the Terms and Conditions and the School Inventory to signify your conformity.

Sincerely,

_____
(School Head)

TERMS AND CONDITIONS
FOR THE USE OF DEPED SCHOOL AS ___(Indicate intended use) __
BY THE LOCAL GOVERNMENT UNIT

The Local Government Unit of the City/Municipality of _____, with office address at _____, and represented by _____, Mayor, hereinafter referred to as the "LGU", has requested from the DepEd-Regional Office of _____, as represented by _____, Regional Director, hereinafter referred to as the "RO", the use of ___(Name of School)___, with address at _____ and School Head, (Name of School Head), as a _____ relative to the COVID-19 public health emergency.

The request is made under the following premises:

The President issued Proclamation No. 922 dated March 8, 2020, "Declaring a State of Public Health Emergency Throughout the Philippines", in view of the COVID-19 outbreak;

Section 2 of Proclamation No. 922, s. 2020, states that "(a)ll government agencies and LGUs are hereby enjoined to render full assistance and cooperation and mobilize the necessary resources to undertake critical, urgent, and appropriate response and measures in a timely manner to curtail and eliminate the Covid-19 threat";

The LGU needs a facility for _____ relative to its response to the COVID-19 public health emergency and it has no other available place or structure for use, thus it submitted a request to the RO for the use of the (Name of School), hereinafter referred to as the "School", as _____ of the LGU, subject to OFFICE MEMORANDUM OM-OSEC-2020-00___;

The RO, acting on the recommendation of the Schools Division Office, approved the request, in adherence to applicable laws, rules and guidelines, upon a clear showing by the LGU of the need to use the School as _____ due to absence of other available facility, and pursuant to an assessment by the Regional Director of the Department of Interior and Local Government/Head of the Regional Task Force COVID-19 that the use of the school is compliant with the national directives on COVID-19 and a certification by the proper local official that the use of the school is suitable for the specific intended purpose, in accordance with applicable rules and guidelines.

The approval of the RO was conditioned upon the presentation of the planned management of the facility and undertaking of the LGU for the safekeeping of all property and valuables in the school premises during the operation of the facility, payment of all expenses including utilities in relation to the use of the School as a

_____, conduct of the general cleaning and fumigation, repair and/or replacement of damaged or lost school facilities as a result of, and incidental to, the use of the School by the LGU, and compliance of the LGU with the safety regulations and precautionary measures enforced during the public health emergency.

Foregoing premises considered, the LGU commits and binds itself to the following terms and conditions set by the DepEd in its use of the School as _____:

I. SCOPE

This Terms and Conditions (TAC) pertains to the use of (NAME OF THE SCHOOL) as _____ of the LGU in relation to the COVID-19 outbreak during the period of Public Health Emergency under Proclamation No. 922, s. 2020. The School may only be used by the LGU for this purpose if classes are not being conducted therein.

II. ROLES AND RESPONSIBILITIES

A. **The LGU shall:**

1. Prepare the areas of the School approved by the RO to be used as _____, and not require students/pupils and DepEd personnel to be engaged in the preparation of the School for this purpose. The LGU shall vacate the designated areas and remove education equipment and resources therefrom, as may be necessary, under the supervision and guidance of the School.

2. Use only the specified School area and facilities approved by the RO to be used as _____ under the supervision of the LGU.

3. Take charge of the management and maintenance of the School used as _____.

4. Cordon off the _____ facility to be used by the LGU from the rest of the School premises or facilities.

5. Provide measures to ensure the safety and security of the School.

6. Provide all resources and equipment required for the use of the School as _____.

7. Ensure that water supply will be sufficient and there will be no cooking in the School during its use as _____.

8. Ensure compliance with the sanitation and health standards applicable to the School before, during and after its use by the LGU as _____, including disinfecting the premises used and ensuring the use of required protective equipment.

9. Facilitate and provide for the general cleaning, maintenance and upkeep of School premises, structures, facilities, equipment, and resources, and repair and replace them if damaged, destroyed or lost as a result of their use by the LGU as _____. Such repair and replacement shall be completed prior to the return of the use of the School to the School Head.

10. Clean up and fumigate the School within a maximum period of one week after its use by the LGU as a _____ during the public health emergency. The proper health authorities shall certify whether the School is fit for education use subsequent to the fumigation, in accordance with pertinent guidelines of the Department of Health (DOH) and other applicable rules and issuances.

11. Pay for utilities during its use of the School as _____, and until it has returned the use of the School to its School Head for education use and the School Head has accepted the same.

12. Ensure that the School and facilities be restored to their original or better state, compared to their condition upon commencement of their use as _____ by the LGU.

13. Prior to return by the LGU of the use of the School to the School Head, secure clearance from the School with respect to the LGU's compliance with the TAC.

B. The School shall:

1. Identify the School spaces/structures/comfort rooms and other facilities approved by the RO to be used as _____. School areas beyond those approved by the RO shall be off limits to the LGU and users of the _____ facility.

2. In preparation for the use of the School as _____, ensure proper storage and safekeeping of all learning and education equipment, resources, materials and school records. The School shall provide supervision and guidance to the LGU in the vacating, as may be necessary, of designated School spaces/structures and removal of education equipment and resources therefrom by the LGU, provided that all DepEd personnel involved in the preparation of the school premises shall strictly observe all existing health precautions and social

distancing protocols of the DOH and the World Health Organization (WHO).

3. Prepare and implement work protocols that would not require DepEd personnel to report to the School for the performance of regular functions during the period the School is used as _____.

4. Inform the LGU of any damage, destruction, or loss of School facilities and resources due to, or incidental to, the use of the School, if any, to serve as basis for repair, maintenance, and/or replacement by the LGU after use of the School as _____.

5. Have the authority to monitor and access the School, subject to strict observance of safety and health requirements applicable during the public health emergency.

C. **The LGU and the School**

1. The School shall make a School Inventory and record the condition of school premises, structures, facilities, equipment and resources immediately prior to use, and after the use and fumigation of the School by the LGU. The Inventory prior to use shall be signed by both the School Head and Mayor and shall form an integral part of this TAC (*See* Annex A).

2. Any and all expenses relative to the preparation and operation of the School as _____ as well as the clearing, fumigation and restoration of the School to its educational use shall be shouldered by the LGU.

3. The School and LGU shall each designate focal person/s who shall be responsible for coordination between the Parties to ensure compliance with this TAC.

III. GENERAL PROVISIONS

1. The LGU shall use the School as _____ only upon its showing to the RO that there is no other available space or structure which can be used for that purpose. The use of the School as _____ is a continuing requirement. Should a place or structure which can be used for this purpose become available, the LGU shall terminate its use of the School as _____.

2. This TAC shall take effect upon its execution, and shall be in full force and effect for a period of (Indicate number of days approved by the RO) days during the period of Public Health Emergency under Proclamation No. 922, s. 2020, unless mutually extended by the LGU and the RO in writing, or sooner terminated by either the LGU or the RO upon fifteen-day written notice for valid reasons.

   Notwithstanding the lifting of the said Public Health Emergency, the responsibilities and obligations of the LGU under this TAC shall subsist until fully complied with.

3. When warranted by compelling circumstances, the RO may amend, modify or supplement this TAC for valid reasons, upon prior written notice to the LGU.

4. The LGU represents and warrants that it has the requisite power and authority to make, deliver, and comply with the provisions of this TAC, and has taken all the necessary actions to duly and validly authorize the execution, delivery and performance of this TAC.

5. Should there be any conflict between the provisions of this TAC and other Agreements between the LGU and the DepEd through the Regional Office, Schools Division Office or the School, this TAC shall prevail.

LOCAL GOVERNMENT UNIT OF THE CITY/MUNICIPALITY OF:

_____

By:

_____

Signature over Printed Name
City/Municipal Mayor

Date:

_____

REPUBLIC OF THE PHILIPPINES)
CITY/MUNICIPALITY OF _____) s.s.

Before me, a notary public for and in the City of _____, this _____, personally appeared the following:

Name	Competent Evidence of Identity	Date/Place Issued
School Head		
Mayor		

known to me to be the same persons who executed the foregoing documents on Terms and Conditions for the Use of DepEd School by the Local Government Unit as _____ with School Inventory consisting of _____ (___) pages, including the Annex A-School Inventory and the page on which this Acknowledgment is written, and they acknowledged to me that the same are their free and voluntary act and deed.

WITNESS MY HAND AND SEAL, on the date and in the place first above written.

NOTARY PUBLIC

Doc. No. _____;
Page No. _____;
Book No. _____;
Series of 2020.

ANNEX A

INVENTORY OF FACILITIES OF
(NAME OF SCHOOL)
FOR USE AS _____

Designated Facilities for Use as _____**:**

1. E.g. Gymnasium
2. Room _____
3. Room _____
4. _____

Facility (Gymnasium, Room, etc.)	Item (Furniture and Fixture, Equipment, etc.)	Quantity	Condition

Other Remarks on Premises/Structures/Facilities

_____
_____

Prepared by:

_____
Signature over Printed Name
School Head

Date _____

Conforme:

_____
Signature over Printed Name
Mayor

Date_____

Republika ng Pilipinas
Kagawaran ng Edukasyon
Tanggapan ng Pangalawang Kalihim

DepEd Task Force COVID-19
MEMORANDUM No. 268
07 December 2020

For: **Secretary LEONOR MAGTOLIS BRIONES**
Executive Committee
Management Committee

Subject: **SUBMISSION OF DTFC-19 DRAFT GUIDELINES ON THE CONDUCT OF FACE-TO-FACE ENGAGEMENTS INVOLVING LEARNERS AND PERSONNEL**

In October 2020, the Office of the Undersecretary for Administration (OUA), as the chair of the DepEd Task Force COVID-19 (DTFC-19), and the OUA strand expressed its **support for the resumption of limited, critical, and feasible face-to-face engagement with learners**, provided that the health and safety of learners are ensured, and that strategies as prescribed by health authorities – the Department of Health and the Inter-Agency Task Force on Emerging Infectious Diseases (IATF) - are in place to **mitigate and suppress the possible transmission** of COVID-19 in settings where the face-to-face engagement will take place. Draft guidelines for these were likewise submitted.

Informed by the Omnibus Guidelines on the Implementation of Community Quarantine in the Philippines, DepEd's Basic Education Learning Continuity Plan for School Year 2020-2021 In Light of the COVID-19 Public Health Emergency, and the Guidelines on the Required Health Standards in Basic Education Offices and Schools, the said position considered the following:

1. Anecdotal reports of learners encountering difficulty in accessing alternative learning modalities show that for many learners and communities, face-to-face engagement remains essential for holistic learning to be effective. This is particularly applicable for low-risk areas and those with limited to no documented community transmission of COVID-19;

2. While deferring to the Curriculum and Instruction Strand for an assessment on the benefits of face-to-face engagement to the teaching-learning process, it is emphasized that mental and psychosocial health factor greatly both in the learners' development of the needed competencies, and in their holistic learning and development;

3. Responsible face-to-face engagements are integral to building and strengthening mental resilience;

4. Physical interaction and activities optimize learner support services;

5. The school can be a safe place as long as protective measures are properly observed, noting that learners and personnel have acquired COVID-19 even at a home through close contact with family members; and

6. School health and nutrition policies, programs, and activities are currently in place and can help ensure the health and safety of learners.

In light of this, the **DTFC-19 resubmits its revised Guidance to Regional Directors on the Conduct of Face-to-Face Engagements Involving Learners and Personnel** for the consideration of the Department's leadership. The draft Guidelines provides the criteria and coordination needed for allowing the conduct of essential, safe, and limited school-based face-to-face engagements; measures for COVID-19 prevention and mitigation in schools; and the protocols on the management of possible cases of COVID-19 among personnel and learners engaged in face-to-face activities.

For all future correspondence and queries on this matter, please contact the Bureau of Learner Support Services - School Health Division through email address blss.shd@deped.gov.ph or telephone number (02) 8632-9935; or the Disaster Risk Reduction and Management Service through email address drrmo@deped.gov.ph or telephone number (02) 8637-4933.

ALAIN DEL B. PASCUA
Undersecretary
Chairperson, DepEd Task Force COVID-19

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Republika ng Pilipinas

Department of Education

OFFICE MEMORANDUM
OM-O S E C-2 0 2 0-00_

GUIDANCE TO REGIONAL DIRECTORS ON THE CONDUCT OF FACE-TO-FACE ENGAGEMENTS INVOLVING LEARNERS AND PERSONNEL

To: Undersecretaries
Assistant Secretaries
Bureau and Service Directors
Regional Directors and BARMM Minister of Education
Schools Division Superintendents
Public and Private Elementary and Secondary School Heads
All Others Concerned

1. The Department of Education (DepEd) remains fully committed to support the Office of the President, the Inter-Agency Task Force for the Management of Emerging Infectious Diseases (IATF), and the Cabinet in undertaking measures to curtail and eliminate the COVID-19 threat and its secondary impacts.

2. The *Omnibus Guidelines on the Implementation of Community Quarantine in the Philippines, with amendments as of November 19, 2020* continues to be guided by DepEd's *Basic Education Learning Continuity Plan for School Year 2020-2021 In Light of the COVID-19 Public Health Emergency* (BE-LCP).

3. While the BE-LCP, adopted through DepEd Order No. 12, s. 2020, states that no face-to-face classes shall be held until safe, it clarifies that DepEd shall continue to monitor developments in the COVID-19 epidemiological picture and localized COVID-19 situation, to contribute to continuing discussions in the IATF, the Cabinet, or with the President, on the safety of reopening schools/Community Learning Centers (CLCs) for face-to-face classes.

4. Since the release of the BE-LCP, key indicators released by the Department of Health show that the government and communities have been faring better in curbing the spread of COVID-19. As sustaining this positive trend requires complementary non-pharmaceutical interventions, DepEd efforts are aligned with the *Guidelines on the Risk-Based Public Health Standards for COVID-19 Mitigation* (DOH Administrative Order No. 2020-0015) which identifies as one of the four core strategies for mitigating COVID-19 increasing physical and mental resilience.

5. Along these lines, the Department continues to pursue the continued delivery of quality, accessible, relevant, and liberating basic education for all, in a safe manner amidst, the evolving challenges of the COVID-19 pandemic. Aside from the adoption of blended learning, DepEd has initiated various online and TV-based Mental Health and Psychosocial Support Services (MHPSS) initiatives, and developed, printed, and disseminated MHPSS materials for learners. However, existing DepEd MHPSS measures may not be sufficient.

6. To optimize physical, mental, and social development of learners, DepEd finds that face-to-face engagement with and between learners remains essential particularly for areas with low risk of community transmission and high levels of public healthcare system capacities; and in areas with recognized challenges in implementing distance learning.

7. The need for face-to-face engagement is further driven by a recognition of the negative mental and psychosocial impacts of the pandemic on learners. Children, recognized as a vulnerable group, have a unique set of needs that must be addressed to enable them to be more well-rounded individuals. Central to this is physical and social interaction with their peers and teachers, which have been severely limited due to the imposition of preventive measures. In line with the expressed priority of the State to increase mental resilience, DepEd recognizes that mental health factors greatly both in the learners' development of the needed competencies, and in their holistic learning and development.

8. It will be recalled that in preparation for the eventual resumption of face-to-face activities and physical classes, DepEd Order No. 14, s. 2020 was released to detail the *Guidelines on the Required Health Standards in Basic Education Offices and Schools.* This prescribes systems and protocols for the protection of the health, safety, and well-being of learners, teachers and personnel, and the prevention of further transmission of COVID-19 by facilitating the safe return of learners, teachers, and personnel to schools/CLCs and offices, at the time and to the extent allowed. Thus, as long as protective measures are properly and consistently observed, the school can be considered a safe space.

9. The Department has likewise been receiving feedback on the need for more localized and context-specific policies governing allowable activities for the basic education sector which more heavily factor in local conditions and capacities.

10. In this light, DepEd shall allow for the conduct of essential, targeted, responsible, safe, and limited school-based face-to-face engagements involving learners and personnel for the purpose of:

a. Conducting limited face-to-face classes;
b. Conducting limited face-to-face activities in aid of distance or home-based learning (e.g., access to school-based learning resources such as books in the library and the school's internet connection, physically distant face-to-face consultation with school personnel);
c. Provision of mental health and psychosocial support services; and
d. Provision of access to and/or implementation of learner support services (e.g., school health and nutrition activities, youth formation activities, permitted school sports activities), and other co-curricular and extracurricular activities.

11. The conduct of such face-to-face engagements shall only be allowed in schools and CLCs that have met the standards stipulated in DO 14, s. 2020 (Enclosure No. 1), as well as any new standards that may be/have been set by national authorities, as disseminated/adopted by DepEd, and local authorities as mandated to the schools within their jurisdiction.

12. I hereby delegate to Regional Directors the responsibility to assess, plan, coordinate, and if deemed necessary and feasible, implement any or a combination of the school-based face-to-face engagements involving learners and personnel listed above.

13. The *Omnibus Guidelines on the Implementation of Community Quarantine in the Philippines, with amendments as of November 19, 2020* states that for areas placed under Modified General Community Quarantine, the BE-LCP shall be adopted. Per the BE-LCP, the option of conducting face-to-face engagements shall only be applicable for schools/CLCs in low-risk areas, which are either under Modified General Community Quarantine or under the Post-Quarantine Scenario or the New Normal, at the time and to the extent allowed by the national IATF. The DepEd Task Force COVID-19 (DTFC) shall facilitate communications to the national IATF on behalf of DepEd and provide necessary guidance to the concerned regions with regards to the decisions of the national IATF on allowing the physical opening of schools and/or the conduct of face-to-face classes.

14. It is further emphasized that the safety of learners and personnel remains a paramount consideration in determining the need for and feasibility of conducting school/CLC-based face-to-face engagements, and such, shall be treated as a last resort. Decision-making, planning, and implementation shall be guided by the following:

a. The DepEd Regional Office concerned must have determined that the conduct of the face-to-face engagement is necessary, based on an assessment that shows that the other methods for delivering the desired outcomes have been demonstrated to be insufficient.

b. All applicable measures stipulated in the **DepEd Required Health Standards (DepEd Order No. 14, s. 2020)** must be established in the school where the face-to-face engagement will take place. All logistics and systems for the face-to-face engagement must be established with corresponding financial allocation to ensure that the required health standards are consistently and thoroughly met. Particular attention shall be given to Enclosure No. 2 to DepEd Order No. 014, s. 2020 or the **Specific Measures for COVID-19 Prevention and Mitigation in Schools**, which is reiterated in this Office Memo as Enclosure No. 1. This covers the following:

    i. Routines and Protocols for Health and Safety
        (a) General Health and Safety Protocols
        (b) Detection and Referral
        (c) School Activities and Events
        (d) School Clinic and Health Services
        (e) DepEd Health and Safety Policies

    ii. Physical Arrangement in Schools
        (a) Ventilation and classroom layout (proposed layout is provided in Enclosure No. 5 to DepEd Order No. 014, s. 2020, which is reiterated in this Office Memorandum as Enclosure No. 2)
        (b) Proper sanitation and hygiene facilities
        (c) Common area for visitors and/or clients
        (d) Provision of sanitation and hygiene items
        (e) Information, education, and communication materials

(f) Materials Recovery Facility

iii. Support Mechanisms
   (a) Physical and Mental Resilience
   (b) Administrative Support

iv. Screening of Returning Personnel and Learners and Testing Protocol

c. All local measures set by local health authorities (e.g., Local IATF, LGU) must be established in the school and the community where the face-to-face engagement will take place. Compliance to these standards shall be evidenced by a certification from the Local IATF.

d. Scheduling of face-to-face activities must permit a reduced number of learners inside the classroom or school facility to ensure that physical distancing is observed. The physical arrangement of classrooms shall be guided by Enclosure No. 5 of DepEd Order No. 14, s. 2020.

e. The selection of learners who will be provided with face-to-face engagement must be strategic.

   i. Priority shall be given to learners who are capable of observing precautionary measures (e.g., wearing of face masks, observing physical distancing, disinfecting their hands) with minimal adult supervision;
   ii. Learners with existing health or medical conditions that make them vulnerable to the severe effects of COVID-19 (i.e., immunocompromised) shall not be selected, except for essential school health and nutrition activities that cannot be otherwise effectively delivered in their homes.
   iii. Learners who live with household members who have existing health or medical conditions that make them vulnerable to the severe effects of COVID-19 shall be prioritized for distance/home-based modalities.
   iv. Learners having the most difficulty learning through distance/home-based modalities, including learners with disabilities whose conditions require face-to-face instruction, and those documented to be affected by mental health concerns that may be alleviated by guided physical interactions shall be prioritized.
   v. Learners residing proximate to the school vicinity shall be prioritized to lessen the risk of exposure using public transport.

f. The Section IV (Screening of Returning Personnel and Learners and Testing Protocol) of the Specific Measures for Covid-19 Prevention and Mitigation in Schools (Enclosure No. 2 to DepEd Order No. 014, s. 2020) shall be strictly observed, especially for learners who were suspect, probable, or confirmed cases of COVID-19.

g. The Regional Office must have devised an appropriate system for monitoring and evaluating the effectiveness of the face-to-face engagements and the safety and welfare of all concerned.

h. The **conduct of the face-to-face engagement must be approved by the concerned LGU and the Regional IATF.** In the interest of public safety, the Regional Directors are enjoined to make the conduct of the face-to-

face engagement a joint endeavor between DepEd, the LGU, and the Local IATF; and shall exercise sound discretion in considering all available local data and indicators.

15. The attached protocols on the management of possible cases of COVID-19 among personnel and learners involved in face-to-face activities (Enclosure No. 3), based on the Required Health Standards and the Preventive Alert System in School (PASS), shall be adopted.

16. These guidelines shall be likewise applicable to additional learning spaces in the community near the schools that may be identified by DepEd field offices and school authorities as safe for face-to-face engagement of learners.

17. Private schools are encouraged to refer to these guidelines in determining the strategies for the conduct of similar face-to-face activities for their learners.

18. For policy-related clarifications and concerns, contact the DepEd Task Force COVID-19 headed by the Bureau of Learner Support Services - School Health Division (email address blss.shd@deped.gov.ph or telephone number (02) 8632-9935). Matters on the implementation may meanwhile be directed to the concerned Regional COVID-19 DRRM Teams. Formed and activated by DepEd Memorandum No. 015, s. 2020, these COVID-19 DRRM Teams are led by School Health and Nutrition Personnel and supported by DRRM Coordinators.

19. For immediate dissemination and implementation.

LEONOR MAGTOLIS BRIONES
Secretary

Enclosure No. 1 to OM-OSEC-2020-____

REITERATION OF SPECIFIC MEASURES FOR COVID-19 PREVENTION AND MITIGATION IN SCHOOLS
(Enclosure No. 2 to DepEd Order No. 014, s. 2020)

I. Routines and Protocols for Health and Safety

A. General Health and Safety Protocols

1. Practice respiratory etiquette and other protective measures.

    a. Practice physical distancing (at least 1 meter apart) at all times.

    b. Frequently clean hands by using alcohol-based hand rub/ disinfectants or by proper handwashing with soap and water. Teachers shall allot a specific period among learners for regular and thorough handwashing with soap and water, subject to the strict observance of physical distancing.

    c. When sneezing/coughing, use tissue or inner portion of elbow to cover nose and mouth, and be sure that proper distance is maintained. Do not cover the mouth with the hand.

    d. Observe proper use of face masks at all times. Both nose and mouth must be covered.

    e. Those with no symptoms may use cloth/washable face masks, earloop masks, indigenous, reusable, do-it-yourself masks, or face shields, handkerchiefs, or such other protective equipment or any combination thereof, which can effectively lessen the transmission of COVID-19.

    f. Surgical masks—to be stored in the school clinic and available at the school entrances, shall be reserved for symptomatic individuals and health care providers. Individuals who will manifest symptoms shall immediately be provided with a surgical mask and brought to the school clinic for checking/monitoring/advice, e.g., send home, refer to a hospital/appropriate health authority.

    g. Practice proper disposal of tissue and masks after use.

2. All learners, teachers and personnel, on the first day of their reporting to school, shall be provided with an initial orientation on the respiratory etiquette and other protective measures. It shall be reiterated that the same measures are expected to be practiced in other public places, including when they travel to and from the school, and even at home should risk factors exist.

3. The school shall ensure that each learner, teacher, and personnel has access to the following upon return to school:

    a. Cloth/washable face masks, earloop masks, indigenous, reusable, do-it-yourself masks, or face shields, handkerchiefs, or such other protective equipment or any combination thereof, which can effectively lessen the transmission of COVID-19
    b. 1 toothbrush and 1 toothpaste (K-6 learners)
    c. 1 bar of soap (K-6 learners)

4. The school shall ensure availability of hand soaps/hand-sanitizers/alcohol-based solutions/other disinfectants in restrooms, classrooms, entrances, etc. by doing routine monitoring and replacement/replenishment if needed.

5. The school shall ensure routine cleaning/disinfection of frequently touched surfaces and objects (tables, doorknobs, desks, and school items) using bleach solution at least twice a day, preferably before the start of scheduled physical classes (e.g., once in the morning, once in the afternoon), as well as the routine cleaning and the replacement of disinfectant solutions in foot baths. More intensive cleaning and disinfection shall be done on weekends.

B. **Detection and Referral**

1. All learners, teachers, personnel, and when applicable, visitors, shall be subjected to temperature checks using a thermal scanner prior to entering the school. Those who will have a reading of 37.5˚ Celsius or above shall be provided with a surgical face mask and brought to a private screening area that shall be set up near the entrance of the school where the concerned teacher, personnel, learner, or visitor can be further examined, for appropriate management, intervention, or referral.

2. Entrance to the school of visitors and other external stakeholders shall be discouraged. Non-face-to-face communications and coordination through available platforms (e.g., telephone, cellular network, the internet) shall be prioritized.

3. Teachers shall conduct daily rapid health check in the classroom. Those who will show symptoms of COVID-19 shall be given a surgical face mask and further assessed in the school clinic.

C. **School Activities and Events**

1. The school shall implement adjustments of schedule of classes and activities to allow for physical distancing in the classroom.

2. The school shall restrict conduct of physical or face-to-face large gatherings and activities that will require close contact or where physical distancing may not be possible (e.g., school activities, field trips, sports festivals, flag ceremony).

3. The school shall provide and maximize the use of online platforms which do not require physical interactions or congregations for the performance of tasks, including learning delivery, training, and conferences.

4. Travel of learners, teachers and personnel shall be limited only to the most critical or essential as determined by the Secretary or her designated officers.

5. Teachers shall devise and implement alternative means of recording and monitoring attendance.

D. **School Clinic and Health Services**

1. The school, with the support of concerned DepEd offices, shall ensure the establishment/setting-up/refurbishment of a school clinic to provide basic health services to learners, teachers and personnel, and when applicable, for visitors, such as:

    a. Health assessment and physical examination, as needed;
    b. Appropriate intervention, first aid, or treatment;
    c. Proper management of symptoms, including rest at home;
    d. Referral and follow-up of learners, teachers and personnel to appropriate health facilities

2. Aside from the school clinic, the school shall also designate:

    a. a private screening area near the entrance of the school where teachers, personnel, learners, and visitors who show symptoms upon screening at the entrance can be further examined, for appropriate management, intervention, or referral, and
    b. a separate space where sick learners, teachers and personnel who have been managed in the clinic can temporarily stay, awaiting referral to the appropriate health facility, without creating stigma.

3. In the absence of school health personnel, the school shall designate (a) clinic teacher(s) who shall manage the clinic every school day, to provide basic health services and facilitate referral as needed, in close coordination with the school health personnel at the SDO. Clinic teachers shall be provided prior orientation by the school health personnel at the SDO for proper guidance on how to effectively run the school clinic.

4. The school shall ensure that learners, teachers, and personnel who manifest COVID-19 symptoms shall not physically report to school and shall seek medical advice—virtual, if possible—as needed.

5. The school shall cooperate with the local health authorities in the tracing and quarantine of close contacts of confirmed cases of COVID-19, consistent with DOH guidelines.

6. The school shall ensure that learners and personnel who have tested positive for COVID-19 shall not return to school, even if they are already asymptomatic, unless cleared by medical authorities.

7. The school clinic shall ensure the availability of Emergency Health Kits that include PPEs and other needed supplies and materials. The PPEs should be available for COVID-19 DRRM team members, health personnel, maintenance, and security guards. The use of PPEs should be guided by the DOH Interim Guidelines on the Rational Use of Personal Protective Equipment for COVID-19-04-02 as summarized in the tables below:

   a. PPE requirement depending on the nature of the activity:

Activity	**Required PPE**
Triage and screening of individuals in points of entry (for personnel in school entrances)	Medical mask
Caring for a suspected case of COVID-19 with no aerosol-generating procedure (for personnel in school clinics)	Medical mask, goggles or face shield, gloves, gown
Caring for suspected/ confirmed cases of COVID-19 with aerosol-generating procedure (for personnel in school clinics)	Goggles or face shield, respirator (N95 or FFP2), gloves, gown
Assisting in transporting passengers to a healthcare facility	Full PPE

   b. Technical specifications of PPE:

Item	**Technical Specifications**
Medical Mask	Medical or surgical mask, disposable earloop, 3-ply, conforms to EN 14683 rating type standards or equivalent
Googles	Googles or laboratory safety googles, polycarbonate lens, soft, flexible, adjustable head strap, anti-fog, conforms to EN 166 standard or equivalent
Face Shield	Full face shield, anti-fog, latex-free, one-size fits all, soft head foam, comfortable stretch band, disposable, conforms to EN 166 standard or equivalent
Gown	Examination gown, disposable, non-sterile, SMS/PE coated polyethylene material, fluid-resistant, solid-front and rear opening, long sleeved with elastic cuffs, conforms to ASTM F1671 standards or equivalent

E. **DepEd Health and Safety Policies**

1. The school shall ensure the operationalization of the Preventive Alert System in Schools (PASS) for COVID-19 per DepEd Memorandum No. 15, s. 2020.

2. The school shall strengthen the implementation of DepEd Task Force COVID-19 Memorandum No. 25, s. 2020, or the Minimum Standards on Social Distancing.

3. The school shall develop its School Contingency and Response Plan for COVID-19.

4. To ensure the effective adoption of the proper hand and respiratory hygiene and other safety precautions, the school shall strengthen the implementation of DepEd Order No. 10, s. 2016, or the Policy and Guidelines for the Comprehensive Water, Sanitation and Hygiene (WASH) in Schools (WinS) Program.

5. To ensure the availability of nutritious foods in schools and support the promotion of ensuring a strong immune system among learners and personnel to fight COVID-19, the school shall strictly enforce DepEd Order No. 13, s. 2017 or Policy and Guidelines on Healthy Food and Beverage Choices in Schools and in DepEd Offices, as well as provide nutrition education and post nutrition education and information materials; e.g., *Pinggang Pinoy*, Food Pyramid and Cycle Menu.

6. In line with studies that link COVID-19 and smoking, the school shall strictly enforce the ban on smoking/vaping per DepEd Order No. 48, s. 2016, or the Policy and Guidelines on Comprehensive Tobacco Control and DepEd Memorandum No. 111, s. 2019 entitled Prohibiting the Use of E-Cigarettes and other Electronic Nicotine and Non-Nicotine Delivery System and Reiterating the Absolute Tobacco Smoking Ban in Schools and DepEd Offices. Brief Tobacco Intervention Providers at the SDO may be tapped to help learners and personnel who smoke to quit. The DOH Quitline can also be reached through https://www.facebook.com /DOHQuitlineofficial/. The schools are enjoined to communicate with local government units (LGUs) to pass an ordinance/implement the existing law that prohibits the sale of tobacco products to minors or within 100 meters from any point of the perimeter of the school, or implement stricter measures, if possible, as reiterated in DepEd Task Force COVID-19 Memorandum No. 39, entitled Strict Enforcement of Tobacco Control Policies, Including Smoke-Free and Vape-Free Policies, During the Enhanced and General Community Quarantine. Schools are also warned against partnerships with tobacco companies and NGOs and foundations funded by tobacco companies.

II. Physical Arrangement in Schools

A. All classrooms must meet the following standards:

1. Proper ventilation (open windows are preferred over air-conditioning systems)

2. Adherence to the attached classroom layout (Enclosure No. 4 of DepEd Order No. 014, s. 2020), specifying the physical designs of chairs and classroom arrangements that ensure proper physical distancing

B. The school shall establish and maintain proper sanitation and hygiene facilities:

1. Foot baths in all entrances

2. Toilets (with adequate water and soap)

3. Handwashing stations

C. The school shall create and operate a common area where physical distancing and appropriate prevention measures can be strictly enforced for accommodating visitors and/or clients.

D. The school shall ensure that the following are sufficiently provided in its premises:

1. Tissue paper/towel

2. Designated trash bins for tissue disposal

3. Adequate water and soap for handwashing (especially for all toilet facilities)

4. Hand-sanitizers/alcohol-based solutions/other disinfectants in all rooms, entrances, corridors, communal areas, and other amenities especially eating areas

E. Information, education, and communication (IEC) materials containing the key messages on health and safety shall be displayed in key strategic areas of the school, such as the school entrances, corridors, toilets, and other communal areas, or if practicable, distributed to the learners or personnel for their ready reference. The same IEC materials shall be shown or provided to visitors who need to enter the school premises.

F. The school shall ensure that a Materials Recovery Facility (MRF) is set up for proper waste segregation.

III. Support Mechanisms

A. Physical and Mental Resilience

1. The first five school days that the learners are physically present in school shall be devoted to discussion/facilitation of modules related to mental health, facilitated by their respective classroom advisers or designated teachers. Before the opening of the school year, classroom advisers or designated teachers are expected to take the training on how to facilitate the modules, which cover the following mental health topics, in addition to modules on the nature of COVID-19 and preventive measures (WASH, physical distancing, etc.):

    a. Validating and Normalizing Feelings

    b. Calming Down and Controlling One's Emotions

    c. Identifying and Addressing Needs

    d. Sources of Strength

    e. Other relevant topics as needed

2. The school shall maintain/set-up a guidance office that will remain operational for the entire school year.

    a. The school shall ensure that the guidance office is staffed by a registered guidance counselor (RGC) or a designated guidance associate (not an RGC but is trained on MHPSS and is capable of effective referral) every school day, to provide basic mental health services to learners, teachers and personnel who may need such services.

    b. The Schools Division Office (SDO) shall set up a hotline/online platform to provide counseling services to learners, teachers and personnel who require counseling services. In the absence of an RGC, learners, teachers and school-based personnel shall be referred to this platform for counseling services.

3. The school, through its guidance office, shall ensure the provision of specialized psychosocial support to learners, teachers and personnel who are confirmed to be positive, under isolation/ quarantine, and categorized as suspect and probable. The most appropriate method, which duly considers the safety of the MHPSS provider, shall be employed (e.g., provision through the internet or hotlines).

4. The school shall engage parents, guardians, or any care providers of learners on taking care of mental health and creating a positive environment.

5. The school shall ensure strict adherence to Republic Act No. 10173 or the Data Privacy Act of 2012 in the provision of mental health services and referral.

6. The school shall promote "school-life balance" through proper scheduling of schoolwork that will allow learners to enjoy quality time at home.

7. The DepEd Task Force COVID-19, in collaboration with the Bureau of Human Resource and Organizational Development (BHROD), the Bureau of Curriculum Development (BCD), the Bureau of Learning Delivery (BLD), National Educators' Academy of the Philippines (NEAP), and Youth Formation Division (YFD), shall issue guidelines on the mental health program and psychological support system for learners and personnel across all governance levels in DepEd.

8. The school shall continue to engage learners in at least 60 minutes of daily physical activities consisting of any one or a combination of activities based on the 2010 Physical Activity Prescription, Philippine National Guidelines in Physical Activity—namely, (a) active daily tasks; (b) exercise, dance, and sports; (c) high impact play (unstructured spontaneous play); and (d) muscle strengthening and flexibility activities—subject to the strict observance of physical distancing, proper hygiene and safety, and other precautionary measures.

B. **Administrative Support**

1. The school, with the support of concerned DepEd offices, shall ensure that teaching and non-teaching personnel undergo annual physical examination, in accordance with the provisions of RA 11223 or the Universal Health Care Act and its Implementing Rules and Regulations. The conduct of the physical examination shall be in accordance with precautionary and protective measures in light of the COVID-19 health emergency.

2. The school, with the support of concerned DepEd offices, shall re-establish the regular and safe delivery of essential services, including, but not limited to:

    a. protection referrals

    b. specialized services for children with disabilities

    c. school health and nutrition services such as medical and dental services, school feeding, immunization program, counseling, and brief tobacco interventions

3. Guidelines for the delivery of such services shall be issued by the Bureau of Learner Support Services–School Health Division (BLSS-SHD).

4. The school shall prioritize to provide alternative arrangements to learners, teachers and personnel who are elderly, who have underlying health conditions, or who are pregnant in the duration of the COVID-19 event. If alternative arrangements are not possible, designated areas must be available to high-risk groups.

5. The school shall explore partnerships to assist learners, teachers and personnel especially those belonging in vulnerable groups through initiatives including but not limited to transportation, provision of PPEs and social amelioration. The school shall reiterate policies that will help reduce expenses of families (e.g., non-mandatory use of school uniforms; no collection policy).

6. The school shall ensure that personnel on work-from-home arrangement are provided with logistical support, and that reasonable expenses incurred are covered in accordance with CSC Memorandum Circular 10, s. 2020 and with the DepEd revised guidelines on implementing alternative work arrangements to minimize contact in offices and schools.

7. The school, with the support of concerned DepEd offices, shall ensure the provision of the following:

    a. Temporary accommodations to learners, teachers and personnel, if necessary (e.g., for personnel requiring daily/long travel/commute; visiting health personnel who will need to provide services for an entire week).

    b. Financial, transportation, internet/communication allowance, food, and other commodities (e.g., medical and dental supplies and supplements) for essential workforce, if necessary and practicable, may be considered as allowable expenses. The provision of transportation shall be subject to standards of physical distancing, disinfection, and observance of other health protocols measures.

    c. Assistance to learners, teachers and personnel who contract the virus in coordination with PhilHealth to avail of the case-based payment of the benefits of patient with probable or confirmed COVID-19 under the PhilHealth Circular No. 2020-0009 and other relevant government health institutions.

IV. Screening of Returning Personnel and Learners and Testing Protocol

A. Screening of Returning Personnel and Learners

1. All returning personnel and learners physically reporting to the school shall be screened for symptoms of COVID-19, including fever, cough, colds, and other respiratory symptoms, and/or relevant history of travel or exposure within the last 14 days. The following should have happened two (2) days before or within 14 days from onset of symptoms of a confirmed or probable case:

a. Face-to-face contact with a confirmed or probable case within 1 meter and for more than 15 minutes

b. Direct physical contact with a confirmed case

c. Direct care for a patient with a probable or confirmed COVID-19 disease without using proper personal protective equipment

2. Returning personnel and learners who **are symptomatic with relevant history of travel/exposure on the date of reporting to the school** shall not be allowed to physically report to the school and must consult with their primary care provider. The use of telemedicine is encouraged for proper care and coordination.

3. Returning personnel and learners who **were symptomatic with relevant history of travel/exposure within the last fourteen (14) days prior to the date of reporting to the school** shall present the Certificate of Quarantine Completion duly issued by the step-down care facility or local health office, whichever is applicable based on the latest DOH guidelines.

4. If **asymptomatic** within the last fourteen (14) days prior to the date of physically reporting to school, personnel and learners **without relevant history of travel or exposure** can be **allowed** to physically return to the school.

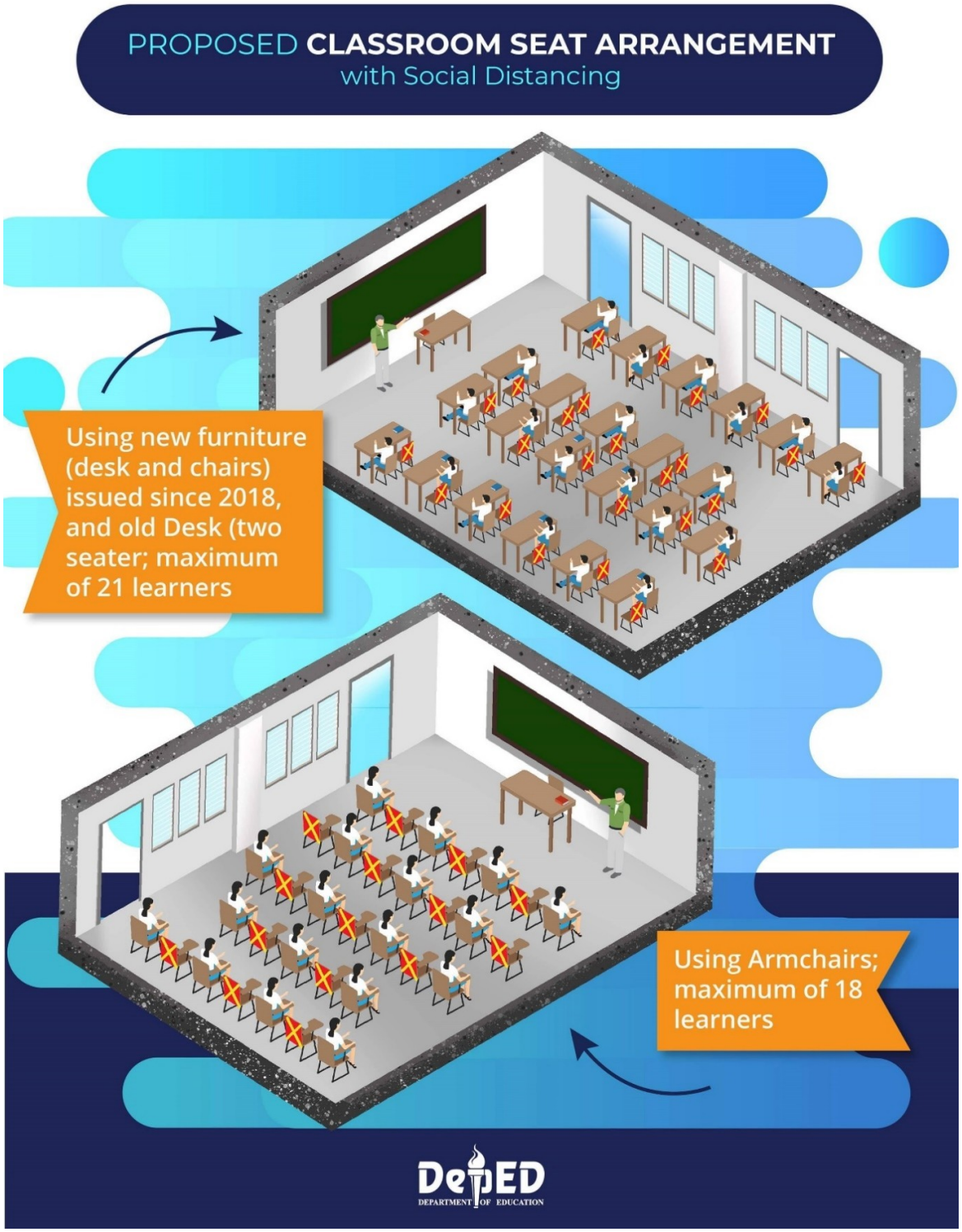
5. If **asymptomatic** within the last fourteen (14) days prior to the date of physically reporting to school, personnel and learners **with relevant history of travel or exposure** can be **cleared to physically return to the school only upon presentation of a medical certificate** issued by local health authorities such as DepEd school health personnel or the provincial, city, or municipal health office.

6. If **symptomatic** within the last fourteen (14) days prior to the physically reporting to school, personnel and learners **without relevant history of travel or exposure** shall **seek medical advice** for proper treatment/intervention and the issuance of the necessary **medical certificate** prior to reporting back to the school.

B. The testing protocol shall be as provided in Enclosure No. 1 of DepEd Order No. 014, s. 2020.

Enclosure No. 2 to OM-OSEC-2020-____

REITERATION OF
PROPOSED CLASSROOM SEAT ARRANGEMENT WITH SOCIAL DISTANCING
(Enclosure No. 5 to DepEd Order No. 014, s. 2020)



This new arrangement uses existing school furniture as physical barriers between learners to better implement social distancing measures, and does not require moving the furniture.

Enclosure No. 3 to OM-OSEC-2020-____

PROTOCOLS ON THE MANAGEMENT OF POSSIBLE CASES OF COVID-19 (CLOSE CONTACTS, SUSPECT, PROBABLE, CONFIRMED) AMONG PERSONNEL AND LEARNERS ENGAGED IN FACE-TO-FACE ACTIVITIES

All Regional offices (ROs) and Schools division offices (SDOs) shall adapt the following prescribed guidelines and protocols on the management of possible cases of COVID-19 (close contacts, suspect, probable, confirmed) among their personnel and learners engaged in face-to-face activities, contextualizing or localizing where necessary, based on the prevailing issuances of their respective local authorities and/or the directives of national authorities.

I. Overall responsibility of the School Head in the management of cases

A. It is emphasized that the **School Head, with the support of the School DRRM Team, shall ensure the monitoring** of all COVID-19 cases (close contacts, suspect, probable, confirmed) among all learners and personnel under his/her jurisdiction, as well as the necessary coordination with DepEd school health personnel and local health authorities, and the provision of necessary support to the concerned personnel and learners, as the school may be able to provide.

B. The role of **School Health and Nutrition Units/Sections** (composed of medical doctors, dentists, nurses, and nutritionist-dietitians) in providing technical assistance to the schools in the management of COVID-19 cases, including the establishment and operations of the school clinics, is also emphasized.

II. Ensuring the establishment of a school clinic/presence of health personnel/designated clinic teacher(s)

A. It is reiterated that per the **Required Health Standards**, the school, with the support of concerned DepEd offices, shall:

1. Ensure the establishment/setting-up/refurbishment of a **school clinic** to provide basic health services to learners, teachers and personnel, and when applicable, for visitors;

2. Designate **rest space/separate space** where sick learners, teachers and personnel who have been managed in the clinic can temporarily stay, awaiting referral to the appropriate health facility, without creating stigma; and

3. Designate a **private screening area near the entrance of the school** where teachers, personnel, learners, and visitors who show symptoms upon screening at the entrance can be further examined, for appropriate management, intervention, or referral.

B. It is also reiterated that per the **Required Health Standards**, the school shall, in the absence of school health personnel, designate (a) **clinic teacher(s)** who shall manage the clinic every school day, to provide basic health services and facilitate referral as needed, in close coordination with the school health personnel at the SDO.

III. Establishing coordination lines/referral system with local health authorities

A. The school shall ensure that Preventive Alert System in Schools (PASS) for COVID-19, per DepEd Memorandum No. 15, s. 2020, is operationalized. This means that the teacher shall ensure that health inspection is routinely conducted during the conduct of the face-to-face activities.

B. The school shall also ensure that health personnel or designated clinic teacher(s) are **physically present at the school clinic** on every day that the school will open to learners for face-to-face activities.

C. Consequently, the health personnel or the designated clinic teacher(s) shall ensure that the school has **an established and open communication line/referral system with local health authorities** identified by the local government unit to respond to and manage COVID-19 cases in the locality where the school is situated (e.g., barangay health station, rural health unit, etc.) This includes the availability of the necessary contact information (e.g., emergency numbers) of the said health authorities.

D. The health personnel or the designated clinic teacher(s) shall also ensure **an established and open communication line with the School Health and Nutrition Unit/Section of the SDO** for proper coordination and necessary reporting.

IV. Management of cases arising from face-to-face engagement

A. **At the onset of symptoms/upon being informed of possible exposure to COVID-19**

1. Personnel or learners who show any COVID-19 symptom(s) shall be immediately provided with a **surgical mask** and assisted to either the clinic (if the symptom[s] is/are detected during the face-to-face activity) or to the private screening area near the gate (if the symptom[s] is/are detected upon entrance to the school). The same shall be done to personnel or learners who while in the school are informed of their exposure to/status as a close contact of a confirmed case.

2. The health personnel, or the designated clinic teacher receiving guidance from health personnel, shall ensure the provision of necessary emergency care to the personnel or learner, following precautionary measures.

3. The family/parent(s)/guardian(s) of the concerned learner shall be immediately notified.

4. The situation shall be referred/fully disclosed to the identified health authority (e.g., barangay health station, rural health unit) for further evaluation or referral to a hospital if needed. The same process shall be observed for teachers or other personnel who will exhibit symptoms of the virus.

B. **Contract tracing, disinfection of school facilities, and modification/suspension of face-to-face activities**

1. The School DRRM Team shall ensure that **contact tracing activities**, as required by the local health authorities, are initiated and completed among the possible close contacts among DepEd personnel and learners.

2. The School DRRM Team shall also ensure that necessary **disinfection activities** are conducted especially in the areas of the school frequented by the concerned personnel or learner.

3. The School Head, in coordination with the SDO and with the local government/local health authorities and in adherence to LGU/local IATF guidelines, shall **re-strategize/modify the implementation of face-to-face activities in the school, or suspend them, if needed.**

4. The declaration of a lockdown shall be dependent on the assessment and decision of the Local Task Force against COVID-19 (LTF).

C. **Monitoring of the cases during quarantine, isolation, or treatment**

1. The **School Head shall be overall responsible for the monitoring of all cases** (close contacts, suspect, probable, confirmed) among all learners and personnel under his/her jurisdiction, as well as the necessary coordination with DepEd school health personnel and local health authorities, and the provision of necessary support to the concerned personnel and learners, as the school may be able to provide.

2. Trained PFA providers of the school shall be mobilized to provide **necessary mental health and psychosocial support** to concerned personnel or learners.

3. Concerned learners and personnel shall strictly observe the advice of health authorities, including the possibility of home quarantine or isolation in a quarantine facility or confinement. If not sick, learners on home quarantine shall be given alternative delivery mode of education, while

personnel shall be shifted to a work-from-home arrangement.

4. The condition of the learner or the personnel shall be **closely followed up by the attending/assigned school health personnel or the designated clinic teacher**, and necessary information shall be reported to the SDO School Health and Nutrition Unit/Section, as required by existing reporting mechanisms (e.g., submission of data for the DepEd COVID-19 Situational Report).

D. **Upon completion of quarantine, isolation, or treatment/Before return to work/face-to-face activities**

The school health personnel or the designated clinic teacher shall ensure that the provisions of Section IV (**Screening of Returning Personnel and Learners and Testing Protocol**) of the Specific Measures for Covid-19 Prevention and Mitigation in Schools (Enclosure No. 2 to DepEd Order No. 014, s. 2020) are strictly observed before the personnel or learners are allowed to participate again in face-to-face activities.

V. Capacitating health personnel and designated clinic teachers for health services in the new normal

The DepEd Task Force COVID-19 (DTFC), through the Bureau of Learner Support Services-School Health Division (BLSS-SHD), shall design and implement a **comprehensive training for School Health and Nutrition personnel and designated clinic teachers**, on how to effectively run the school clinic, including the management of COVID-19 cases among DepEd personnel and learners.

The Philippine National Deployment and Vaccination Plan for COVID-19 Vaccines

Interim Plan
January 2021

Foreword

The COVID-19 pandemic has indubitably been be a great challenge to every Filipino in the past year. While this unprecedented situation has caused major changes in the everyday life of our citizens, we have proven well our ability to forge forward in the face of this crisis. In the past year, our strategy has focused on ensuring the minimum public health standards through the BIDA Solusyon campaign to mitigate the spread of the virus and protect the most vulnerable in the absence of a cure for the virus.

The hard work of scientific and medical professionals all over the world allowed us to enter the new year with not just brand new insights, but renewed confidence and vigor to fight this pandemic. The breakthroughs in the development of a vaccine for COVID-19 is an effective way of protecting our communities by reducing the possibility of severe cases. Now, countries all over the world are launching their respective vaccination programs to turn the tides of the pandemic, with the Philippines among the ranks of countries to have given the green light for the largest vaccination campaign to date.

Through the National Vaccine Deployment Plan, the Philippine government brings together all national agencies, local government counterparts, as well as partners in the private sector and civil society. By approaching the vaccination program in a whole-of-system, whole-of-government, whole-of-society approach, we can ensure the successes of the national vaccine deployment program in delivering safe, effective, and accessible vaccines for all Filipinos.

As our history, experience, and science has proven in the past decades, vaccines save lives. An effective and national vaccination program, in tandem with the continued observance of the minimum public health standards, will pave the way for the recovery of our beloved country and bring us one step closer to our vision of a Healthy Pilipinas.

FRANCISCO T. DUQUE III, MD, MSc
Secretary of Health
Chair, Inter-Agency Task Force for the Management of Emerging Infectious Diseases

Foreword

In the past year, we have faced the most challenging of times in our country's and in the world's history with the COVID-19 pandemic drastically affecting our lives. Globally, there are more than 90 million confirmed cases and 2 million deaths. Of this number half a million Filipinos have contracted the virus while nearly ten thousand have died. The pandemic has disrupted the economy, causing a nine percent contraction in the first half of 2020 and increased unemployment rate to 17.7 percent. While we are resuming economic activities and continuously adapting to the "New Normal", the risk of us or our loved ones getting infected and the uncertainty as to how or when the pandemic will end remains.

One of the most important developments in our fight against the pandemic is the development of COVID-19 vaccines at an unprecedented speed. While there is no cure and none of the vaccines that are being developed have been proven to prevent transmission, the vaccines still serve very important purposes. These are that of preventing severe disease thereby reducing deaths caused by severe effects of the virus and preventing symptoms from occurring thereby reducing transmission.

The Philippine situation must also be understood in light of the following major challenges in the national deployment and vaccination program. First, there is a very limited global supply of vaccines where every country in the world is seeking to gain access to vaccines and where 80% of available supply has already been taken by the richest countries. Knowing there is a limited supply, our policy is to build a portfolio of safe and effective vaccines and working with the private sector and our local government units because gaining access to more vaccine manufacturers and more partners enables us to secure more supply for our countrymen. Second, is that the effects of the vaccine have not been fully observed in some population groups.

Combatting the COVID-19 pandemic requires a Whole-of-Nation Approach. To ensure efforts are synchronized and integrated, there must be strong leadership and governance starting from the President, the Inter-Agency Task Force, the National Task Force, with the DOH and the DILG playing crucial roles in exercising command and control with the cooperation and strong participation of supportive academic societies, engaged government agencies and the private sector, highly committed LGUs and LCEs, adequately informed communities and well-prepared health systems.

While the vaccine is among the solutions, it is not the only solution to end the pandemic. Thus, it is critical for everyone's health, safety and well-being to still adhere to minimum public health standards, make smart choices based on correct information, practice safe behavior and for the health sector to conduct effective surveillance, contact tracing and have adequate capacity to manage the sick. The Department of Health, through the Task Group COVID-19 Immunization Program, has diligently worked on this comprehensive plan for vaccine deployment and vaccination in collaboration with other national government agencies under the COVID-19 Vaccine Cluster. This document will help unify the efforts of all stakeholders to effectively implement the National Deployment and Vaccination Plan for COVID-19 Vaccines and inform the general population on the plans of the government. We hope the combined efforts of all stakeholders will enable us to implement a sustainable immunization program essential to start economic recovery and restore normalcy in the lives of the Filipino people.

SECRETARY CARLITO G. GALVEZ, JR.
Chief Implementer and Vaccine Czar
National Task Force Against COVID 19

Acknowledgement

The Philippine National Deployment and Vaccination Plan for COVID-19 Vaccines (NDVP) was developed by the Philippine Government under the leadership of President Rodrigo Roa Duterte, and under the guidance of Health Secretary Franscisco T. Duque III and COVID-19 Vaccine Cluster Chair, Secretary Carlito G. Galvez Jr.

All government agencies under the COVID-19 Vaccine Cluster have contributed in the development of this plan: Office of the President (OP), Office of the Chief Presidential Legal Counsel (OCPLC), Department of Health (DOH), Department of Science and Technology (DOST), Food and Drug Administration (FDA), Research Institute for Tropical Medicine (RITM), Department of Trade and Industry (DTI), Department of Foreign Affairs (DFA), National Development Company (NDC), Department of Finance (DOF), Department of Budget and Management (DBM), Department of Interior and Local Government (DILG), Department of Social Welfare and Development (DSWD), Department of Education (DepEd), Department of National Defense (DND), Department of Information and Communications Technology (DICT), Department of Transportation (DOTr), Department of Justice (DOJ), Department of Labor and Employment (DOLE), Armed Forces of the Philippines (AFP), Office of Civil Defense (OCD), Philippine National Police (PNP), Bureau of Corrections (BuCor), Bureau of Jail Management and Penology (BJMP), and Task Group Resource Management and Logistics (TGRML) under the National Task Force Against COVID-19.

The Task Group COVID-19 Immunization Program, under the guidance of Undersecretary Myrna C. Cabotaje and Director Napoleon Arevalo, consolidated and ensured the completion of this plan. Further, special thanks to the following for doing the technical writing, editing and proofreading: Dr. Marianne B. Calnarv, Dr. Rhodora S. Cruz, Ms. Christine Joy Candari, Dr. Kezia Lorraine Rosario, Dr. Shaymae Ufano, Mr. Jay Dulay, Dr. Sarah Lazaga, Mr. Venjie Benito and Ms. Rowena J. Capistrano.

The contributions and insights of everyone are truly appreciated.

List of Acronyms

AEFI	Adverse Event Following Immunization
AESI	Adverse Event of Special Interest
AFP	Armed Forces of the Philippines
API	Application Program Interface
BHERTs	Barangay Health Emergency Response Teams
BJMP	Bureau of Jail Management and Penology
BuCor	Bureau of Corrections
CEIR	COVID-19 Electronic Immunization Registry
CHD	Center for Health Development
CHO	City Health Office
CIOMS	Council for International Organizations of Medical Sciences
COVID-19	Coronavirus Disease 2019
CPG	Clinical Practice Guidelines
CPR	Certificate Product of Registration
CSO	Civil Society Organization
DBM	Department of Budget and Management
DENR	Department of Environment and Natural Resources
DepEd	Department of Education
DFA	Department of Foreign Affairs
DICT	Department of Information and Communications Technology
DILG	Department of Interior and Local Government
DND	Department of National Defense
DOF	Department of Finance
DOH	Department of Health
DOJ	Department of Justice
DOLE	Department of Labor and Employment
DOST	Department of Science and Technology
DOTr	Department of Transportation
DPA	Data Privacy Act
DPCB	Disease Prevention and Control Bureau
DSWD	Department of Social Welfare and Development
DTI	Department of Trade and Industry
EB	Epidemiology Bureau
EO	Executive Order
ESU	Epidemiology and Surveillance Unit
EUA	Emergency Use Authorization

EXECOM	Executive Committee
FDA	Food and Drug Administration
GAA	General Appropriations Act
GAVI	Global Alliance for Vaccines and Immunization
GFI	Government Financial Institutions
GOCC	Government-owned and Controlled Corporation
H1N1	Influenza A virus subtype H1N1
HCWM	Health Care Waste Management
HEMB	Health Emergency Management Bureau
HIS	Health Information System
HPDPB	Health Policy Development and Planning Bureau
HTAC	Health Technology Assessment Council
HUC	Highly Urbanized Cities
IATF-EID	Inter-Agency Task Force on Emerging Infectious Diseases
ICC	Independent Component Cities
ICT	Information and Communication Technology
IHR	International Health Regulation
IPC	Infection Prevention Control
JV	Joint Venture
KMITS	Knowledge Management and Information Technology Service
LCE	Local Chief Executive
LGU	Local Government Unit
MERS-CoV	Middle East Respiratory Syndrome Coronavirus
MOH-BARMM	Ministry of Health-Bangsamoro Autonomous Region of Muslim Mindanao
MR-OPV SIA	Measles-Rubella Oral Polio Vaccine Supplemental Immunization Activity
NAEFIC	National Adverse Events Following Immunization Committee
NAP	National Action Plan
NART	National AEFI Response Team
NCDA	National Council on Disability Affairs
NDA	Non-Disclosure Agreement
NDC	National Development Company
NDVP	National Deployment and Vaccination Plan
NEDA	National Economic Development Authority
NIP	National Immunization Program
NITAG	National Immunization Technical Advisory Group
NPC	National Privacy Commission
NRA	National Regulatory Authority
NTC	National Telecommunications Commission
NTF	National Task Force
OCD	Office of Civil Defense
OCPLC	Office of the Chief Presidential Legal Counsel

ODA	Official Development Assistance
OHCS	One Hospital Command System
OP	Office of the President
PCG	Philippine Coast Guard
PCHRD	Philippine Council for Health Research and Development
PCOO	Presidential Communications Operations Office
PDL	Persons Deprived of Liberty
PDOHO	Provincial DOH Office
PHEIC	Public Health Emergency of International Concern
PHO	Provincial Health Office
PIA	Philippine Information Agency
PIC	Personal Information Controllers
PIDSR	Philippine Integrated Disease Surveillance and Response
PIP	Personal Information Processors
PNP	Philippine National Police
PPE	Personal Protective Equipment
PWD	Persons with Disability
RHU	Rural Health Unit
RITM	Research Institute of Tropical Medicine
RMP	Risk Management Plan
rVSV-ZEBOV	Recombinant Vesicular Stomatitis Virus-Zaire Ebola Virus
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SAGE	Strategic Advisory Group of Experts
SCB	Safety Collector Boxes
SOP	Standard Operating Procedure
STG	Sub-Task Group
TG	Task Group
TGRML	Task Group Resource Management and Logistics
UNICEF	United Nations Children's Fund
VAL	Vaccination Administration Location
VEP	Vaccine Expert Panel
VIMS	Vaccine Information Management System
VIRAT	Vaccine Introduction Readiness Assessment Tool
VOC	Vaccination Operation Center
WHO	World Health Organization

Table of Contents

Executive Summary

This document describes the National Deployment and Vaccination Plan for COVID-19 vaccines. It is comprised of an Introduction, Special Chapters, and the Main Chapters for the seven phases of the plan, namely: Scientific Evaluation and Selection, Access and Acquisition, Procurement and Financing, Shipment and Storage, Distribution and Deployment, Implementation of Nationwide Vaccination, and Assessment, Monitoring, and Evaluation.

The Introduction provides the rationale, guiding principles, and process for development of the Plan. The Special Chapters includes discussion on the governance structure of the deployment and vaccination program, the risk communication and community engagement, and the vaccination registry and data management of vaccination information.

The first chapter in the Main Chapters section is the Scientific Evaluation and Selection which defines the criteria to be used in evaluating the COVID-19 vaccines and the prioritization mechanism for the vaccines that will be initially considered for evaluation.

The second chapter is the Diplomatic Negotiation and Engagement which describes the process of engagement of the government with foreign entities as to the vaccine development, evaluation, and selection that are to be considered for procurement and clinical trials in accordance with the national regulatory processes.

The third chapter is on Procurement and Financing which discusses the three phases of the vaccine procurement process, the resources and funding requirements for the vaccination program and the measures placed in ensuring that the government funds are allocated and provided to entities with vaccines that are proven safe and with efficacy.

The fourth chapter is the Shipment and Storage which provides the technical details on the adequate supply chain system for the COVID-19 vaccination program which includes the proposed distribution process flow and distribution scenarios based on the vaccine specifications, the cold chain management, and details on the ancillary immunization supplies.

The fifth chapter is on Distribution and Deployment and discusses the principles that will guide the distribution and deployment of COVID-19 vaccines, its corresponding strategies and the identification of the segments of the population that are considered eligible for vaccination.

The sixth chapter provides a discussion on the Implementation of a Nationwide Vaccination. This section provides a detailed explanation on the three phase approach, namely the i) Pre-implementation Phase, ii) Implementation Phase, and iii) Post-Implementation Phase of the national government in operationalizing the COVID-19 vaccination program.

The final chapter is on Assessment, Evaluation and Monitoring which discusses the post-implementation phase events where it describes in details the vaccines safety monitoring, the management of adverse events following immunization, the protocols for safety surveillance and responses, and the mechanism for appropriate reporting, monitoring and evaluation of the COVID-19 vaccination program.

Overall, this plan has been developed with input from experts of various government agencies wherein central to its crafting is the objective of providing the operational guidance in the implementation of the COVID-19 vaccine deployment and vaccination program in the Philippines.

Introduction

Background

On 30 January 2020, the World Health Organization (WHO) declared Coronavirus Disease 2019 (COVID-19) as a Public Health Emergency of International Concern (PHEIC). On the same date, the Philippines, an archipelagic country in Southeast Asia with a population of 109,581,078 (based on the 2020 Philippine Statistics Authority census), had its first laboratory-confirmed case of COVID-19. COVID-19 is a disease caused by a novel coronavirus first reported from Wuhan, China last 31 December 2019, and was later named as the Severe Acute Respiratory Syndrome-Coronavirus 2 (SARS-CoV-2). On 7 March 2020, the Department of Health (DOH) announced the country's first reported local transmission when a 60-year-old male, without any travel history outside the Philippines was confirmed to be positive for SARS-CoV-2. On 11 March 2020, the WHO characterized COVID-19 as a pandemic.

Since then, the Philippines has been responding to mitigate the impact of COVID-19 pandemic and has been implementing numerous interventions with varying levels and degrees of success. These interventions are anchored on the National Action Plan Against COVID-19 (NAP), the national strategic plan for COVID-19 pandemic response, and utilized the Prevent-Detect-Isolate/Quarantine-Treat-Reintegrate (PDITR) strategy. For NAP Phase I (March-June 2020), the National Government focused on preventing and containing the COVID-19 pandemic while mitigating its socioeconomic impact. For NAP Phase II (July-September 2020), the National Government focused on socioeconomic recovery. Lastly, for NAP Phase III (October 2020-March 2021), the National Government focused on managing the health risk while gradually transitioning to full socioeconomic recovery, and inclusion of vaccines as part of the COVID-19 interventions.

Vaccines have saved millions of lives in the past. Countries around the world have implemented numerous immunization programs against more than 20 life-threatening diseases, such as measles, poliomyelitis, hepatitis B, influenza, and many others. These vaccination efforts prevented almost 2-3 million deaths every year and allowed people to live longer and healthier lives. Also, through vaccination, eradication and near elimination of diseases have been made possible, such as in the case of smallpox and poliomyelitis.

In the past, vaccines have also been utilized as an integral part of epidemic (pandemic) response to infectious diseases. Examples are the 2009 Influenza pandemic vaccines against the novel influenza A (H1N1) virus and the Recombinant Vesicular Stomatitis virus–Zaire Ebola virus (rVSV-ZEBOV) vaccine against Ebola in 2014 to 2016. Such vaccines have prevented succeeding outbreaks and further disease spread, and have aided in saving thousands of lives. An exemplar of the benefit of vaccines in halting disease outbreaks and breaking the chain of transmission was in August 2018 when the Democratic Republic of Congo (DRC) declared the Kivu Ebola epidemic as 53 individuals were infected and 29 deaths were reported, 300,000

individuals were vaccinated immediately thereafter. This endeavor resulted in halting the outbreak within the region, and due to continuous efforts via *the ring vaccination strategy*, the reported number of deaths among those who were infected and infected cases of tertiary contacts (contacts of contacts) were significantly reduced.

Thus, with the COVID-19 pandemic, the Philippines is exploring all means to access COVID-19 vaccines and prepare the country for the implementation of a COVID-19 deployment and vaccination program once a safe, effective and good quality vaccine is readily available.

Rationale for the National Deployment and Vaccination Plan

The Philippine National Deployment and Vaccination Plan for COVID-19 Vaccines was drafted for the purpose of providing operational guidance in the implementation of the COVID-19 vaccine deployment and vaccination program.

The drafting of the plan involved the participation of various government agencies to ensure alignment of policies and plans among agencies and integration of the said plans into national governance mechanisms.

In addition, the deployment of COVID-19 vaccines and the implementation of the COVID-19 vaccine program necessitates the participation of all members of the society. Thus, a whole-of-society approach is being implemented where all members of the society and government are encouraged to participate and take action to achieve collective goals and objectives. In this regard, while the government leads in the deployment of vaccines and implementation of a vaccination program, the private sector and other organizations are engaged to collaborate and work closely with the government to ensure a unified and coordinated vaccination campaign is conducted.

Target Audience

The target audience for the Philippine National Deployment and Vaccination Plan for COVID-19 vaccines include but are not limited to:

- Policy makers
- Planners
- Program and project implementers
- Development partners
- Health service providers
- Partners in public and private sector
- Civil Society Organizations
- Health consumers and the general public.

Dissemination of the Plan

Providing this Plan to the different audiences in a meaningful way that will engage the audience and enable action will require that there are different versions and formats of this plan. The visual below summarizes the proposed dissemination of the plan.

Users	*Needs*	*Dissemination*
● Government at all levels ● Development partners ● International agencies ● Private Sector ● Academic and Research Institutions ● General Public	● Taking stock ● Any changes / updates in the plan ● Follow-up ● Planning and Projections ● Sector analysis ● Buy-in	*Contents (what)* ● Tables ● Graphs and maps ● Analysis ● Policy briefs and briefers ● Powerpoint presentations *Media (How)* ● hard copy of the plan ● Soft copy of the plan ● media (TV, newspapers) ● workshops and seminars ● government's knowledge management website.

Implementers at all levels should bear in mind the *science, scale, skills, speed and systems* needed for proper, effective and seamless execution of this plan.

Guiding Principles

The development of the Philippine National Deployment and Vaccination Plan for COVID-19 vaccines is guided by the following principles:

A. *National Ownership*

The Philippine Government recognizes the huge national endeavor that the country needs to undertake to ensure equal access to vaccines and to implement quality vaccination services; the complexity of the vaccine deployment and vaccination activities; and the necessity to protect national interests while ensuring that rigorous scientific review has been undertaken prior to deployment and considering population safety. Thus, the national government shall be the primary responsible entity to ensure good governance in the implementation of vaccination services and provision of quality and effective immunization services for all.

B. *Shared Responsibility*

The COVID-19 vaccine deployment and vaccination program is an endeavor necessitating the participation of all members of the society where each member has a vital responsibility to uphold and role to play. The Filipino Citizen, the communities, the national government and the private sector have intertwined responsibilities in which when rightfully upholded can positively dictate the success of the COVID-19 vaccination efforts of the country.

A whole-of-society approach shall be applied where all members of the society and government are encouraged to participate and take action to achieve collective goals and objectives. In this regard, while the government leads in the deployment of vaccines and implementation of a vaccination program, the private sector and other organizations are encouraged to collaborate and work closely with the government to ensure a unified and coordinated vaccination campaign is conducted.

C. *Integration*
With the COVID-19 pandemic, vaccination against COVID-19 is provided to Filipino citizens as an intervention and as an integral part of the national government's pandemic response. However, the COVID-19 vaccination services shall be fully integrated into the country's health systems and eventually to the regular immunization services.

D. *Innovation*
There has been a tremendous abundance of innovations and breakthroughs in the development of COVID-19 vaccines. Developers and regulatory experts have collaborated early on to help speed up vaccine development by ensuring that standards of safety and efficacy are integrated in the process of development. In this regard, the Philippine government recognizes the vitality of adapting newer knowledge and scientific evidence gathered through research and innovation on COVID-19 vaccine and immunization to ensure effective implementation of COVID-19 immunization services.

The allocation and prioritization of COVID-19 immunization shall be anchored to the following principles:

A. *Human well-being:* where health, social and economic security, human rights and civil liberties of all citizens and individuals are protected and promoted.

B. *Equal respect:* where all human beings are treated equally and their interests are considered with equal moral consideration.

C. *National equity:* where equity in vaccine access is assured nationally and those with greater burden of COVID-19 pandemic.

D. *Reciprocity:* where individuals and groups who bore a greater burden in the COVID-19 pandemic response and have higher significant risks brought by their responsibilities and roles shall be given greater priority.

E. *Legitimacy:* where decisions are made through transparent processes based on shared values and scientific evidence.

Process for Developing the Plan

The development process for this Plan was participatory and involved various stakeholders led by the COVID-19 Vaccine Cluster and its Task Group (TG) and Sub-Task Group (STG) members. These TGs and STGs were composed of various Departments and Agencies as outlined in the section of Governance. The TGs and STGs under the COVID-19 Vaccine Cluster developed briefs to guide the implementation of the vaccine. Key Informant Interviews were also conducted to understand various perspectives in addition to various rapid assessments. A short-term technical assistance staff was hired to collate the briefs/guides developed by each of the TGs and STGs. A series of meetings were held to review and enrich the plan. The final draft of the plan was presented to the DOH Executive Committee, COVID-19 Vaccine Cluster of the National Task Force for endorsement. This is a living plan and will be updated as more information becomes available or as recommendations are provided by WHO and Unicef.

Lay-out of the Plan

This Plan is set out in two sections: Special Chapters and Main Chapters.
The Special Chapters details cross-cutting interventions which covers:

- Governance
- Risk Communication and Community Engagement
- Registry and Data Management.

The Main Chapters cover the 7 stages of the Vaccine Roadmap:

- Scientific Evaluation and Selection of the Vaccine
- Access and Acquisition
- Procurement and Financing
- Shipment and Storage
- Distribution and Deployment
- Implementation of Nationwide Vaccination
- Assessment, Evaluation, and Monitoring

Special Chapter

Governance

COVID-19 vaccine deployment and vaccination program is a combined national, regional, and local responsibility that requires close collaboration between public health, external agencies, and community partners. It is imperative that national and local agencies, public and private sectors, and other planning partners clearly understand each other's roles and responsibilities in the COVID-19 vaccination program. Therefore, a comprehensive and extensive organizational structure is critical in the planning and execution of COVID-19 vaccine plans and policies; and essential for establishing a robust system of leadership, accountable and transparent decision-making structure and process to protect national interests. A wide array of expertise shall be represented among team members; thus, a multi-sectoral organizational structure capable of making transparent and robust decision-making and organizational processes is organized.

Using the guidance provided by the World Health Organization's Vaccine Introduction Readiness Assessment Tool (VIRAT), a multi-sectoral national organizational structure for the COVID-19 vaccine is established, institutionalized, and integrated with existing organizational structures and coordination mechanisms for COVID-19 response. The VIRAT recommends creating the following: a National Coordinating Committee, Technical Working Groups and Sub-Technical Working Groups; and establishment and institutionalization of the National Immunization Technical Advisory Group (NITAG) and National Adverse Events Following Immunization Committee (NAEFIC), both are independent/external advisory bodies.

Therefore, the Philippine Government established the COVID-19 Vaccine Cluster Organizational Structure. The COVID-19 Vaccine Cluster shall serve as an unified command, control, coordination, communication, and cooperation mechanism that ensures the procurement, deployment of COVID-19 vaccine and the vaccination of identified eligible populations *(see Figure 1).*

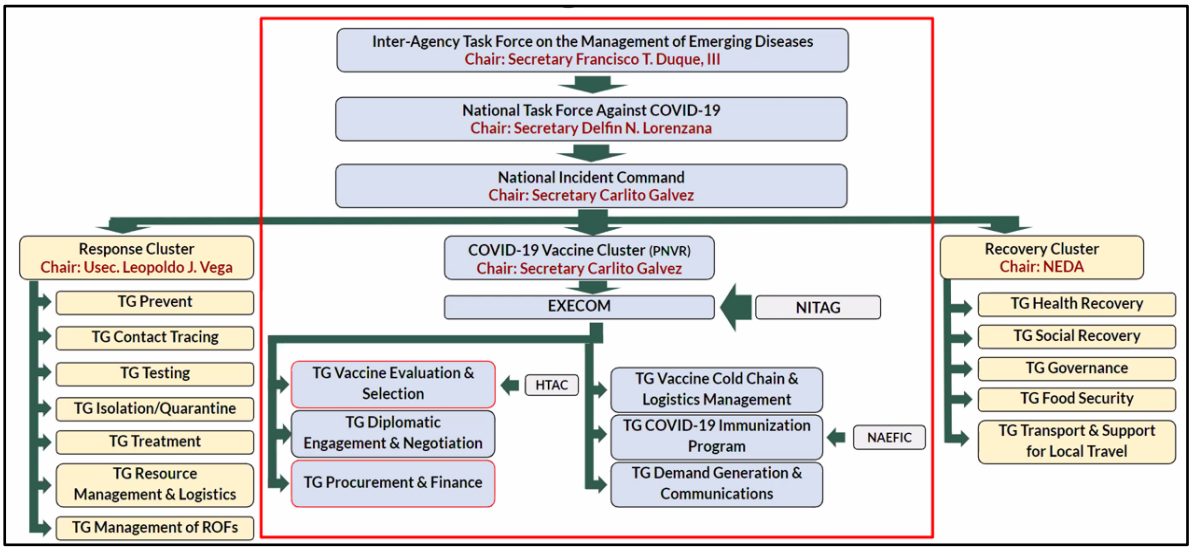


Figure 1. COVID-19 Vaccine Cluster organizational structure.

Specifically, utilizing existing organizational structures and coordination mechanisms established for the COVID-19 pandemic response, the organizational structure and line of command for COVID-19 vaccines is as follows:

1. The *Inter-Agency Task Force on Emerging Infectious Diseases* (*IATF-EID*, or merely the *IATF*) is a task force created through Executive Order No. 168 s. 2014 by the Philippine President to respond to affairs concerning emerging infectious diseases in the country. For COVID-19 vaccines, the IATF-EID shall serve as the National Coordinating Committee.

2. For the COVID-19 pandemic response, President Rodrigo Roa Duterte established the *National Task Force (NTF) Against COVID-19* to oversee the operations of the national response. Detailing the strategic framework of the pandemic response, the National Task Force drafted the National Action Plan Against COVID-19 (NAP) to guide the operations of the pandemic response anchoring on the principle that the response should be national-government-enabled, local government unit (LGU)-led, and people-centered.

3. Under the NTF Against COVID-19, there are three clusters namely, the Response Cluster, the Recovery Cluster and the *COVID-19 Vaccine Cluster*. As mentioned above, seeing the need for an organizational structure to support the strategic directions of the national government, the COVID-19 Vaccine Cluster was added based on the guidance stipulated in the NAP Phase III. In line with the directions of the VIRAT, the COVID-19 Vaccine Cluster shall serve as the National Technical Working Group. The COVID-19 Vaccine Cluster is led by Secretary Carlito G. Galvez, Jr., who was designated by President Rodrigo Roa Duterte as the COVID-19 Vaccine Czar.

4. Under the COVID-19 Cluster are six *Task Groups*, and based on the direction of the VIRAT, shall serve as the Sub-Technical Working Groups. Each TGs is represented by

the designated lead in the COVID-19 Vaccine Cluster Executive Committee. The Committee, in turn, advises and updates the COVID-19 Vaccine Cluster Chair. The six Task Groups are (*see Figure 2)*:

a. Scientific Evaluation and Selection
b. Diplomatic Engagement and Negotiation
c. Procurement and Finance
d. Cold Chain and Logistics Management
e. Immunization Program
f. Demand Generation and Communications.

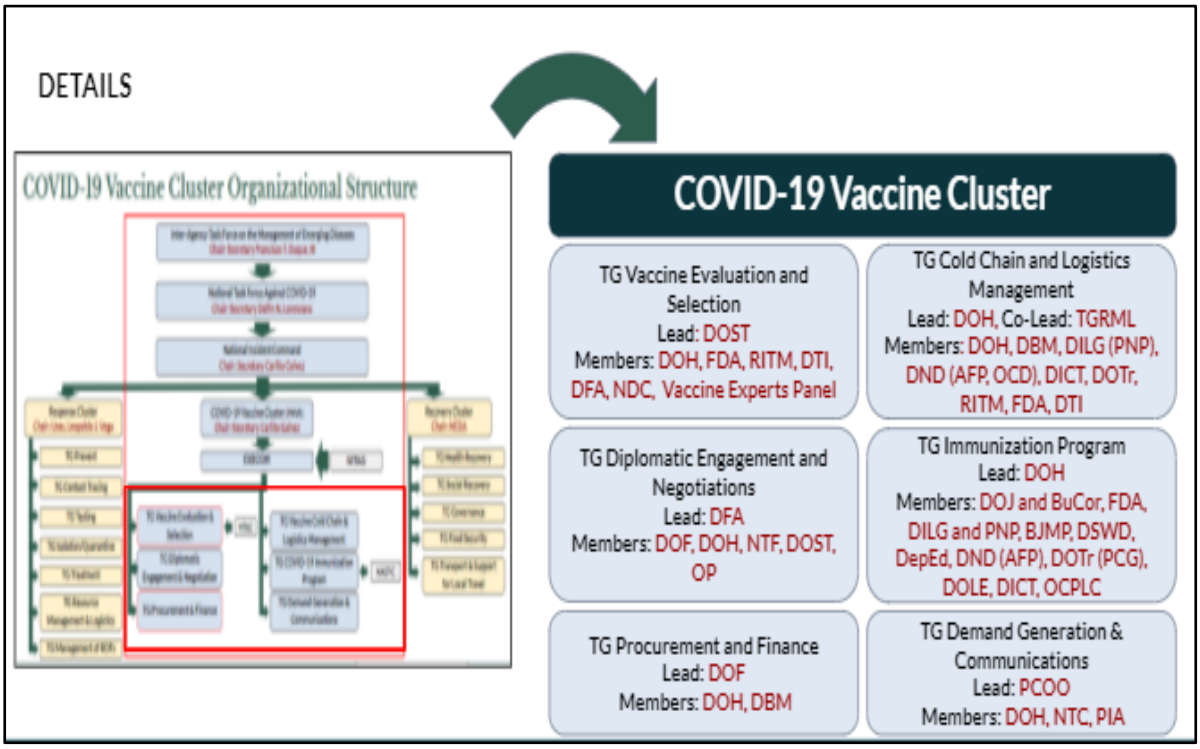


Figure 2. The COVID-19 Vaccine Cluster and its Task Groups.

The Task Groups are composed of various government agencies and participated by diverse experts and professionals:

a. TG Scientific Evaluation and Selection

i. Lead: Department of Science and Technology (DOST)
ii. Members: Department of Health (DOH), Food and Drug Administration (FDA), Research Institute for Tropical Medicine (RITM), Department of Trade and Industry (DTI), Department of Foreign Affairs (DFA), National Development Company (NDC), and the Vaccine Expert Panel (VEP)
iii. Roles and Responsibilities:
    1. Provide oversight on the evaluation of applications and conduct of COVID-19 vaccine clinical trials in the country.
    2. Evaluate results of COVID-19 vaccine clinical trials as part of the inputs on the criteria for COVID-19 vaccine selection.

3. Develop criteria and provide recommendations of the evaluation and selection of COVID-19 vaccines that will be considered for procurement.
4. Continue engagement with bilateral partners for clinical trials interested in pursuing local manufacturing and technology transfer.

b. TG Diplomatic Engagement and Negotiation

i. Lead: Department of Foreign Affairs (DFA)
ii. Members: Department of Finance (DOF), DOH, National Task Force, DOST, Office of the President (OP)
iii. Roles and Responsibilities:
1. Initiate diplomatic engagements with other governments, international bodies, international non-government organizations, international financial institutions, and international cooperation agencies.
2. Provide feedback and updates to the other respective TGs pertaining to vaccines in the global market.
3. Coordinate and collaborate with TG Procurement and Finance in identifying viable global market vaccine manufacturers and entities.
4. Negotiate agreements for the provision of technical and financial assistance.

c. TG Procurement and Finance

i. Lead: DOF
ii. Members: Department of Budget and Management (DBM), DOH
iii. Roles and Responsibilities:
1. Facilitate procurement through various mechanisms allowed under existing laws, rules and regulations through bilateral, multilateral and other financial modalities (e.g. COVAX Facility and etc.).
2. Activate price negotiation board subject to HTA's cost-effective price, if applicable.
3. Coordinate with legislators, as may be necessary on budget and co-payment ceilings.
4. Explore local vaccine production and supply, if applicable.

d. TG Cold Chain and Logistics Management

i. Lead: DOH, Co-Lead: Task Group Resource Management and Logistics (TGRML) under the Response Cluster
ii. Members: DBM; Department of Interior and Local Government (DILG), specifically, the Philippine National Police (PNP); Department of National Defense (DND), specifically the Armed Forces of the Philippines (AFP) and the Office of Civil Defense (OCD), Department

of Information and Communications Technology (DICT), Department of Transportation (DOTr), RITM, FDA, and DTI

iii. Roles and Responsibilities:

1. Map the potential port(s) of entry, points of storage (stores), and fallback facilities in the country with their respective cold chain and transportation/distribution capacity for vaccines and ancillary products and assess dry storage and cold chain capacity at all levels.
2. Facilitate acceptance and inventory of vaccines and logistics.
3. Facilitate and ensure storage, distribution and delivery of vaccines and logistics to target areas.
4. Monitor cold chain practices and ensure that vaccines are handled and disposed correctly and properly.
5. Develop a distribution plan down to the local level; adapt needs of vaccines, syringes and safety boxes to planning of stages or phases according to vaccine availability.
6. Schedule transportation of vaccines and other supplies at all levels.
7. Implement monitoring systems for vaccine distribution and conduct inventories using logistics information software integrated into existing systems and technology development (barcodes, electronic tracking, etc.).
8. Define indicators to evaluate the supply chain from the international up to the service delivery points.

e. TG COVID-19 Immunization Program

i. Lead: DOH

ii. Members: DILG, DND, Office of the Chief Presidential Legal Counsel (OCPLC), Bureau of Corrections (BuCor), Philippine Coast Guard (PCG), Department of Social Welfare and Development (DSWD), Department of Justice (DOJ), Department of Education (DepEd), AFP, PNP, BJMP, DICT, FDA, Department of Labor and Employment (DOLE)

iii. Roles and Responsibilities:

1. Plan and craft policies, guidelines and standard operating procedures related to the COVID-19 vaccine deployment and program implementation.
2. Estimate potential numbers of target populations that will be prioritized for access to vaccines stratified by target group and geographic location
3. Identify potential COVID-19 vaccine delivery strategies
4. Create a data information system for all vaccine recipients
5. Provide capacity building and trainings to implementers
6. Develop or adapt existing and implement AEFI/Post-marketing

surveillance and monitoring framework

7. Ensure or craft guidelines, procedures and tools for planning and conducting vaccine pharmacovigilance activities

f. TG Demand Generation and Communications

i. Lead: Presidential Communications Operations Office (PCOO)

ii. Members: DOH, National Telecommunications Commission (NTC), Philippine Information Agency (PIA), DILG

iii. Roles and Responsibilities:

1. Design a demand and risk communication plan.
2. Implement social mobilization and community engagement activities.
3. Ensure social preparation of target population groups and geographical areas prior to vaccination.

5. Under the TG COVID-19 Immunization Program, are *four Sub-Task Groups (STGs)*, namely: STG Planning, Policy & Technical Support, STG Program Implementation, STG Registry, Data Management and Monitoring & Evaluation, and STG Safety Surveillance & Response. The STGs are composed of (*see Figure 3)*:

a. STG Planning, Policy & Technical Support

i. Lead: DOH [Disease Prevention and Control Bureau (DPCB)]

ii. Members: DOH [Epidemiology Bureau (EB), and Health Policy Development and Planning Bureau (HPDPB)], OCPLC, DepEd, DILG

b. STG Program Implementation

i. Lead: DOH (DPCB)

ii. Members: DOH [Health Emergency Management Bureau (HEMB) and Health Human Resource Development Bureau (HHRDB)], DILG (BFP, PNP, BJMP), DSWD, DepEd, DND (AFP), DOJ (BuCor), DOTr (PCG)

c. STG Registry, Data Management & M&E

i. Lead: DOH (EB)

ii. Members: DOH [Knowledge Management and Information Technology Service (KMITS) and DPCB], DICT, DWSD, DepEd

d. STG Safety Surveillance & Response

i. Lead: FDA

ii. Members: DOH [EB, Field Implementation and Coordination Team (FICT), DPCB, HEMB]

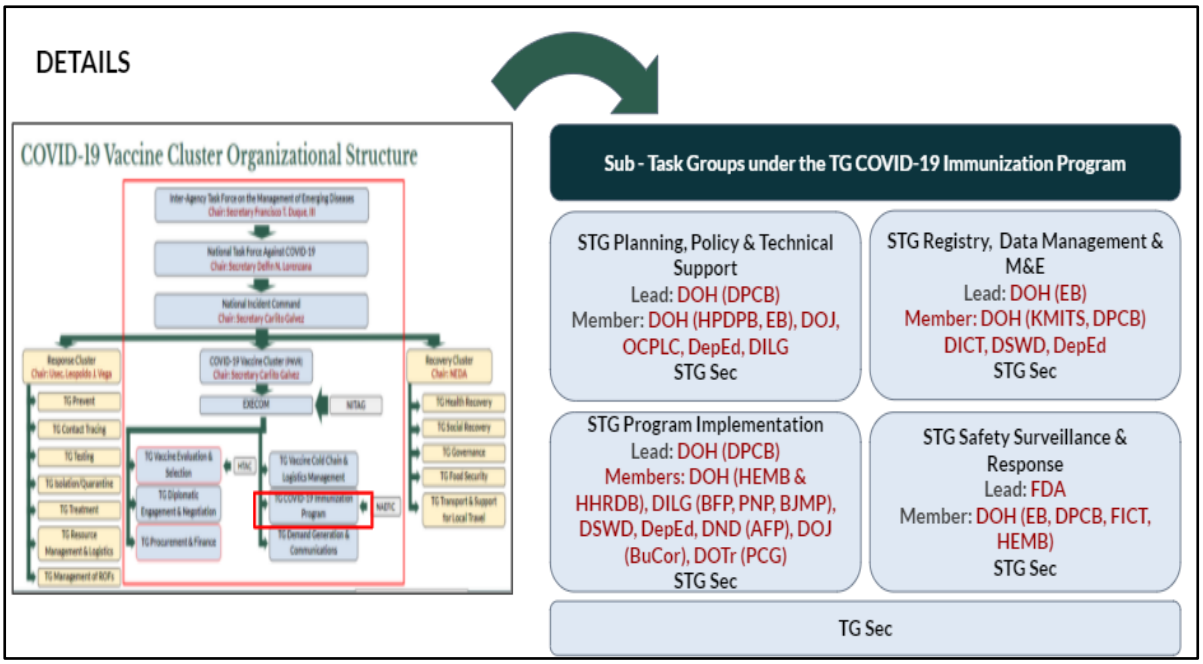


Figure 3. Sub-Task Groups under the TG COVID-19 Immunization Program.

6. The COVID-19 Vaccine Cluster is supported by several independent bodies. These are:
    a. The *National Immunization Technical Advisory Group (NITAG) for COVID-19 Vaccines* is a multidisciplinary group of national experts responsible for providing independent, evidence-informed advice to policymakers and program managers on immunization and vaccine policy issues. The Philippine NITAG was organized and created through a Department Personnel Order as issued by the Secretary of Health of the Republic of the Philippines. The NITAG shall serve as an independent body that provides recommendations to the DOH and COVID-19 Vaccine Cluster, ensuring transparency, credibility, and technical soundness to the decision-making process and contributes to building public confidence COVID-19 vaccination program.
    b. The *National Adverse Event Following Immunization Committee (NAEFIC),* comprises representatives from different medical societies and vaccine experts. It reviews, analyzes, and comes up with causality assessment as the basis for the Food and Drug Authority (FDA) action and appropriate DOH bureaus/offices on Adverse Events Following Immunization (AEFI) and Adverse Events of Special Interest (AESI).
    c. The *Health Technology Assessment Council (HTAC),* whose mandate is to undertake technology appraisals by determining their clinical and economic values in the Philippine healthcare system, with the aim to improve overall health outcomes and ensure fairness, equity and sustainability of coverage for all Filipino citizens.

Coordination

A coordination mechanism shall be set in place to ensure sufficient communication and information are shared between Task Groups, Sub-Task Groups, and independent bodies such as the NITAG, NAEFIC and HTAC, and the Vaccine Expert Panel.

The Vaccine Expert Panel shall provide regular updates to the COVID-19 Vaccine Cluster Head, HTAC, NITAG, and NAEFIC.

Complementation

The national organizational structure, the COVID-19 Vaccine Cluster, is complemented with the activation of an Incident Command System (ICS), which is supported by an operations center, duly named as the COVID-19 Vaccine Operations Center. The VOC shall be established and operationalized at all levels, as follows:

1. National COVID-19 Vaccination Operations Center
2. Regional COVID-19 Vaccination Operations Centers
3. Local COVID-19 Vaccination Operations Centers

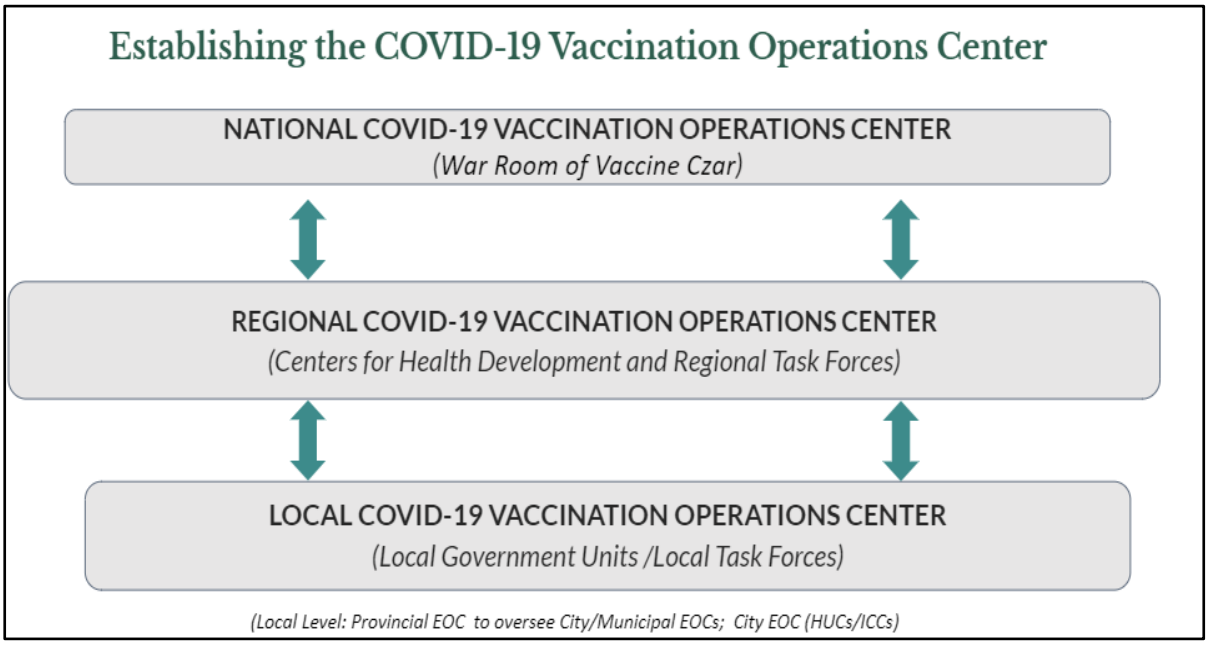


Figure 4. The COVID-19 Vaccination Operations Centers at all levels.

The National COVID-19 Vaccination Operations Center shall be headed by the COVID-19 Vaccine Cluster Chair, The Regional COVID-19 Vaccination Operations Center shall be led by the Centers for Health Development with the participation of other government agencies and the Regional Task Forces Against COVID-19. And lastly, the Local COVID-19 Vaccination Operations Center shall be led by the Local Government Units. The Provincial Vaccination Operations Center shall oversee the Municipal and City Vaccination Operations Center (component cities). To avoid overlapping of functions and oversight, the COVID-19 Vaccination Operations Centers shall be distinctly separated from the EOCs of the COVID-19 Response Clusters which are headed by the Regional/Local Task Forces.

The COVID-19 Vaccination Operations Center shall compose of various teams, namely:

1. *Planning, Campaign Management and Technical Team [DOH, DILG, DSWD, DepEd, AFP (their counterparts in the regional and local levels)]*
   Roles and Responsibilities:
   - ***a. National VOC:***
     i. Develop and release guidelines, policies, bulletins and advisories relevant to the vaccination campaign.
     ii. Set-up the National Vaccination Operations Center (NVOC).
     iii. Conduct orientations/training to program managers, stakeholders, implementers and monitors.
     iv. Monitor the implementation of the campaign.
     v. Review preparedness plans of the Regional VOCs and provide guidance/recommendations to Regional VOCs.
   - ***b. Regional VOC:***
     vi. Develop and release bulletins and advisories relevant to the vaccination campaign.
     vii. Set-up the Regional VOCs within their respective areas; and advocate for the establishment of the Local VOCs.
     viii. Roll-out the conduct orientations/training to program managers, stakeholders, implementers and monitors.
     ix. Conduct orientations/training to program managers, stakeholders, implementers and monitors.
     x. Monitor the implementation of the campaign.
     xi. Review preparedness plans and provide guidance / recommendations to implementers.
     xii. Analyze and report data to the National VOC.

   - ***c. Local VOC:***
     xiii. Develop and release bulletins and advisories relevant to the vaccination campaign.
     xiv. Set-up the Local VOCs within their respective areas.
     xv. Roll-out the conduct orientations and capacity building to program managers, stakeholders, implementers and monitors.
     xvi. Monitor the implementation of the campaign.
     xvii. Review preparedness plans of barangays and provide guidance/recommendations to implementers.
     xviii. Analyze and report data to the Regional VOC.

2. *Finance, Cold Chain and Logistics Team [OCD, DOH, AFP; (their counterparts in the regional and local levels)]*
   Roles and Responsibilities:

a. National VOC:

i. Conduct inspection and ensure the quality of logistics to be delivered.
ii. Ensure timely delivery of vaccines, syringes, personal protective equipment (PPEs) and other logistics to Centers for Health Development (CHDs) and Ministry of Health - BARMM, and those that are delivered directly to implementing units.
iii. Closely coordinate with CHDs to ensure availability of vaccines, vaccine carriers for cold chain management, and other supplies.
iv. Manage inventory of vaccines, its storage and distribution.
v. Coordinate with regional offices and LGUs on the latest inventory of logistics, supplies and its actual utilization.
vi. Facilitate the budget for the campaign's operations.
vii. Prepare sub-allotment upon receipt of the approved sub-allotment guidelines and ensure downloading of budget to regions prior to the campaign.

b. Regional VOC:

viii. Conduct inspection and ensure the quality of logistics to be delivered.
ix. Deliver vaccines, syringes, PPEs, and other logistics to Local Government Units, and or if required to implementing units.
x. Closely coordinate with CHDs to ensure availability of vaccines, vaccine carriers for cold chain management, and other supplies.
xi. Manage inventory of vaccines, its storage and distribution.
xii. Coordinate with LGUs and implementing units on the latest inventory of logistics, supplies and its actual utilization.
xiii. Facilitate the budget for the campaign's operations.

c. Local VOC:

xiv. Conduct inspection and ensure the quality of logistics to be delivered.
xv. Ensure timely delivery of vaccines, syringes, personal protective equipment (PPEs) and other logistics from national or regional delivery hubs.
xvi. Deliver vaccines, syringes, PPEs, and other logistics to implementing units.
xvii. Closely coordinate with CHDs to ensure availability of vaccines, vaccine carriers for cold chain management, and other supplies.
xviii. Manage inventory of vaccines, its storage and distribution.
xix. Coordinate with implementing units on the latest inventory of logistics, supplies and its actual utilization.
xx. Facilitate the budget for the campaign's operations.

3. *Coordination Team [OCD, DOH, DILG; (their counterparts in the regional and local levels)]*

Roles and Responsibilities:

a. National VOC:

i. Coordinate and collaborate with other government agencies, response partners and stakeholders.
ii. Coordinate immediate concerns to appropriate DOH and NGA offices and bureaus.
iii. Assist the Finance and Logistics Team for concerns related to delivery and distribution of logistics and supplies.
iv. Oversee and provide human resource support to the National EOC.

b. Regional VOC:

i. Coordinate and collaborate with other government agencies, partners and stakeholders at the regional level.
ii. Coordinate immediate concerns of LVOCs to the RVOCs. Coordinate with regional government agencies and partners to provide assistance and response, and address concerns raised.
iii. Assist the RVOC Finance, Cold Chain and Logistics Team for concerns related to delivery and distribution of logistics and supplies.
iv. Oversee and provide human resource support to the RVOC.

c. Local VOC:

i. Coordinate and collaborate with barangays, health facilities, partners and stakeholders.
ii. Coordinate immediate concerns of implementing units to the LVOCs. Coordinate with partners to provide assistance and response, and address concerns raised.
iii. Assist the LVOC Finance, Cold Chain and Logistics Team for concerns related to delivery and distribution of logistics and supplies.
iv. Oversee and provide human resource support to the LVOC.

4. *Vaccine Safety, Surveillance and Response Team [DOH, FDA, DILG; (their counterparts in the regional and local levels)]*
   Roles and Responsibilities

a. National/Regional VOC:

i. Oversee the design and implementation of the AEFI/AESI surveillance system.
ii. National to assist regions in the conduct of AEFI/AESI case investigation and comprehensive data analysis.
iii. Generate National AEFI/AESI Surveillance Report and provide information to N/R VOC.
iv. Provide technical assistance or training to develop/enhance capacity of regional/local AEFI/AESI surveillance.
v. Facilitate the convening of the National/Regional AEFI Committee meetings for causality assessment.
vi. Coordinate AEFI/AESI surveillance activities with all VOC levels.
vii. Maintain a database of all reported AEFIs/AESIs.

viii. Provide regular updates on COVID-19 vaccine surveillance to the N/R VOC.

b. Local VOC:

i. Implement AEFI/AESI surveillance activities.
ii. Lead in the conduct of AEFI/AESI case investigation and comprehensive data analysis.
iii. Generate AEFI/AESI Surveillance report and provide information to Local VOC, then submit to RVOC.
iv. Provide technical assistance or training to develop/enhance capacity of regional/local AEFI/AESI surveillance.
v. Provide regular updates on COVID-19 vaccine surveillance to the N/R VOC.

5. *Communications, Advocacy and Partnership Team [PCOO, PIA, DOH (their counterparts in the regional and local levels)]*

Roles and Responsibilities

a. National/Regional VOC:

i. Develop a communication and community engagement plan, advocacy/information materials, and/or other relevant communication documents/materials.
ii. Capacitate Health Education and Promotion Officers, social mobilizers and communicators.
iii. Issue press releases relevant to the COVID-19 vaccination campaign.
iv. Document COVID-19 vaccination campaign activities.
v. Monitor the implementation of communications and community engagement activities in the LGUs.
vi. Provide feedback or report communications and community engagement issues and concerns to NVOC.

b. Local VOC:

i. Advocate to and conduct partnership meetings with partners and stakeholders such as but not limited to the Local Chief Executives, LGU officials, medical societies, civil societies, religious sector, private physicians and other stakeholders.
ii. Distribute advocacy/information materials, and/or other relevant communication documents/materials.
iii. Document COVID-19 vaccination campaign activities.
iv. Monitor the implementation of communications and community engagement activities in the implementing units and communities.
v. Provide feedback or report communications and community

engagement issues and concerns to LVOC.

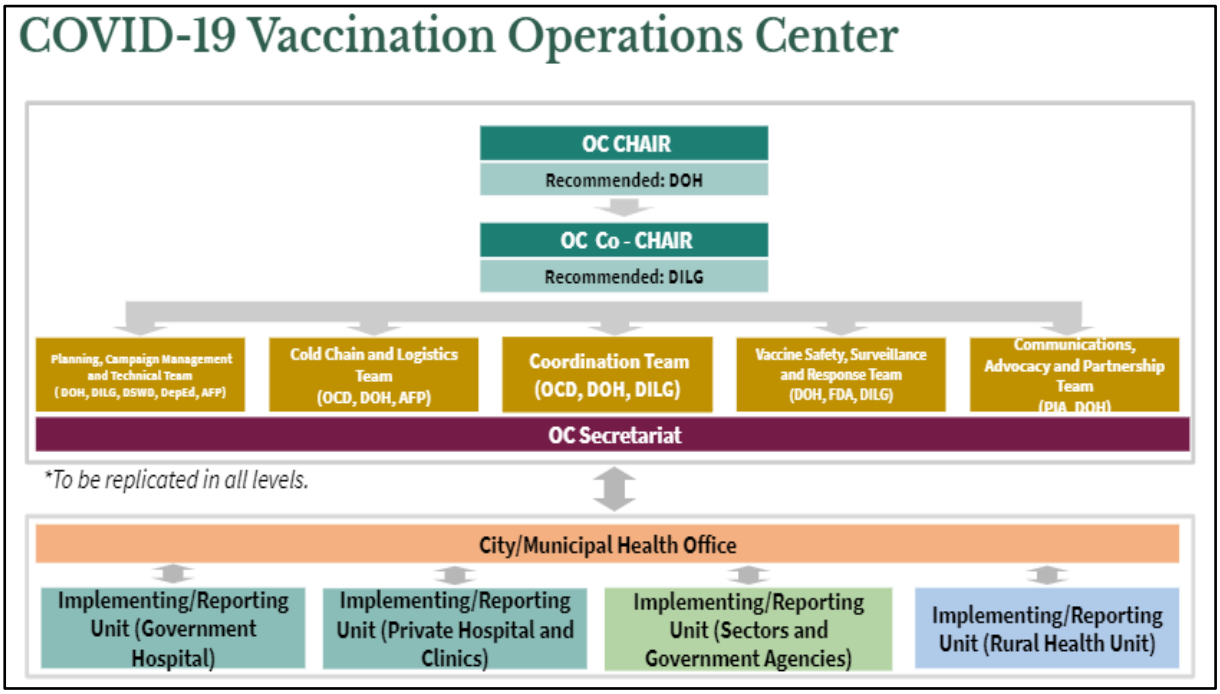


Figure 5. The teams under the COVID-19 Vaccination Operations Center.

The National Government is enjoining all Regional Offices and Local Government Units to establish the Vaccination Operations Center as soon as possible.

The implementing units such as government hospitals (both private and public), private clinics, government agencies, rural health units) shall forward all concerns and reports to the City/Municipal Health Offices. The City/Municipal Health Offices, in turn, are required to report all concerns and updates to the VOC.

All reports and unsettled issues of a VOC shall be raised to the overseeing VOC. The overseeing VOC, on the other hand, shall provide feedback and provide recommendation to the reporting VOC.

Three months prior to the vaccination activity, the VOCs are required to conduct regular meetings and to submit readiness assessments on a regular basis to the overseeing VOC. During the campaign period (as determined by DOH), all VOCs are required to operate for 24 hours in a week, and to submit daily bulletin detailing coverage, refusals and deferrals, and AEFIs and AESIs monitored. The reporting mechanism will be expounded on Chapter 7. After the campaign period, all VOCs are required to conduct a program implementation review and submit the final coverage report.

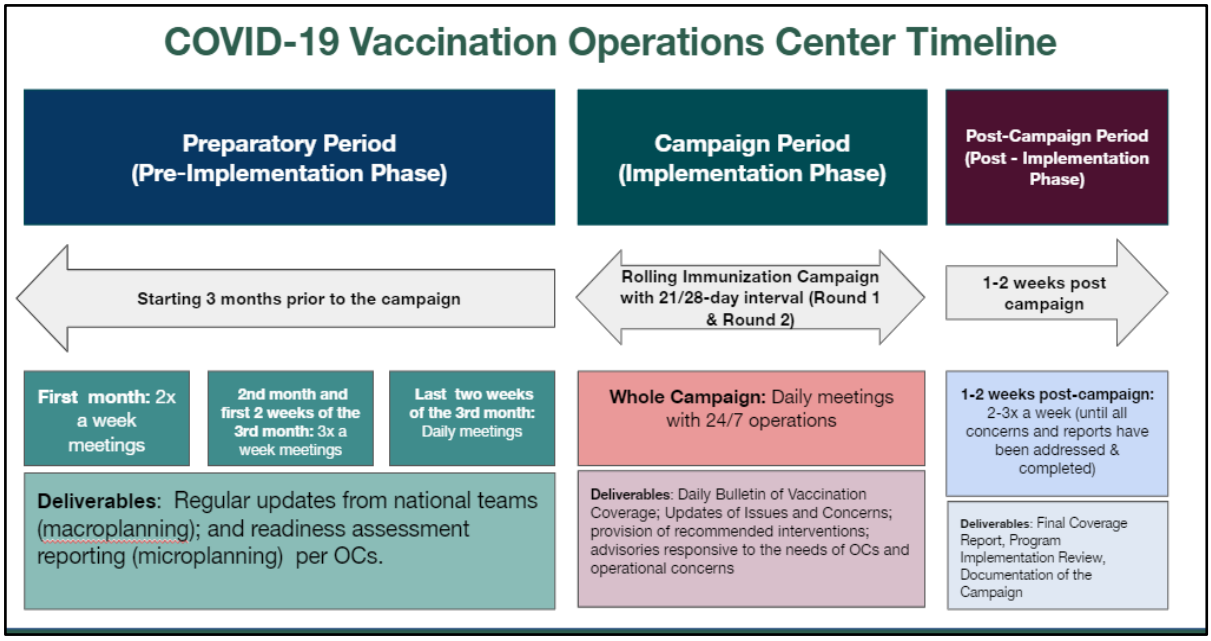


Figure 6. COVID-19 Vaccination Operations Center timeline.

Special Chapter

Risk Communication and Community Engagement

When a vaccine is introduced, it is necessary to guarantee that the population will receive the necessary information about its characteristics and benefits to boost confidence and generate demand. Demand Generation is a communication and engagement process to enable, inform, motivate and empower specific groups to access a health service and claim their right to do so[1]. Strategies to achieve this include advocacy, ongoing community engagement and trust-building, active hesitancy prevention, regular national assessment of vaccine concerns, and crisis response planning.

Table 1. Strategies and their definition.

Term	*Definition*
Advocacy	Building coalitions and communicating evidence to influence decision-makers, stakeholders and relevant audiences to change law, policies and administrative practices
Social Mobilization	Uniting partners at national and community levels through dialogue, coalition building and group activities to create an enabling environment for positive health behaviors.
Social Change Communication	Enabling interpersonal communication and community dialogue to allow groups of individuals to engage in a participatory process to define their needs, demand their rights and transform their social system.
Behavior Change Communication	Implementing interpersonal communication and mass/social media campaigns to change individual knowledge, attitudes, motivation, self-efficacy and behavior.
Capacity building and motivation	Training of program managers, health workers, community health workers and civil society organizations (CSOs) to enable them to implement and manage Demand Generation activities and effectively link vaccination services to communities.

Strategic communications and public messaging will be critical to ensure maximum acceptance of vaccines, requiring a saturation of messaging across the national and local media platforms. This communication and messaging will target the different audience groups like opinion makers and social communicators who can influence the uptake, health care providers in both public and private sectors, and the vaccine's primary beneficiaries. Partnerships with the media are essential to ensure their support in promoting these messages. The information campaign led by the PCOO, through the PIA, will include key messages on vaccine safety and efficacy and target key populations and communities addressing vaccine hesitancy[2]. The campaign will be developed using human-centered design, extensive public and stakeholder engagement, and research on message development and delivery. The different agencies of the TG Demand Generation and Communications will work collaboratively to ensure that consistent and

[1] Definition was adopted from the WHO-UNICEF guide on Positioning Demand Generation in National EPI Planning and Implementation Processes

[2] These messages target identified drivers of motivation as per the Increasing Vaccination Model by the WHO-established group, measuring behavioral and social drivers of vaccination (BeSD)

accurate information is at the foundation of the communications effort. The communication plan will also help inform the Filipino people about the national strategy of delivering the COVID-19 vaccine faster while still safeguarding the national standards for safety and effectiveness as with any other vaccine.

Identifying the right messages to promote vaccine confidence, countering misinformation, and targeting outreach to vulnerable and at-risk populations will be necessary to achieve high coverage. The members of the national task group will build on its existing relationships with key regional and local government offices to effectively implement communication campaigns. The national task group will also be working to develop innovative approaches to improve vaccine uptake among hard-to-reach critical populations.

Initiate demand generation

Ensuring sustainable demand for vaccination is only possible when beneficiaries and communities trust the safety and efficacy of vaccines and the quality and reliability of the vaccination services. They also need to have the necessary information, access, and motivation to complete the recommended vaccination schedule on time.

The COVID-19 vaccination demand promotion strategy embraces contextualized and targeted evidence-informed approaches, including social and behavior change communication, political will and advocacy, health workforce capacity development, social mobilization, and community engagement activities. The strategy provides the why, what, when, and how of COVID-19 vaccination. In support of the key messages on the COVID-19 vaccination, the demand promotion and communication strategy will also leverage an enhanced BIDA Solusyon campaign to emphasize the continued need to practice essential preventive behaviors, to enforce minimum public health standards, to address myths and misinformation, and to empower individuals.

Understand and act on drivers of vaccine acceptance and uptake

Ideally, before preparing any informational material, the population's knowledge and perception of the disease and vaccination should be evaluated so that information and education needs can be determined and appropriate content prepared.

The SAGE working group on vaccine hesitancy classified contributors to vaccine hesitancy into 3 main groups:[3]

- Complacency: Low perceived risk of vaccine-preventable diseases, and vaccination not deemed necessary. Other life/health issues are a higher priority.
- Confidence: Low levels of trust in vaccines, in the delivery system, and in health authorities.
- Convenience: Barriers related to geographic accessibility, availability, affordability, and acceptability of services.

[3] 3C framework is adopted from the report of the SAGE working group on vaccine hesitancy.

The IEC materials developed will address all three factors. In addition to IEC material for the general public, materials for several different target populations, including physicians, vaccinators, and journalists, will be developed.

An integrated demand approach supporting informed decision among citizens participating in the vaccination program

a. Informed Consent

Obtaining informed consent for immunization is both an ethical and legal requirement in any vaccination program. Consent derives from the principle of autonomy and forms an important part of medical and public-health ethics, as well as international law. The importance of consent is that it facilitates the freedom to make choices that reflect the individual's own values, beliefs and life experiences. The primary principle for informed consent described in the Guide to Professional Conduct, states: "Patients must be given enough information, in a way that they can understand, to enable them to exercise their right to make informed decisions about their care. Consent is not valid if the patient has not been given enough information to make a decision." While the context of a public health immunization program differs from both primary and secondary care prescribing, similar principles apply. For consent to be valid, it must be informed, understood and voluntary, and the person consenting must have the capacity to make the decision. Special consideration must be given to consent arrangements for those individuals who may lack capacity to give consent. Informed consent must be preceded by disclosure of accurate, adequate and relevant information in a manner that is comprehensible to the person about the nature, purpose, benefits and risks of vaccination. The benefits of vaccination should address both benefit to the individual and to society such as the potential for individual and herd immunity. Risks, both in terms of known risks e.g. adverse side effects as well as the potential for unknown risks attaching to the vaccine, should be communicated to the vaccine recipient. In the current situation, it will be important to make clear to potential recipients of a COVID-19 vaccine that the duration of immunity conferred is currently unknown and may not be equally effective across all age-groups. The benefits and risks that are disclosed will depend on what is known about them at the time consent is given. Knowledge about the vaccines will continue to advance and it is important that the benefit/ risk ratio be continually reviewed and updated in all information and consent material provided to potential recipients will often change.

b. Building Confidence for the Vaccine

It must be acknowledged that people will have questions about the COVID-19 vaccine. Potential recipients should be given an opportunity to ask questions and to discuss any fears they may have around vaccination. This is particularly pertinent in the context of promoting vaccine confidence. The Philippines is no different to other countries when it comes COVID-19 vaccination planning and the myriad of challenges this presents. As the health system gets ready for the national effort to vaccinate against COVID-19, public health and healthcare and clinical experts, policy makers, and the public will benefit from lessons learned from planning

and workshop exercises and examining the experience of previous public health mass vaccination programs. This Plan has considered both the expertise developed and the experience gained by Expert Groups, organizations and agencies across the country and continent from pandemics and outbreaks that have affected the Philippines in the past, including the 2009 H1N1 Pandemic, and have proactively applied these lessons learned to COVID-19 vaccination planning.

c. Provision of Concise and Clear Information

The members of the national TG Demand Generation and Communications, will generate information for patients, consistent with the available authorized product information. For each vaccine, this will be written in plain language including all major dialects and English and will be displayed prominently and be freely available at all vaccination sites. It will also be available online. A copy of the regulatory, approved patient information leaflet will also be made available (paper or electronic means). This will help to ensure that each person receiving a vaccine is giving informed consent to receive a COVID-19 vaccination, and that they (or their parents or guardians) will be provided with consent forms and sufficient information to allow an informed choice to be made. This information will be provided in a way that is fully comprehensible, and will describe the nature, purpose, benefits and risks of the vaccination and any measures to alleviate the symptoms arising from aftereffects (e.g. paracetamol to relieve high temperature). All information surrounding the vaccine development, testing limitations (if any), and administration held by the manufacturer and regulatory authorities must be fairly represented in a balanced and summarized manner. To provide valid consent, potential recipients, who might have a range of literacy and numeracy skills, should understand the core message of the vaccine's purpose, benefits and risks. This includes disclosing that suspected adverse reactions might not be caused by the vaccine and that rare side effects may not have been detected in clinical trials.

d. Providing Up to Date information

All information, education and communication materials (including posters, social media releases, patient information leaflets) will be subject to change as new data emerges, and may include, but will not be limited, to the following relevant information about the COVID-19 vaccines:

- Approval process related to the vaccine's market authorization, including testing and limitations of testing
- Licensing
- Any new component or technology that has not been licensed or used previously
- Post-marketing analysis by the relevant regulatory agencies
- Potential and known side effects and adverse reactions including that described in the regulated package leaflet (issued by EMA)
- How and where to report side effects – a phone number will be included
- How to alleviate possible symptoms arising

Accurate and updated information should be accessible to the target eligible population, with an available central information source (such as a designated telephone service) that can be easily approached for additional concerns/queries. While all information provided will represent the state of knowledge at that time, new information and emerging facts will be documented and promulgated where appropriate and in a timely manner. It is strongly recommended that none of the communication strategies to be undertaken will compare or provide recommendations between vaccine variants (currently available or yet to be approved) in a way that may devalue/denigrate one in favor of the other.

e. Continuous Engagement with the Regulatory Authority

The TG Demand Generation and Risk Communication will continually monitor data from the regulatory authority (FDA) in relation to vaccine safety signals, as well as any data arising from public health monitoring and surveillance activities. As stated elsewhere within this plan, the relevant authorities will be carrying out formal post-monitoring surveillance on the use of the COVID 19 vaccines to identify any emerging issues including significant adverse, purported or coincidental events. The TG Demand Generation and Risk Communication will also ensure that any necessary information arising from this monitoring of the vaccines will be adequately and promptly communicated. Healthcare Professional Communications will be issued by DOH/Dept for Human Resource. Any emerging safety issues will be communicated to DOH, or escalated to National Immunization Program (NIP), as appropriate.

Communication and engagement of the public

Since the start of the COVID-19 pandemic, consistent communication of the public health advice to protect from COVID-19 has played a central role in the Government's response to the pandemic, earning wide public co-operation. Clear and transparent communication on all aspects of COVID-19 vaccines, led by subject matter experts, to build public trust in vaccine safety and efficacy will be a critical element to the success of the Philippines' vaccination program. The approach will build on the successful communication and engagement program delivered throughout the COVID-19 pandemic to date, ensuring the communications response to the vaccine program is integrated into existing COVID-19 communications. The arrival of vaccines will not mean zero COVID-19. Instead, the COVID-19 vaccine will be added to the existing public health toolkit. Aligned to this, Government public health advice will expand to include the availability of a vaccine. As the vaccines roll out across the country, it will remain important that we continue to work with the public health advice which asks us to wash our hands, cough into our elbows, maintain 2m social distance and wear face coverings where appropriate.

a. Communications Strategy

This strategy aims to position COVID-19 vaccines as an additional tool in the public health advice to protect against COVID-19 and encourage universal vaccination. Communication around the program will be informed by the following principles:

- Ongoing understanding of public sentiment regarding vaccine
- Open and transparent communication, to be led by the PCOO's Philippine Information Agency (PIA), and developed by public health and immunization experts
- Clear and consistent communication to encourage vaccine uptake
- Cross Government collaboration reinforcing the public health advice

Communication on COVID-19 public health advice, including the COVID-19 vaccination program, will need to be agile as with our response to the pandemic to date this will involve regular communications and updates via the different government platforms, including but not limited to, the Office of the President, the PCOO, and the DOH. Once the vaccination program has commenced, data on the vaccine uptake will be incorporated into the daily COVID-19 press release, COVID-19 data hub, and current communication channels.

b. An Evidence Informed Approach

Since the early days of the COVID-19 pandemic, the different government agencies have actively listened to the public. Understanding, reacting and responding to public sentiment have been core elements of the COVID-19 campaign. As progress has been made in vaccine development, that work has continued, and has informed every element of this Strategy. Key insights from work to date with the public:

- Many people who doubt the vaccine are in a dilemma: they want the vaccine but are cautious. People are concerned as to the speed of the development of the vaccines and want to be reassured as to their safety and effectiveness.
- Overall, we must own the idea that science is never 100%; no guarantees; no cast iron certitudes.
- We should be forthright and proportionate in what we say. People of different ages have different understanding and expectations about what vaccines will bring in the short to medium term.
- Communication on the vaccine must be led by medics coming from a perspective of expertise, science and health advice.
- Whatever the unknowns are, they need to be stated and owned; only communicate when we have the facts.
- We need language that anyone will understand - so that everyone feels welcomed into the communication.

c. Key Elements

c.1 A Phased Approach

The communications and engagement strategy will have three main phases.

- The *first phase (pre-roll out)* will focus on preparing for the vaccine roll-out - this includes speaking about the safety and regulatory processes that are in place in the Philippines and across the world; engaging with people who have genuine hesitancies

around the vaccine; communicating the Government Plan from acquisition to prioritization to distribution; and communicating about the results of the clinical trials when they are available.

- The *second phase (deployment)* will focus on the deployment of the COVID-19 vaccine – this includes national and local communication from key champions (including medical societies, allied healthcare workers, local chief executives, etc) encouraging the public to get the vaccine, informing who will administer it and where, identifying people of trust, opinion leaders to act as ambassadors for the vaccine. Active expert participants in the campaign will come from the DOH and other collaborating agencies, ensuring clear and consistent communications from a trusted source.
- The *third phase (post-deployment)* will focus on strategies for after the COVID-19 vaccine deployment (post-deployment) - this includes continuous monitoring and updates for key stakeholders and the general public, and building a sense of community and responsibility to ensure the sustained protection of communities and continued promotion of preventive behaviors (eg. wearing a mask, social distancing, etc)

c.2 Trusted Voices and Peer to Peer support

Healthcare workers are an important at-risk population group. They are also a recognized and trusted source of information and influence. Nurses, in particular, are trusted sources of information for the public. The national TG Demand Generation and Communications will prepare targeted messaging and briefings for this important stakeholder group. One of the most effective means of increasing uptake of the flu vaccine among healthcare workers (HCW) continues to be peer-to-peer communication and support. The national TG Demand Generation and Communications will identify and inform local champions on the importance of all HCWs receiving the COVID-19 vaccine when it is available to them.

This approach will also be taken with the general public. The Regional and Local VOCs will be supported to work with local print and broadcast media, as well as local stakeholders to inform their communities and support uptake of vaccine in their community. It is recognized that uptake will be influenced by a wide range of influencers, depending on demographics. The role of community leaders, religious leaders, celebrities and other influencers, will be important in conveying the message.

c.3 Audiences and Stakeholders

The COVID-19 vaccine program will touch every person, every healthcare worker, every household, every family in the Philippines. This is a challenge in terms of scale and timing, but it also offers us an enormous open door to build trust and confidence in this vaccination program, because, like COVID-19 itself, the vaccine is something that everyone cares about and has been affected by. There are challenges in the scale of the program, the need for sequencing how the vaccine is offered to people in priority groups, and in providing assurance about safety and effectiveness. Pressures may grow in the coming months in these areas of

challenge, but with the benefit of a comprehensive demand generation and communication plan, these challenges can be addressed.

c.4 Initial Key Messages

The vaccine communications and narrative has already begun. The first key messages are already being communicated (for the *pre-roll out phase*) and these include the following themes for the general public:

- Benefits of Vaccine Urgency and Deployment
- Prioritization and Timing
- Rigorous Development, Approval, and Monitoring
- Global Cooperation

These identified themes include the following supporting messages:

- The Philippines will only use a vaccine if it meets the required standards of safety and effectiveness. All the recommended vaccines used in the country are licensed by the EMA (European Medicines Agency), the US Food and Drug Authority as well as our FDA. The vaccines will be subject to ongoing monitoring in the Philippines by the FDA. They are licensed for use only when they have been shown to be both safe and effective.
- Due to the urgency posed by the pandemic, exceptional efforts are ongoing to develop COVID-19 vaccines and make them available as soon as possible. Unprecedented levels of scientific research and collaboration, investment and early and proactive engagement between vaccine developers and regulators has helped speed up development and ensured that quality, safety and effectiveness are not compromised.
- Vaccines are a proven, cost-effective intervention to protect public health; second only to the provision of clean water. Worldwide, they save at least 2-3 million lives each year – and many more from crippling and lifelong illnesses.
- Certain priority groups will be vaccinated first. For example, frontline healthcare workers and people who are most at risk from serious infection if they catch COVID-19. Once these priority groups have been vaccinated, the vaccine will be available to the rest of the population.
- The vaccines will be delivered in stages so it will take time to vaccinate everyone. This means we will need to continue to be careful about our individual actions to stop the spread of COVID-19. For example, social distancing, wearing a face covering and regular hand washing. We cannot afford to drop our guard now.

After the pre-rollout phase, the messages for the next phase (*deployment phase*) will address themes focusing on 1) Patient responsibility and follow-through; and 2) Legitimate sources of vaccines and reliable vaccination posts.

Then for the third and last phase (*post-deployment phase)*, the messages will focus on 1) Continuous monitoring and responsible reporting; and 2) Sense of community.

d. Promoting Vaccine Confidence

The vaccine confidence continuum includes a small minority who refuse all vaccines with conviction, and those who have valid concerns and need more information before deciding to take a vaccine as well as those who have a positive predisposition to vaccination programs. From the October 2020 IDinsight survey commissioned by the DOH Health Promotion Bureau and UNICEF, about half (52%) of the participants responded that they would get vaccines for themselves if available. Effectiveness was the most frequently cited important piece of information necessary for deciding whether to get a vaccine (40%), followed by side effects (18%) and safety risks (17%).

As part of the approach to building confidence, the TG Demand Generation and Communications will strategically address misinformation which may appear on social media and the internet, and direct people to more credible sources of information such as the online platforms/websites of the PCOO-PIA and the DOH. There is precedence for the introduction of novel vaccines in response to significant health risks associated with certain diseases, for example, polio, meningitis and haemophillus influenza B (HiB) vaccines as part of the childhood vaccination programme, and pertussis vaccine in pregnancy.

After the Ebola outbreak of 2014-2016, researchers in Oxford University began preparing plans to create a vaccine for any new emerging diseases that might afflict the world in the shortest possible time. This body of work formed the basis of the Oxford AstraZeneca vaccine development process. The Pfizer/BioNTech Phase 3 Clinical trials involved over 43,000 participants. Normally, clinical trials can be held back due to low volunteer numbers and low disease prevalence – neither of which have been an issue in the case of COVID-19.

While we await regulatory reports from the vaccine trials, government communication will prioritize that proportion of the population that are unsure, addressing their questions and concerns through clear and transparent evidence-based communication via a multitude of channels.

Special Chapter

Registry and Data Management

A robust and comprehensive data management system using information and communications technologies, shall be established and utilized to monitor progress of vaccination activity, including monitoring of vaccine safety and effectiveness. The data management system shall be used to:

1. Measure real-time and equitable uptake and coverage over time by geography and eligible population groups.
2. Monitor implementation of the national vaccination program encompassing population eligibility, supply chain logistics, and other important parameters.
3. Monitor vaccine safety, disease surveillance, and effectiveness.
4. Retrieve personal vaccination records or certification as deemed required.
5. Ensure data collection, consolidation, and analysis compliant with data privacy and security standards.

I. Masterlisting during Pre-Implementation Phase

A nationwide profiling of eligible population shall be conducted prior to the implementation of the vaccination activity and shall be utilized to determine the eligibility of the priority groups receiving the vaccine.

To prepare the country for the COVID-19 vaccination program of the DOH, creation and maintenance of a masterlist of priority sectors is necessary to: (a) provide basis for identification of target eligible groups for vaccination and identification of priority areas for registration of eligible individuals; (b) ensure uniqueness of individuals in the vaccine administration plan; and (c) provide input to operational planning especially for costing and allocation of resources. Masterlisting shall use the phased approach, and be initiated at the LGU level, specifically municipalities and cities, with profiling and screening of eligible target population cohorts will be conducted prior to registration into the electronic immunization registry. An informed consent is required before proceeding to the registration.

The COVID-19 Electronic Immunization Registry (CEIR) shall be the official platform for masterlisting and registration for COVID-19 vaccination. External systems may be used to submit the necessary information following the Interim Minimum Required Data Fields based on DOH standards and policies.

Local Government Units, specifically municipalities and cities, shall lead masterlisting, and monitoring and evaluation within their catchment area, which shall be consolidated by province/ HUC/ ICC.

LGUs shall ensure that data provided in submission platforms are unique through deduplication of linelists across facilities within their catchment. The DOH shall likewise conduct deduplication checks on the final endorsed masterlists.

Consistent with actions necessary for Universal Health Care, LGUs should initiate profiling the health status of their population and generate a masterlist of population with comorbidities and other important information that will be necessary to implement the National Deployment and Vaccination Plan. Health profiling through Electronic Medical Records consistent with DOH standards is recommended.

II. Reporting and Data Management during Vaccination Date and for Adverse Events Following Immunization (AEFI)

Municipalities/CC/HUC/ICC may utilize the CEIR or third party solutions that may link to the CEIR, following set data standards. Reporting processes and data standards during actual vaccine administration and monitoring for adverse events following immunization shall be released in succeeding issuances. Ongoing simulation activities in select hospitals and LGUs shall inform these standards.

In addition, registration of official members of the vaccination workforce (i.e., vaccinators) will be conducted with data being recorded vis-à-vis the official vaccination sites/facilities as recorded in an expanded version of the current National Health Facility Registry.

III. Overall Dashboard: Vaccination Information Management System

Pursuant to IATF Resolution No. 85, section B, item 8, the DICT shall lead and manage the design, development, deployment, monitoring and evaluation of the Vaccine Information Management System (VIMS). The VIMS shall serve as an electronic, confidential, and secure information system that will record all vaccination doses administered by participating providers to people residing within a given geopolitical area. It will be used to assess local vaccination coverage levels or to assist during disease outbreaks, public health emergencies, or vaccine shortage situations to identify individuals in need of vaccination. The VIMS shall be used to ensure vaccine management and accountability, in tracking of vaccine safety issues, and in the evaluation of vaccine effectiveness.

The objectives of the VIMS will be as follows:

1. Provide visibility and control over vaccine stock balances and supplies beyond the central stores (to correct overstocking and understocking);
2. Determine the status of our current cold chain capacity in near real-time;
3. Monitor temperatures in storage equipment to help identify underperforming equipment or causes of (persistent) cold chain breaks
4. Determine vaccine consumption rates on a daily basis for purposes of forecasting and distribution planning;

5. Determine, and potentially anticipate, if stockouts at the local government levels are a problem; and
6. Determine how much vaccine ends up being wasted.

The following shall be the components of the VIMS:

1. Immunization registry
2. Logistics management
3. Stock management
4. Warehouse management
5. Supply chain management
6. Cold chain management

In order to successfully implement the VIMS, it shall follow a clearly defined governance model using key global interoperability standards for a digital smart yellow card and leveraging a trusted architecture to support roll out of the anticipated COVAX, and application to other routine immunization systems.

The following will be the minimum required set of solutions:

1. A governance framework
2. A common enterprise architecture
3. Use of interoperability standards (i.e., HL7 FHIR) with a common taxonomy (i.e., SNOMED)
4. Defined certification specifications for secure issuance of certificates
5. Vetted digital solutions that incorporate all above items

Finally, the VIMS shall have the ability to issue a vaccination event certification, which shall be an electronic form of the hard copy immunization card that the NIP issues to all vaccine recipients.

IV. Adoption of National Health Data Standards for Interoperability

The implementation of Universal Health Care Act recognizes the vital role of information and communications technologies (ICTs) in the adoption of an integrated and comprehensive approach to health development. Under Sections 31 and 36 of the Act, two of the key strategies identified are to strengthen evidence-based sectoral policy and planning, and to improve the country's health information system (HIS).

To tangibly operationalize these strategies requires the use of common data standards to enable seamless and interoperable health services and information flow operating under a functional national health information infrastructure. The Department of Health shall regularly update mandatory national health data standards for interoperability, enabled by establishing a core set of terminologies, definitions, and structures for data and reports processing, sharing and exchange.

V. Ensuring Data Privacy and Security

a. Consent of the Data Subject

Parties tasked to collect personal data should assure and undertake to obtain the consent of the data subject and inform them of the following:

1. The identity of personal information controllers (PICs) and personal information processors (PIPs) that will be given access to the personal data;
2. The purpose of data sharing;
3. The categories of personal data concerned;
4. Intended recipients or categories of recipients of the personal data;
5. Existence of the rights of data subjects, including the right to access and correction, and the right to object. However, the other party shall be informed of any request to access or correct personal information which is the subject matter of this sharing agreement; and
6. Other information that would sufficiently notify the data subject of the nature and extent of data sharing and the manner of processing.

b. Procedures of Use or Process of Personal Data

Sharing and processing of personal data should be via a secure encrypted link, with a middleware that shall have full control over such online access. Actual transfer of shared personal data or a copy thereof from one party to another like in the form of emails or physical submission of printed copies from one party to another may be done provided that processing and sharing must adhere to the data privacy principles laid down in Republic Act No. 10173 (Data Privacy Act of 2012 [DPA]), its Implementing Rules and Regulations, and other issuances of the National Privacy Commission (NPC).

Recipients of the personal data shall likewise use appropriate safeguards to protect the personal data from misuse and unauthorized access or disclosure, including maintaining adequate physical controls and password protections for any server or system on which the personal data is stored, ensuring that personal data is not stored on any mobile device (for example, a laptop or smartphone) or transmitted electronically unless encrypted (using encryption standard prescribed by the National Privacy Commission), and taking any other measures reasonably necessary to prevent any use or disclosure of the personal data other than as allowed under this Agreement.

All identified personnel that have been authorized to receive, access and process shared personal data shall sign a Non-Disclosure Agreement (NDA), specifically for the purpose of the national COVID vaccination program.

Chapter 1: Vaccine Selection and Evaluation

There are 235 COVID-19 candidate vaccines under development as of 5 January 2021 based on the WHO Draft landscape of COVID-19 candidate vaccines. Of these, 63 are under clinical development with 15 candidates in Phase 3 clinical trials and 6 candidates in Phase 2/3 clinical trials. To guide the choices on which vaccines will be considered for negotiation and procurement, the VEP developed criteria for the technical evaluation of the candidate vaccines.

The VEP mandates are defined in the Philippine Council Health Research and Development (PCHRD) Special Order No. 20-073 Series of 2020:

1. To identify and evaluate possible vaccine candidates from the local and international partners of the DOST.
2. To identify local partners or institutions for the conduct of preclinical and clinical trials of the vaccine candidates in the country.
3. To provide recommendations and action plans on the engagement of partners, preclinical and clinical trials' requirements of the FDA Philippines, DOH and WHO.
4. To evaluate project proposals on vaccine development seeking financial assistance from PCHRD or DOST.
5. The mandate was expanded to evaluate applications for Emergency Use Authorization (EUA).

Table 2. Criteria developed by the Vaccine Expert Panel for technical evaluation of COVID-19 Vaccines.

Criteria	*Weight*
1. Track record of company in developing and/or manufacturing other vaccines	10%
2. Technology platform (reliability and stability related to storage requirement)	10%
3. Safety based on Phase 1 and 2 clinical trials	20%
4. Immunogenicity (potential efficacy based on Phase 2 clinical trials)	20%
5. Potential efficacy and safety based on published Phase 3 interim result and/or with Emergency Use Authorization	30%
6. Vaccine implementation (i.e dosing schedule)	10%
TOTAL	100%

The above-mentioned criteria adapt the WHO Criteria for COVID-19 Vaccine Prioritization and WHO Target Product Profiles for COVID-19 Vaccines with additional criteria and considerations suited for local needs. The two (2) guiding documents describe the preferred and minimally acceptable profiles for human vaccines for long term protection of persons at high ongoing risk of COVID-19 such as healthcare workers and for reactive use in outbreak settings with rapid onset of immunity.

Considering that the Vaccine Roadmap will span three years with a target to start the vaccination of eligible priority population by 2021, a prioritization mechanism was adopted by

the Task Group on Vaccine Evaluation and Selection to shortlist which vaccines will be initially considered for evaluation:

1. Candidate vaccine is in advanced stage of clinical development, preferably in Phase III clinical trial;
2. Vaccine developer is from a country with bilateral S&T partnership with the Philippines;
3. Vaccine developers expressed interest to conduct clinical trials in the Philippines and/or engage in local manufacturing and/or technology transfer in the medium term.

Following the above-mentioned prioritization mechanism, the following vaccines were short-listed, scored and weighted using the criteria developed by the Vaccine Expert Panel:

Table 3. COVID-19 vaccines shortlisted for VEP evaluation.

Vaccine Developer	*Technology Platform*
Sinovac	Inactivated
Sinopharma	
Bharat Biotech	
Anhui Zhifei	Subunit
Novavax	
Clover	
Janssen	Viral-vectored
Gamaleya	
AstraZeneca	
Pfizer	mRNA
Moderna	

Based on the overall scores, a ranking across platforms and ranking within platforms was endorsed by the VEP to the Task Group on Vaccine Evaluation and Selection. This takes into account the consideration that a vaccine per technology platform may need to be selected as it is expected that there will be differences in vaccine characteristics depending on the type of technology platform used, and a particular platform may be better suited to specific sectors or groups based on the results of clinical trials.

The evaluation is subject to updating as more scientific data and evidence becomes available. Further, as more candidate vaccines are expected to advance in late-stage clinical development, the vaccines for consideration may be updated as there are still populations targeted for vaccination in 2022 and 2023.

The list of vaccine platforms, as ranked by the Task Group on Vaccine Evaluation and Selection will advise the negotiations by the Vaccine Czar through the Task Group on Diplomatic Engagement and Negotiation. Once an Agreement is reached, an Official Purchase Agreement will be affected either thru bilateral or multilateral negotiations. To ensure safety and efficacy, it is to be clearly understood that ONLY vaccines which are granted Emergency Use Authorization (EUA) or Certificate of Product Registration (CPR) by the Philippine FDA will be purchased by the government.

In the subsequent years of the Vaccine Roadmap implementation, as global supplies become stable, and broad-base knowledge of vaccine efficacy and safety is established, the Department of Health will develop a "Clinical Practice Guidelines (CPG) on the Use of Different Vaccines for Specific Population Groups" in collaboration with professional societies and relevant stakeholders. The vaccine selection will be based on this CPG, which will be further reviewed by the NITAG and the Health Technology Assessment Council. The ultimate recommendation will be sought from HTAC by the Department of Health before it procures from a portfolio of FDA-registered COVID-19 vaccines, subject to the provisions of Republic Act 9184 or the Philippine Procurement Reform Act.

Chapter 2: Diplomatic Negotiation and Engagement

The Department of Foreign Affairs (DFA) oversees engagement with foreign governments, pharmaceutical companies, and other relevant entities on vaccine development and evaluation and selection of vaccines to be considered for procurement and clinical trials, with the view of assuring that Filipinos will have access to COVID-19 vaccines.

The country apart from bilateral negotiations is also pursuing the multilateral track through the COVID-19 Vaccines Global Access (COVAX) Facility that would ensure the country's access to COVID-19 vaccines for 20 million Filipinos.

Regulatory Preparedness

The COVID-19 vaccines may be accessed through: (1) conduct of clinical trial, and (2) emergency use authorization (EUA) and eventually, market authorization. The Food and Drug Administration (FDA), as the National Regulatory Authority (NRA), has the mandate on both as provided under Republic Act No. 3720, or the "Food, Drug and Cosmetic Act," as amended by Executive Order No. 175, s. 1987, and Republic Act No. 9711, or the "Food and Drug Administration Act of 2009".

A. Conduct of COVID-19 Vaccine Clinical Trials

Prior to the pandemic, the conduct of clinical trials in the country is regulated following FDA Administrative Order No. 2020-0010, otherwise known as the "Regulations of the Conduct of Clinical Trials for Investigational Products".

In light of the COVID-19 pandemic, the Inter-Agency Task Force for the Management of Emerging Infectious Diseases (IATF-EID) created the Sub-Technical Working Group on Vaccine Development through its Resolution No. 39 dated May 22, 2020 to coordinate matters pertaining to clinical trials of COVID-19 vaccine candidates. The Sub-TWG is chaired by the Department of Science and Technology, co-chaired by the Department of Health, and with the FDA, Research Institute of Tropical Medicine, Department of Foreign Affairs, Department of Trade and Industry - Board of Investments, and the National Development Company as member agencies.

The IATF-EID further supplemented the earlier resolution with its Resolution No. 65, s. of 2020, which requires that all applications for COVID-19 vaccine clinical trials should first be submitted to the Vaccine Expert Panel (VEP) for technical review, to designated Ethics Board/s (ERB/s) for ethical review, and once approved by the VEP and ERB/s, submitted to the Food and Drug Administration for regulatory review and final approval. The Vaccine Expert Panel (VEP) was created by the DOST to provide technical expertise on the evaluation of candidate COVID-19 vaccine applications and to provide recommendations to the Task Group on Vaccine Evaluation and Selection (then the sub-Technical Working Group on Vaccine Development) on S&T activities on COVID-19 vaccine development. The regulatory process of the FDA and the policies of the IATF-EID has been harmonized and streamlined under FDA Circular No. 2020-029. The same Circular further expedites the evaluation for COVID-19 vaccine clinical trials application to a maximum of 40 working days, provided all requirements are complete.

The functions of the Task Group, with the technical assistance from the VEP, has expanded from providing oversight on the evaluation of applications and conduct of COVID-19 vaccine trials in the country, to include as well the evaluation of COVID-19 vaccines that could be considered by DOH in its selection of COVID-19 vaccines for the Philippines.

B. Emergency Use Authorization

In the Philippines, any new drug and vaccine should have an authorization from the FDA based on an application containing full reports of investigations to show whether or not such vaccine is safe, efficacious and of good quality for use based on clinical studies, prior to manufacture, sale, importation, exportation, distribution or transfer thereof.

In light of the COVID-pandemic, the Philippines was declared under State of Public Health Emergency, pursuant to Proclamation Nos. 922 (s. 2020) and 1021 (s.2020). Subsequently, Republic Act No. 11494 or the "Bayanihan to Recover as One Act" was enacted authorizing the President to suppress the COVID-19 pandemic through the procurement of drugs and vaccines.

Considering that there is no registered drug and vaccine yet for COVID-19 in the Philippines, the President of the Republic of the Philippines issued Executive Order (EO) No. 121 entitled "Granting Authority to the Director General of the Food and Drug Administration to Issue Emergency Use Authorization (EUA) for COVID-19 Drugs and Vaccines, Prescribing Conditions therefore and for other Purposes." The said issuance gave authority to the Director General of the FDA to issue an EUA, and establish the conditions under which said authorization may be issued.

FDA Circular No. 2020-036 provides the process for the issuance of the EUA aimed to sustain and strengthen the county's preparedness and response for the COVID-19 public health emergency. The principles of regulatory reliance and recognition are adopted to accelerate the evaluation and approval process for EUA to ensure immediate access to drug products and vaccines for COVID-19. The said circular defines that the EUA shall only be issued and remain valid when all of the following circumstances are present:

a. Based on the totality of evidence available, including data from adequate and well- known controlled trials, it is reasonable to believe that the drug or vaccine may be effective to prevent, diagnose, or treat COVID-19;
b. The known and potential benefits of the drug or vaccine, when used to diagnose, prevent, treat COVID-19, outweigh the known and potential risks of the drug or vaccine, if any; and
c. There is no adequate, approved and available alternative to the product for diagnosing, preventing or treating COVID-19.

The last condition is deemed present when there exists no registered drug or vaccine in the country for diagnosing, preventing or treating COVID-19. FDA Circular No. 2020-036 likewise provides other conditions for authorization on the distribution requirements, reporting requirements, and safety and monitoring requirements.

Vaccines Access

Based on this guidance, a three-year vaccination roadmap was developed, where, in each year from 2021 to 2023, an identified eligible population will be given the vaccine. The vaccines will be sourced from the COVAX Facility and from bilateral/multilateral sources [e.g.

AstraZeneca, Sinovac, Pfizer, Novavax, Johnson & Johnson, Gamaleya, Moderna, Sinopharm, CansinoBio (in no particular order)].

The COVAX Facility, the vaccine pillar of the Access to COVID-19 Tools (ACT) Accelerator, is a global risk-sharing mechanism for pooled procurement and equitable distribution of COVID-19 vaccines. The said facility will make investments across a broad portfolio of promising vaccine candidates to make sure at-risk investment in manufacturing happens now. This means, by pooling purchasing power from all countries that participate, the facility will have rapid access to doses of safe and effective vaccines as soon as they receive regulatory approval. Guided by an allocation framework being developed by WHO, the COVAX Facility will then equitably distribute these doses to help protect the most at-risk groups in all participating countries. The COVAX Advance Marketing Commitment (AMC), together with GAVI Alliance, will provide assistance and support for the participation of 92 lower-middle and low-income economies, which includes the Philippines.

The selection of vaccines is based on the type of vaccine platform, track record of manufacturer for developing or manufacturing vaccines for other diseases, safety based on Phase I and II clinical trial results, potential immunogenicity based on Phase II clinical trials results, potential safety and efficacy for those with interim Phase III clinical trial results, vaccine implementation (i.e. dosing schedule), vaccine stability, and supply chain considerations. These criteria are weighted, and the type of vaccines are subsequently ranked, and endorsed by the VEP to the Task Group on Vaccine Evaluation and Selection.

Table 4 below shows the yearly eligible population from 2021 to 2023, its proportion to the national population.

Table 4. Target population for COVID-19 vaccination, its proportion to the national population.

Year	*2021*		*2022*		*2023*	
Vaccine Access	*Eligible Population*		*Eligible Population*		*Eligible Population*	
	Number	*Proportion to national population*	*Number*	*Proportion to national population*	*Number*	*Proportion to national population*
PHL Population	*110M*		*112M*		*114M*	
Total Eligible Population	*70M*	*63%*	*42M* *70M* *112M*	*37%* *63%* *100%*	*2M* *112M* *114M*	*2%* *98%* *100%*

Note: National Population Figures used: 2021 - 110,198,654; 2022 – 111,572,254; 2023 – 112,892,781. National Population Figures were based on Population Projections by the Philippine Statistics Authority. Assumptions: By 2022, 16 years old and below can be vaccinated already and this sums to 42M Filipinos. By 2022, the total population of 15 years old and above is 77 M. Those previously vaccinated shall be given booster dose the following years. By 2023, newborns shall be vaccinated.

The COVAX facility will supply 20% of the total population of the country for free, while the other bilateral/multilateral sources will be the source of vaccines to cover the rest of the eligible population from 2021 to 2023.

Chapter 3: Procurement and Financing

The TG Procurement and Finance divides the process for procurement of vaccines into three phases. The first phase involves preliminary meetings with said manufacturers and the signing of a reciprocal Non-Disclosure Agreement (NDA). The NDA is put in place to protect the rights of both the National Government and the manufacturer to their respective confidential information and allow for smooth and transparent negotiations. Through the NDA, both parties agree on the type of confidential information that may be disclosed to each other, the specific purpose for such disclosure, exceptions to the right to confidentiality, as well as the rights of the parties and available reliefs in case of breach. High level meetings facilitated by the TG Diplomatic Engagement are likewise held.

During the second phase, the parties engage in formal negotiations, which normally commence with the exchange of the term sheet. The term sheet ideally outlines all the relevant offers and details on the vaccine procurement, including the number of doses to be ordered, the purchase price, the target date of signing of the definitive and binding Supply Agreement, payment and effectivity dates, delivery schedules, and all other rights and obligations of the parties. The term sheet is also reviewed for possible implications under the procurement law as well as other applicable local laws. With the goal of getting the best deal for the government, the TG Procurement and Finance would engage in several rounds of negotiations with the supplier for possible revisions and/or clarifications of the term sheet.

Matters that are resolved during the course of negotiations are documented, and pending matters are likewise recorded for immediate consideration and resolution by the parties.

Finally, negotiations culminate in the signing by both parties of a Term Sheet, which although not yet binding, then contains all the accepted offers and conditions for the supply of vaccines.

In the third and final phase, the National Government submits the Term Sheet to the financing banks for clearance, and the parties finalize and sign the supply agreement in the form of either an Advance Market Commitment, Supply Agreement or a Research & Development Investment.

The TG Procurement and Finance ensures that safeguards are well in place in the commercial agreements to guarantee that government funds go to vaccines with proven safety and efficacy. Thus, one of the integral terms negotiated by the team as a condition in the agreements is the registration with the Philippine FDA through the Emergency Use Authorization before delivery, and payment of balance. Among others, once the authorization is in place and in case of successful delivery, the GoP stands ready to pay.

The financing for COVID-19 vaccine is made through the following modalities: (i) Using the General Appropriations Act, (ii) Multilateral Financing, (iii) Bilateral Financing, and (iv) Contractual Joint Venture (JV)/ Private Sector Financing. The first mode is carried out in accordance with Republic Act No. 9184 or the "Government Procurement Reform Act" and Republic Act No. 11494 or the Bayanihan to Recover as One Act (Bayanihan II). This amount will partially cover logistics, distribution and monitoring costs. Procurement of COVID-19 goods, supplies, and resources are exempt from the requirement of competitive bidding under Bayanihan II, which has expired on December 13, 2020. Moreover, advance payment of 15% of the contract price will be allowed in areas where a State of Calamity has been declared. Any advance payment exceeding 15% of the contract price will have to be made under the directive of the President.

For procurement of vaccines and the Government's contribution to the COVAX facility, the GoP will tap financing with its multilateral development partners such as the ADB and the WB. The rules governing procurement through multilateral loans are exempt from R.A. 9184 as this will be an Official Development Assistance (ODA) loan. Nevertheless, the procurement rules of the WB or the ADB, which are consistent with international standards, will apply.

To supplement the financing requirements under multilateral facilities with the ADB and the WB, the government may consider co-financing from bilateral partners, such as China (Eximbank), the UK (UKEF), the US, India, Singapore, and Australia, through tied-aid ODAs. Under this mode, the executive agreement will apply when it comes to the procurement rules (limited source bidding).

Lastly, the funding for the vaccines covering the population that are not covered by the foregoing may be through contractual joint venture (JV) agreements between the private sector, the government, and a vaccine manufacturer/supplier. This may also be the route for procurement of higher cost vaccines. With the private sector proponent initiating the process with its proposal, negotiated procurement may be followed under the Revised NEDA Joint Venture (JV) Guidelines. The procedure for a negotiated JV, and the approvals required

depending on the terms of the JV agreement shall be complied with. Ideally, the private sector and GOCC may share in the purchasing process of the vaccine. Generally, no financing cost should be incurred by the Government, however, there may be a need to evaluate the amount of user pay, which can require a subsidy from either the private partner of the Government counterpart.

Resources and Funding

The WHO recommends allocating a budget for COVID-19 vaccination in multiple terms. The short-term budget should consider the initial allocation that covers the first 3% of the national population (health workers) and the next 17% of the population (older people and those with underlying health conditions). The medium-term budget should consider the incremental shipments to cover beyond the initial 20% (the additional priority populations). The 36-month budgetary horizon is practical as it is compliant with ministry of finance (MoF) medium-term budgetary and expenditure exercises.[4]

In addition to the cost of vaccines, other costs include those of the logistics needed to deploy the vaccines (e.g. injection devices, PPEs), costs of hauling and storage, disposal of waste, program operations, health promotion and communications and surveillance.

To fund the procurement of vaccines, several funding sources will be used. These include multilateral and bilateral agreements, Domestic Government Financial Institutions (GFIs) and bilateral negotiations. To procure the logistics needed for the deployment of vaccines, the 2021 General Appropriations Act (GAA) will be used. Table 5 below shows the different funding sources and prospective amounts of funding.

Table 5. Funding sources for COVID-19 vaccine deployment program and corresponding funding amounts.

Object of Procurement	*Source*	*Amount*
Vaccines	Unprogrammed Funds in 2021 GAA (Foreign multilateral and bilateral loans; domestic loans)	₱70 billion
Logistics and other supplies	2021 GAA (DOH)	₱2.5 billion
	Bayanihan II in relation to RA 11520 on Continuing Appropriations	₱10 billion
TOTAL AVAILABLE FUNDS		*₱82.5 billion*

[4] Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines. Geneva: World Health Organization; 2020 (WHO/2019-n-COV/NVDP/2020.1). License: CC BY-NC-SA 3.0 IGO.

Chapter 4: Shipment and Storage

Supply Chain

Successful immunization programs are built on functional, end-to-end supply chain and logistics systems ensuring an effective vaccine storage, handling, and stock management; rigorous temperature control in the cold chain; and maintenance of adequate logistics management information systems. The ultimate goal is to ensure the uninterrupted availability of quality vaccines from manufacturer to service-delivery points, so that opportunities to vaccinate are not missed because vaccines are unavailable. Managing the supply, storage and distribution of potentially multiple COVID-19 vaccines will involve complex logistical operations. In line with other countries, the Philippines will leverage and build on existing vaccination delivery services and structures for the rollout of COVID-19 vaccination plans.

Supply Chain Systems Readiness

To adequately prepare the existing supply chain systems to cope with the additional work required to receive and distribute the COVID-19 vaccines, a rapid assessment of the existing supply chain systems was conducted. The introduction of a new vaccine offers the opportunity to improve the current distribution mechanism.

The assessment identified strengths and gaps in the End-to-End supply chain system including but not limited to storage systems, distribution, real time temperature monitoring and tracking, real-time tracing and reporting of vaccine stocks. The action plan based on the assessment will ensure that:

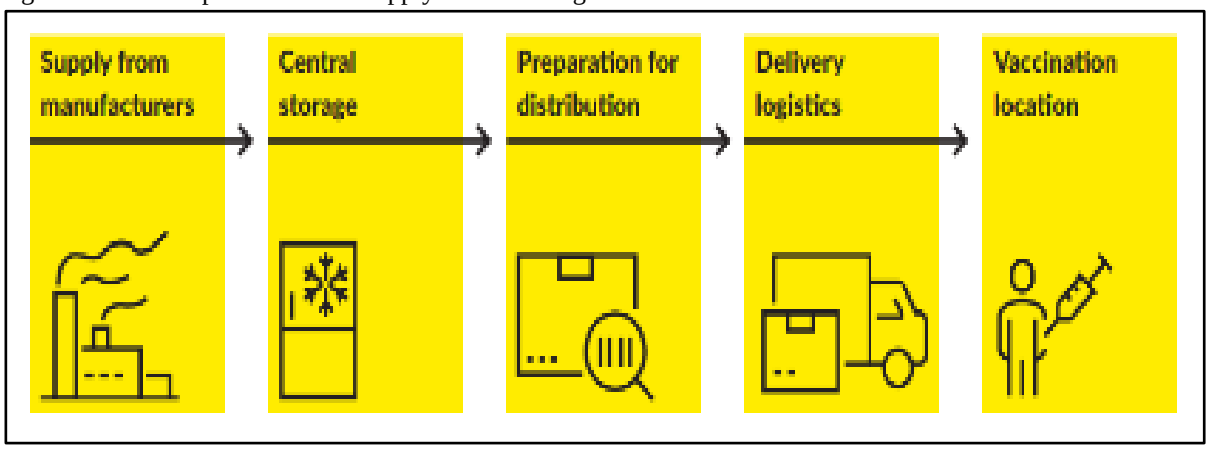
1. There are coordinated deployment plans and standard operating procedures (SOPs) are developed and communicated to all levels of the supply chain;
2. There are adequately trained, and sufficient quantity of supply chain and health staff;
3. There is sufficient cold chain capacity, including surge capacity, and capacity for ongoing maintenance, necessitating the contracting of private providers;
4. There is an efficient supply chain system and infrastructure, preferably leveraging on existing systems;
5. There is a real time robust data recording and reporting mechanism for vaccines and cold chain equipment;
6. There is robust oversight and data-driven management, including systems for monitoring adherence to cold chain practices; and

7. There are adequate secured resources from both internal and external sources.

End-to-End Supply Chain

While the specific logistics associated with each potential vaccine are not yet fully known, each vaccine will broadly follow a similar supply chain to reach the vaccination locations as outlined in the process below. Additional supply chain and logistics expertise across the wider public sector and the private sector will be leveraged where necessary. The supply chain process will involve the receipt of vaccines in the Philippines from several manufacturers, the storage of these vaccines in a temperature controlled central storage facility, preparation of vaccines for distribution to vaccination locations and the delivery logistics to vaccination locations. Figure X below highlights the five components of the Supply Chain Management.

Figure 7. Five components of the Supply Chain Management.



Supply from Manufacturers

The arrangements for supply of potentially approved vaccines from pharmaceutical companies as well as from the GAVI COVAX facility and the timing of delivery to the Philippines are currently under discussion. It is expected that the volume of vaccines delivered will ramp-up through 2021 as production capacity increases. Shipping methods from manufacturing sites will mainly be by air and agreed upon with manufacturers. Supply Chain risks associated with natural disasters and emergencies will be included in contingency planning.

Proposed Distribution Process Flow for COVID-19 Vaccines and Ancillary Immunization

The proposed process flow of the vaccines and other immunization supplies at the national level from the notification of the delivery up to the reverse logistics for the final disposal of the immunization wastes gathered from all the vaccination sites is summarized in the visual below.

The CHDs and the LGUs as well as those that will be identified as recipients of these immunization commodities shall likewise develop their distribution plan appropriate to their

situation. This shall be consolidated by the Task Force to come-up with a comprehensive national cold chain and logistics plan for COVID-19 vaccination.

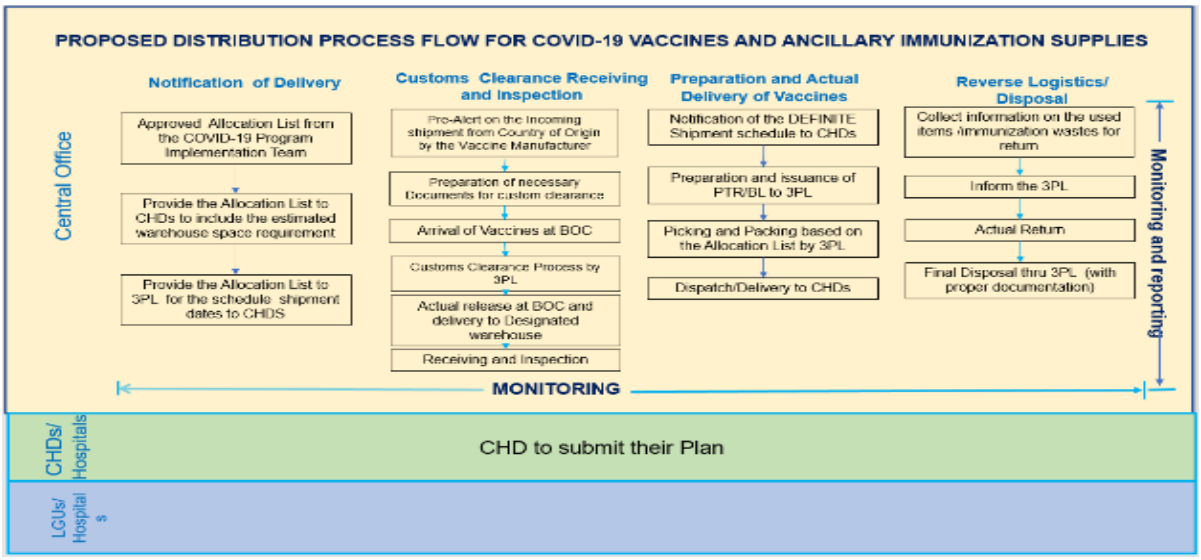


Figure 8. Distribution process flow for COVID-19 vaccines and ancillary immunization supplies.

A detailed process in each category shall be presented. Existing relevant forms required for each process shall be reviewed, revised and adopted specific for this purpose.

Cold Chain Management

COVID-19 vaccines require refrigeration with temperature ranges of +2ºC to +8ºC, -15ºC to -24ºC and to as low as -70ºC to -80ºC; cold chain management, whereby adequate refrigeration levels are maintained from manufacturing, storage and distribution of vaccines, and ensures integrity of vaccine compounds via specialized packaging as well as refrigeration and freezer devices. However, ensuring effective cold chain management for COVID-19 vaccines shall entail particular requirements and constraints around temperature maintenance for transport and storage and administration of the vaccines. With this, supply chain readiness at all the management levels shall be in place to efficiently deploy COVID-19 vaccines to the target population.

STORAGE AND DISTRIBUTION OF COVID-19 VACCINES

Given the Philippine's geographic size and population, storage of the vaccines will be centralized and managed preferably by a single logistics provider, with substantial relevant experience.

As the different types of vaccine require varying temperature storage requirements, (1) ultra-cold (-70°C to -80°C), (2) frozen (-15°C to -25°C), and (3) refrigerated (2°C to 8°C), the identified logistics partner/s have to ensure substantial capacity for each temperature range.

To ensure the correct volume of vaccines are received by each Vaccination Administration Location (VAL) at the right time, a robust, accurate, real-time inventory management system

will be in place to assure availability and maintenance of adequate supplies, minimize potential wastage and accurately forecast demand which can be met. The varying storage temperatures and shelf-lives out of storage of each vaccine type will mean certain vaccine types may be more suited to certain vaccination location types, depending on the volume of vaccinations carried out at the setting and the storage facilities on site. The distribution plan has accounted for this assigning the different vaccines for different locations. Ensuring adequate availability of the vaccine for the second dose will also be considered when managing stock levels.

To cater for the three (3) main temperature categories, namely: (1) +2°C to +8°C, (2) -20°C and (3) -70°C to -80°C, a scenario based planning has been developed. The first two temperature ranges can be handled in the current health structures because vaccines in the National Immunization Program (NIP) has the same temperature requirement. However, the vaccines requiring -70°C to -80°C are new and shall need a special storage package and a complicated distribution mechanism. Thus, the following scenarios has been considered in the vaccine distribution:

> *Scenario 1 & 2:* Distribution shall follow the pathway for the routine vaccines from the national cold storage facilities up the service delivery points, the health centers and hospitals allow the cold chain storage and distribution in NIP pathway of the current vaccines in the National Immunization Program of the DOH. These vaccines require +2°C to +8°C cold storage facilities. Such facilities are in place such as the Research Institute for Tropical Medicine (RITM) as the centralized vaccine hub, regional warehouses and the RHUs and hospitals.
>
> *Scenario 3* requires a cold storage facility of -70°C to -80°C. Currently, none of the government hospitals are capable of such, thus the government will have to procure or outsource/hire a private facility.

These scenarios may also vary based on the services that will be provided by the vaccine manufacturer such as but not limited to direct distribution to the service delivery sites, presence of a distributor in the country.

Within the Philippines, existing infrastructure and established vaccination distribution channels will mean vaccines can be delivered efficiently using air and road distribution channels directly from the central storage facility to the designated cluster hub warehouses. The logistics partner/s will also manage the delivery fleet and outbound logistics / delivery to the principal vaccination locations. All deliveries will be by chilled (+2°C to +8°C) distribution using the selected logistics partner's fleet. The fleet will operate to a very high specification with full GPS monitoring, remote temperature monitoring and redundancy on the cooling systems on the vehicle. The vaccine handling characteristics for other vaccines will be more clearly defined by manufacturers as the regulatory approvals process emerges.

Assessment of Cold Chain Facilities and Dry Storage Capacities

The plan to introduce the vaccine includes the calculation of additional space requirements and cold chain equipment at the national, and local levels, and even in the vaccination rooms. The data on additional storage requirements are based on the dosage form and characteristics of the new vaccine and those currently in use. and transport capacity for the vaccine at each level of the cold chain, determining the need for additional equipment. This evaluation offers an ideal opportunity to update the national cold chain inventory by type of equipment and operating condition. Both public and privately managed cold storage facilities and logistics providers shall be assessed and visited in partnership with the FDA.

Distribution of the Ancillary Immunization Supplies

Ancillary immunization supplies provided by the program shall include auto-disabled (AD) needles and syringes, mixing syringes, safety collector boxes (SCB), PPEs (masks and face shields). The same process as above shall be followed. The plan is all these items shall be delivered earlier than the vaccines.

Chapter 5: Vaccine Distribution and Deployment

Determining the Vaccine Recipients

Vaccination against SARS-CoV-2 offers the possibility of significantly reducing severe morbidity and mortality and transmission when deployed alongside minimum public health standards and improved clinical management of symptoms. However, even if safe and effective COVID-19 vaccines (most of which are still under various stages of development) will officially be authorized for emergency use and eventually licensed by the FDA, these vaccines will not be immediately available in amounts sufficient to vaccinate a large portion of the adult Filipino population. The country's COVID-19 vaccine deployment and vaccination program are largely dependent on the global supply of vaccines available for the Philippines and the country's ability to access them and on the application of foreign manufacturers for EUA and Certificates of Product Registration (CPR).

Equitable allocation of the COVID-19 vaccine is premised on current available evidence on COVID-19 and its transmission, susceptibility to the disease, and risks of severe disease or death. The current public health and clinical policies, recommendations need to be flexible and should be updated as evidence emerges and realities change.

The identification of eligible populations was identified based on the WHO Strategic Advisory Group of Experts on Immunization (SAGE) Values Framework for the Allocation and Prioritization of COVID-19 Vaccination. In addition, the recommendations of the NITAG of COVID-19 Vaccines shall guide the identification and finalization of the eligible population, taking into consideration the national context, the epidemiologic settings and the COVID-19 vaccine characteristics and supply.

The SAGE Values Framework provides the overarching goal and six core principles that should guide the distribution of COVID-19 vaccines, of which, five (except global equity) were adopted by the country. Thus, the identification of eligible population is guided by the following principles:

Table 6. Guiding principles adapted from the WHO SAGE Values Framework.

Principles	
Public Good	The COVID-19 vaccines shall be a main prevention commodity, and shall be made available to all members of the society as public good, without prejudice to practice of public health measures.
Human well-being	Where health, social and economic, security, human rights and civil liberties of all citizens and individuals are protected and promoted.
Reciprocity	Where individuals and groups who have greater burden in the COVID-19 pandemic response and have higher significant risks brought by their responsibilities and roles shall be given greater priority.
Equal respect	Where all human beings are treated equally and their interests are considered with equal moral consideration.

National equity	Where equity in vaccine access is assured nationally and those with greater burden of COVID-19 pandemic.
Legitimacy	Where decisions are made through transparent processes based on shared values and scientific evidence.

The primary goal in identifying the eligible population and vaccination is to directly reduce morbidity and mortality and maintain most critical essential services. The secondary goal is to control transmission and minimize disruption of social economic and security functions. And lastly, the tertiary goal is to resume the country's essential activities to near normal. These goals guided the selection of priority eligible groups. The selection of priority eligible group A fulfills the primary goal, priority eligible group B addresses the secondary goal, and lastly, the priority eligible group C addresses the tertiary goal.

Guided by these principles, the National Government drafted a decision matrix as stipulated in DOH Administrative Order No. 2021-0005 entitled "National Strategic Policy Framework for COVID-19 Vaccine Deployment and Immunization".

Table 7. The Decision Matrix in determining priority eligible population groups.

Principles	*Objectives*	*Population Groups*
Human well-being	● Reduce deaths and disease burden ● Protect those in the health services and essential services	● Health workers ● Older adults (senior citizens with or without comorbidities) ● Persons with comorbidities ● Personnel in government agencies providing essential services (DSWD, DepEd, DILG, BJMP & Bureau of Correction, PNP, AFP, PCG, BFP, CAFGU) ● Government workers, teachers and students, essential workforce (agriculture, tourism, transportation, food industry, tourism, manufacturing, construction, among others) ● All workforce
Principles	*Objectives*	*Population Groups*
Reciprocity	● Protect those who bear significant additional risks and burdens of COVID-19 to safeguard the welfare of others	● Health workers (all) ● Essential workers outside the health sector, those with high-risk of exposure, such as contact tracers, social workers providing social services, among others
Equal respect	● Treat the interest of all individuals and groups with equal consideration as allocation and priority setting ● Vaccinate all citizens	● All citizens based on the availability of vaccines
National equity	● Ensure that vaccine prioritization takes	● People living in poverty (indigent population) ● Disadvantaged groups (PWD, PDLs, among others)

	into account vulnerabilities, risks and needs groups because of underlying societal, geographic or biomedical factors	● Low-income workers ● Hard-to-reach areas ● Overseas Filipino Workers

Thus, the Philippine National Government identified the following priority eligible population:

Table 8. The Priority Eligible Population.

Priorities	*Population Group*	*Definition of Terms*
*Priority Eligible Group A**		
1	Frontline Health Workers	All health workers from the PRIVATE and PUBLIC sector currently on ACTIVE practice/service, whether they are permanent, contractual, job-order and/or outsourced employees or staff:
	a) Public and private health facilities [hospitals, medical centers, laboratories, infirmaries, Treatment Rehabilitation Centers (TRCs) and Temporary Treatment and Monitoring Facilities (TTMFs)]	● All those are working in medical centers, hospitals, clinics, laboratories, Temporary Treatment and Monitoring Facilities (TTMFs), and Treatment Rehabilitation Centers (TRCs). If the vaccine supply is limited, priority shall be given to hospitals and medical centers directly catering to COVID-19 patients, including suspects, probable and confirmed COVID-19 cases. ● Specifically, all those who are assigned in the triage areas, out-patient departments, emergency rooms, wards, intensive care units, operating rooms, delivery rooms, laboratory, radiologic and pathology areas, rehabilitation units, among others. ● Medical and allied health students who are serving as clerks or interns in hospitals ● Those who are assigned as part of the disinfection or decontamination teams, medical social workers, admin personnel, and security guards of the above-mentioned facilities.
	b) Public health workers (all RHU/CHO personnel, PHO, PDOHO, CHD and CO) and LGU contact tracers	All workers in the public health sector: ● ALL employees in the public primary care facilities (Rural Health Units, City Health Offices (whether LGU-hired or DOH-hired/deployed) ● ALL health workers employed/deployed/detailed in Provincial Health Offices, Center for Health Development and Department of Health Central Offices, including Food and Drug Administration and Bureau of Quarantine ● ALL health workers employed/deployed/detailed in DOH-attached agencies such as Philippine Health Insurance Corporation, Philippine National AIDS

		Council, Philippine Institute of Traditional Alternative Health Care, Dangerous Drugs Board, and National Nutrition Council ● LGU-deployed/designated/hired contact tracers [those with appropriate documents stating deployment/designation of government employees as contact tracers either through an Executive Order (EO), resolution and/or ordinance] ● Note: If the vaccine supply is limited, among workers in public health, priority shall be given to those who are providing direct health services.
	c) Barangay Health Workers including Barangay Health Emergency Response Teams (BHERTs)	● ALL Barangay Health Workers in active service ● ALL active members of the BHERTs (based on appropriate documents stating designation either through an LGU EO, resolution and/or ordinance)
	d) Other NGAs (DSWD, DepEd, DILG, BJMP and Bureau of Correction)	● DSWD, and its regional and local counterparts ○ All employees manning close-setting facilities and long-term care facilities, e.g. orphanage, home for the aged, women's crisis centers. ○ Social workers providing social amelioration, and social services in the communities ● DepEd ○ Health and nutrition personnel ● DILG ○ Those hired by DILG as contact tracers (active service) ● BJMP (under DILG) ○ All employees and health workers assigned in direct contact with Persons Deprived of Liberty (PDLs) such as jail officers, wardens, and/or guards ● BuCor (under DOJ) ○ All employees and health workers assigned in direct contact with Persons Deprived of Liberty (PDLs) such as jail officers, wardens, and/or guards
2	Indigent Senior Citizens	ALL indigent senior citizens registered and as determined by DSWD
3	Remaining Senior Citizens	ALL senior citizens (not categorized as indigent) registered and as determined by DWSD
4	Remaining Indigent	ALL indigent population as determined by DSWD

	Population	
5	Uniformed Personnel	All enlisted uniformed personnel in active services under the: ● Armed Forces of the Philippines ● Philippine National Police ● Philippine Coast Guard ● Bureau of Fire Protection ● Citizen Armed Force Geographical Unit ● BuCor (remaining personnel) ● BJMP (remaining personnel)
*Priority Eligible Group B***		
6	Teachers and school workers	ALL teachers and school workers, whether permanent, job-order, contractual or out-sourced in all educational levels, from primary, secondary, tertiary, and vocational educational institutions, both private and public
7	All government workers (national and local government)	ALL government workers, whether permanent, job-order, contractual or out-sourced, in national government agencies, government-owned and controlled corporations (GOCCs), government financial institutions (GFIs), local government units, among others.
8	Essential workers	● All workers providing basic services during this time of pandemic and essential to the growth of the economy as determined by DTI and DOLE ● These workers may come from the following sectors: agriculture, forestry and fisheries; transportation; construction; food industries; manufacturing of essential goods; tourism; essential retail; water-refilling stations; laundry services; logistics service providers; delivery and courier services; water supply and sanitation services; telecommunication services; energy and power companies; gasoline stations, among others
9	Socio-demographic groups at significant higher risk other than senior citizens and indigent populations [e.g. Persons Deprived of Liberty (PDLs), Persons with Disabilities (PWDs), Indigenous Peoples, Filipinos living in high-density areas)	● All Persons Deprived of Liberty as determined by BJMP and BuCor ● All Persons with Disability as determined by DSWD, and National Council for Disability Affairs (NCDA) and LGUs ● All Indigenous Peoples as determined by the National Commission on Indigenous Peoples (NCIP). This may include: the Lumads of Mindanao, the Peoples of the Cordillera, and scattered tribal peoples of the hinterlands of Central and Southern Luzon, Visayas, Mindoro and Palawan ● All Filipinos living in high-density areas as

	Eligible Students	determined by the LGUs (as documented in the LGU's Comprehensive Land Use Plan) such as in slums and temporary shelters, among others; including those who are homeless and living in temporary shelters and homes ● All students in primary, secondary and tertiary and vocational educational institutions. However, vaccination of students below 18 y.o. will depend on the recommendations of WHO and NITAG, with the concurrence of the COVID-19 Vaccine Cluster.
10	Overseas Filipino Workers (OFWs)	Filipino migrant workers who reside in another country for a limited period of employment that were not yet vaccinated
11	Other remaining workforce	All remaining Filipino workforce as determined by the DOLE, DTI and CSC
*Priority Eligible Group C***		
12	Remaining Filipino Citizens	All Filipino Citizens that were not mentioned in priority A and B

** Persons with co-morbidities are being taken into consideration as part of Priority Eligible Group A depending on the latest development and scientific evidence. This is being discussed by the NITAG.*
***The Priority Eligible Group B and C may change as these categories will still undergo review of the NITAG and final approval of the COVID-19 Vaccine Cluster and the IATF.*

Vaccine Deployment Strategies

The deployment of vaccines will be in a phased approach depending on the delivery (timing, available doses, logistical requirements) of vaccines to the country. It will be executed based on a sectoral approach - that is, all frontline healthcare workers will be vaccinated first before proceeding to the next priority group. The number of individuals to be vaccinated in a round will depend on the total number of vaccines delivered, in which computation of the 2nd dose is already considered.

Since the delivery of vaccines to the country is in tranches, the deployment of vaccines in specific geographical areas shall be based on the burden of COVID-19 cases. In the identification of geographical areas, the NITAG set the indicators in determining the areas with high burden of COVID-19 cases. The indicators are as follows:

1. Number of Active Cases in recent four weeks
2. Attack rate per 100,000 in recent four weeks

Active cases refer to the total confirmed cases less those recovered and fatalities. These active cases as such are assumed to be still infectious and currently isolated. For the purpose of this ranking, we computed the attack rate using the total newly reported cases in the recent 4 weeks divided by the region's projected population and a multiplier of 100,000 population.

The determination of priority geographical areas will be per region. Likewise, the NITAG will review the burden of COVID-19 cases in the country every month and will recalibrate the priority areas accordingly.

Table 9. Priority Regions based on burden of COVID-19 cases as of January 2021.

Region	*Total Cases As of Jan 8*	*Total Active Cases as of Jan 6*	*Rank (Active Cases)*	*Number of Cases Recent 4 Weeks (Dec 6 - Jan 2)*	*Attack Rate (Recent 4 Weeks)*	*Rank (Attack Rate)*	*Average Rank (Burden of Disease)*	*Overall Rank (Burden of Disease)*	*Population Density*	*Rank (Population Density)*
NCR	27,104	7,181	1	10,978	80	2	*1.5*	*1*	22,301.54	*1*
Region IV-A	23,134	3,626	2	6,407	40	5	*3.5*	*2,3,4*	968.71	*2*
Region XI	88,405	1,804	4	3,093	58	3	*3.5*	*2,3,4*	258.94	*8*
CAR	212,876	976	6	2,289	127	1	*3.5*	*2,3,4*	91.22	*17*
Region VIII	8,567	1,314	5	2,544	54	4	*4.5*	*5*	204.11	*12*
Region III	2,885	2,144	3	3,771	31	8	*5.5*	*6*	562.12	*3*
Region II	12,157	701	8	1,425	39	6	*7*	*7*	184.57	*13*
Region VI	5,472	751	7	1,684	21	10	*8.5*	*8*	380.15	*6*
Region X	6,131	834	9	1,241	25	9	*9*	*9,10*	245.24	*9*
CARAGA	5,605	573	11	951	35	7	*9*	*9,10*	92.99	*16*
Region I	4,822	569	12	940	18	11	*11.5*	*11*	406.57	*5*
Region VII	2,853	646	10	952	12	14	*12*	*12*	513.77	*4*
Region XII	32,575	499	13	800	16	12	*12.5*	*13*	215.92	*11*
Region IX	13,810	342	14	606	16	13	*13.5*	*14*	228.21	*10*
Region V	5,194	309	15	525	9	16	*15.5*	*15,16*	338.62	*7*
Region IV-B	8,967	185	16	365	11	15	*15.5*	*15,16*	107.24	*15*
BARMM	6,010	126	17	194	5	17	*17*	*17*	114.14	*14*

As shown in Figure 8, in parallel with the preparations of the National Government in accessing COVID-19 vaccines and in reviewing applications of vaccine manufacturers for EUA, the National Government is also preparing for the COVID-19 vaccine deployment and implementation of the vaccination program. As the National Government will roll-out policies and plans, several activities in coordination with the Local Government Units will be conducted, such as simulation activities, such as table activities and drills, to test local plans and

implementation of policies in the local level. The rest of the activities stipulated in Figure 8 will be discuss in Chapter 6.

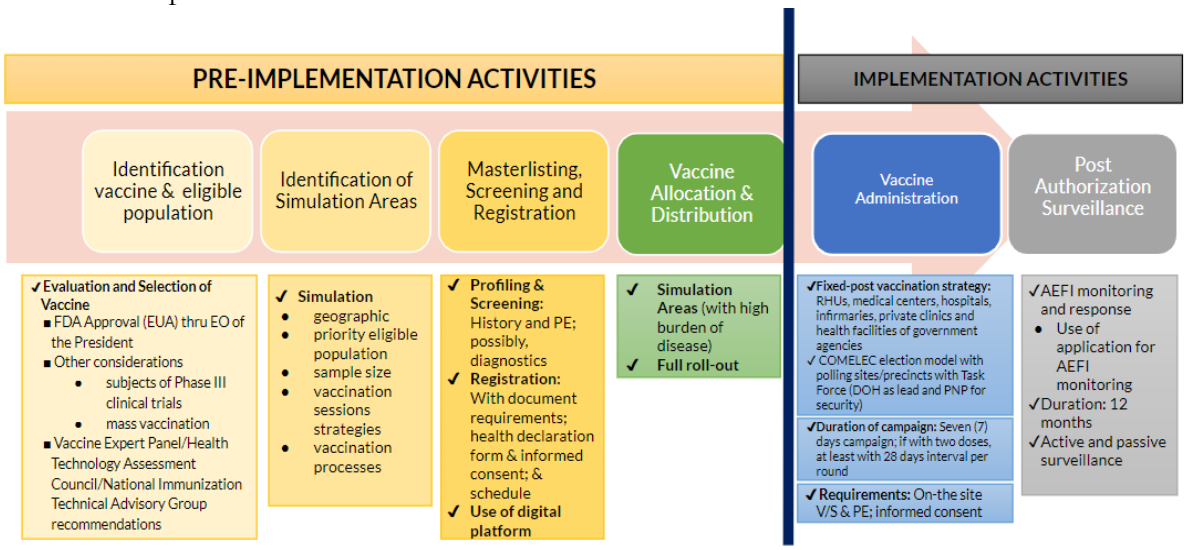


Figure 9. Vaccine Deployment and Service Delivery Activities.

Vaccine Distribution Strategies

The manner of the distribution of vaccines will depend on the storage requirements specific to each vaccine. DOH will provide a Department Memorandum detailing the operational guidelines, including the vaccine storage and cold chain requirements, delivery and deployment mechanisms for each specific vaccine.

For vaccines requiring +2°C to +8°C storage, the vaccines will be delivered from the supplier to the RITM, which will serve as the government Centralized Vaccine Hub. From RITM, the vaccines will be passed on to the regional warehouses/hubs. The Centers for Health Development, in coordination with logistics partners and other government agencies, shall deliver the vaccines to Local Government Units. The LGUs will then allocate vaccines to implementing units such as medical centers, hospitals, infirmaries, RHUs and CHOs, and private clinics, where the vaccine will be administered to the eligible recipient. The distribution process for vaccines requiring -20°C storage will utilize the same process used for vaccines requiring +2°C to +8°C storage.

In addition, for vaccines requiring -70°C to -80°C storage, the vaccines will be delivered from the supplier to a private centralized vaccine hub. And through a private distributor, the vaccines will be delivered to hospitals and medical centers with cold chain capacity to store the vaccines. Or the vaccines can temporarily be stored in rented private warehouses before they are delivered to hospitals and medical centers. Plans and arrangements will be carefully made for the vaccines to be distributed to implementing units and the administration of the vaccine to the eligible recipient.

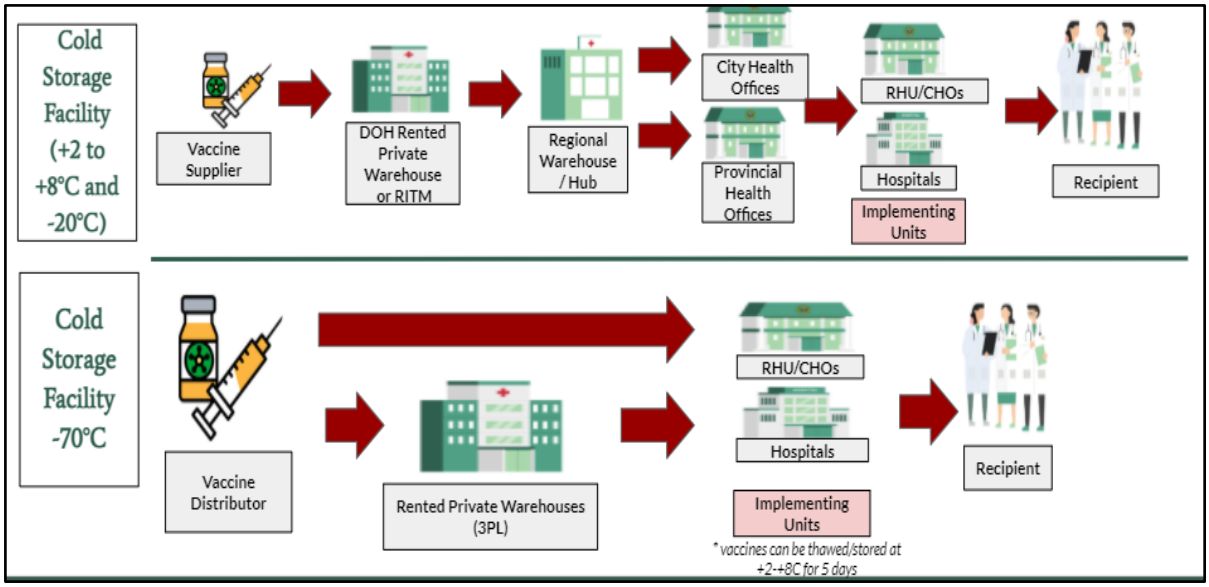


Figure 10. Distribution of vaccines according to storage facility requirements.

Chapter 6: Implementation of a Nationwide Vaccination

The implementation of a nationwide COVID-19 vaccination program shall be in a phased approach taking into consideration the quantity of vaccines delivered to the country, the cold chain requirements, and burden of COVID-19 cases in geographical areas. Therefore, there shall be several rounds of COVID-19 vaccination campaign conducted within the year.

The Local Government Units, as mandated in Republic Act 7160, otherwise known as the "Local Government Code of 1991", shall take the lead in the implementation of the COVID-19 vaccination program in accordance with the policies and guidelines set by the COVID-19 Vaccine Cluster and DOH. Thus, participating agencies and the private sector are enjoined to closely coordinate with the LGUs in which their health facilities are located.

On the other hand, the National Government and its regional counterparts, shall provide strategic direction, and technical and logistical assistance; cascade policies and guidelines; and capacitate implementers, among others.

Specifically, for each deployment of a specific type and quantity of COVID-19 vaccine, the DOH shall provide a Department Memorandum detailing the specific operational guidelines applicable for the specific vaccine.

Further, all vaccination activities, whether the COVID-19 vaccines to be administered have been procured by the National Government, the private sector or the LGU, shall be closely coordinated with DOH and shall follow DOH policies and guidelines. No vaccination activity shall be conducted without the guidance and the knowledge of DOH.

The implementation of a nationwide COVID-19 vaccination program is divided into three phases, namely: 1) the pre-implementation phase, where preparations for the actual vaccination activity are carried out, 2) the implementation phase or the actual vaccine administration schedule, 3) the post-implementation phase, where all activities and reports to conclude a certain round are completed.

Pre-implementation Phase

In the pre-implementation phase, the following activities enumerated are to be undertaken by LGUs, specifically municipalities and cities:

1. Establishment of a VOC (see Special Chapter: Governance)
2. Masterlisting of Eligible Populations, Vaccination Workforce, Implementing Units and Vaccination Sites/Posts
3. Microplanning
4. Mapping of Vaccination Sites and Vaccination Workforce
5. Vaccines, Logistics and Cold Chain Inventory and Management
6. Capacity Building and Training
7. Advocacy, Community Engagement and Social Preparation (see Special Chapter: Risk Communications and Community Engagement)
8. Preparation of Vaccination Sites/Posts
9. Monitoring and Supervision (see Chapter 7: Assessment, Monitoring and Evaluation)

In this section, numbers 2-6 and 8 shall be extensively discussed while other numbers are explained intensively in other chapters of this Plan.

I. Masterlisting, Microplanning and Mapping (3Ms)

The 3Ms, namely, masterlisting of eligible population, vaccination workforce and implementing units and vaccination posts/sites; microplanning; and mapping of vaccination workforce and vaccination posts/sites are critical in the implementation of the COVID-19 vaccination program. In the succeeding section, each of the Ms will be discussed in detail.

1. Masterlisting of eligible population, vaccination workforce and implementing units and vaccination posts/sites

To prepare the country for the COVID-19 vaccination program, creation and maintenance of a masterlist of priority sectors is necessary to: (a) provide basis for identification of target eligible groups for vaccination and identification of priority areas for registration of eligible individuals; (b) ensure uniqueness of individuals in the vaccine administration plan; and (c) provide input to operational planning especially for costing and allocation of resources.

Masterlisting is the linelisting and registration of the population prior to vaccination. This could be done through an online or offline platform developed by the DICT, and DOH's KMITS and EB. From the masterlist, eligible population for specific vaccines will be culled out and accessed by appropriate regions or LGU for registration, scheduling, mapping-out on appropriate vaccination sites and advisory.

a. Phased Submission of LGU Masterlists

Masterlisting shall use the phased approach, as follows:

Table 10. Phases of masterlisting.

Group A	Phase 1: Workers in Frontline Health Services Phase 2: All Senior Citizens (Indicate if indigent) Phase 3: Indigent Population Phase 4: Uniformed Personnels (UPs)
Group B	Phase 5: Other Frontline Workers and Special Populations
Group C	Phase 6: Remaining Population

Targets for Masterlisting are as follows:

1. Submission of total numbers and masterlist of demographics for Group A sectors by *January 31, 2021.*
    a. Minimum demographic fields include complete name, birthdate, sex, address, profession/position, and unique identifier.
    b. Unique identifiers may include QR code, PhilHealth number, or Category ID such as PRC ID for healthcare workers.
2. Completion of patient profile including health status and consent for Group A sectors, especially Phase 1: Workers in Frontline Health Services, by *February 15, 2021.*
3. Completion of full masterlist for Group A and Group B sectors by *March 31, 2021.*
4. Completion of full masterlist of Group C by *June 30, 2021.*

Masterlisting efforts shall be initiated at the LGU level, with profiling and screening of eligible target population cohorts will be conducted prior to registration into the electronic immunization registry. Prioritization for workers in health facilities shall be according to selected health facilities, public or private, such as COVID-19-designated hospitals, those with relatively higher number of admissions past two months, all LGU hospitals; and risk-based categories for healthcare workers that may be determined.

b. Interim Minimum Data Standards for the COVID-19 Electronic Immunization Registry (CEIR)

The COVID-19 Electronic Immunization Registry (CEIR) shall be the official platform for masterlisting and registration for COVID-19 vaccination. External systems may be used to submit the necessary information following the Interim Minimum Required Data Fields as indicated below.

Table 11. Interim minimum required data fields for masterlisting.

Data Set	*Definition*	*Type*	*Format*
1. Category	Category of the Target Eligible Population 01 – Health Care Worker 02 – Senior Citizen 03 – Indigent 04 – Uniformed Personnel 05 – Essential Worker 06 – Other	String	Dropdown
2. CategoryID	ID number depending on the category type For 01 – PRC number 02 – OSCA number 03 – Facility ID number 04 – PWD ID 05 – Other ID	String	Freetext
3. PhilHealth ID	PhilHealth ID	Integer	Freetext, 12 digits only
4. Last name	Surname/Last Name	String	Freetext
First name	First Name/Given name	String	Freetext
Middle Name	Middle Name	String	Freetext
Suffix	Suffix	String	Dropdown
5. Contact_no	Contact Number (Mobile Number or Landline)	Integer	Freetext, 12 digits only
6. Full_address	Unit/ Building/ House Number, Street Name, Purok, Zone	String	Freetext
Province	Name of province	String	PSGC, Dropdown
MunCity	Name of city or municipality	String	PSGC, Dropdown
Barangay	Name of barangay	String	PSGC, Dropdown

7. Sex	Sex 01 – Female 02 – Male 03 – Not to disclose	String	Dropdown
8. Birth date	Date of birth (mm/dd/yyyy)	Date	Date picker
9. Civil status	Civil Status 01 – Single 02 – Married 03 – Widow/Widower 04 – Separated/Annulled 05 – Living with Partner	String	Dropdown
10. Employed	Employment Status 01 – Government Employed 02 – Private Employed 03 – Self-employed 04 - Private practitioner 05 – Others	String	Dropdown
11. Profession	01 – Dental Hygienist 02 – Dental Technologist 03 – Dentist 04 – Medical Technologist 05 – Midwife 06 – Nurse 07 – Nutritionist-Dietician 08 – Occupational Therapist 09 – Optometrist 10 – Pharmacist 11 – Physical Therapist 12 – Physician 13 – Radiologic Technologist 14 – Respiratory Therapist 15 – X-ray Technologist 16 – Barangay Health Worker 17 – Maintenance Staff 18 – Administrative Staff 19 – Other Workers in Frontline Health Services *Categories for other subgroups to be included in succeeding versions; LGU may create sub categories not listed here		
Direct_covid	Providing direct COVID care? 01 – Yes 02 – None	Boolean	Dropdown
12. Employer_name	Name of employer	String	NHFR or freetext
Employer_LGU	Province/ HUC/ ICC of employer	String	PSGC, Dropdown

Employer_address	Full address of employer	String	Freetext
Employer_contact_no.	Contact number of employer	Integer	Freetext,12 digits only
13. Preg_status	If female, pregnancy status 01- Pregnant 02- Not Pregnant	Boolean	Dropdown, conditional (if female only)
14. W_allergy	With Allergy 01 – Yes 02 – None	Boolean	Dropdown
Allergy	Name of Allergy 01 – Drug 02 – Food 03 – Insect 04 – Latex 05 – Mold 06 – Pet 07 – Pollen	String	Freetext, conditional (if with allergy only)
15. W_comorbidities	With Comorbidities 01 – Yes 02 – None	Boolean	Dropdown
Co- morbidity	Name of Comorbidity 01 – Hypertension 02 – Heart disease 03 – Kidney disease 04 – Diabetes mellitus 05 – Bronchial Asthma 06 – Immunodeficiency state 07 – Cancer 08 – Others	String	Dropdown
16. covid_history	Patient diagnosed with COVID-19 01 – Yes 02 – No	Boolean	Dropdown
covid_date	Date of first positive result / specimen collection (mm/yyyy)	Date	Date picker
covid_classification	Classification of infection 01 – Asymptomatic 02 – Mild 03 – Moderate 04 – Severe 05 – Critical	String	Dropdown

17. Consent	Provided electronic informed consent for data collection? 01 – Yes 02 – No 03 – Unknown	String	Dropdown
18. Consent_vacc	Provided initial consent for vaccination? 01 – Yes 02 – No 03 – Unknown	String	Dropdown

c. Prescribed Processes for Masterlisting Intended Vaccinees

1. Local Government Units shall lead masterlisting efforts within their catchment area and consolidate by municipality/CC/HUC/ICC.
2. All institutions (ex: health facilities) shall submit the masterslists to the municipality/CC/HUC/ICC, through any of the following methods:
   a. COVID-19 Electronic Immunization Registry (CEIR);
   b. Information system of the LGU linked to the CEIR through an application program interface (API);
   c. Dataset consistent with prescribed formats for bulk uploading through the CEIR; or
   d. Dataset consistent with prescribed formats for bulk uploading through the assistance of DOH CHDs.

   CEIR platform may be accessed through http://ceir.doh.gov.ph. Training videos and submission templates may be retrieved from http://bit.ly/CEIRdocuments. Regional templates with PSGC codes are also available in said link. For help desk and support please contact covid19ceir@doh.gov.ph.
3. Masterlist data may be submitted and consolidated in phases, to include the following fields:
   a. Patient List - 1, 4, 7, 8, 10, 12
   b. Full Patient Demographics - 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12
   c. Full Patient Health Profile - 3, 13, 14, 15, 16, 17, 18
4. LGUs shall ensure that there will be no duplication in masterlists across facilities within their catchment. The DOH shall likewise conduct deduplication checks on the final endorsed masterlists.
   a. Masterlisting for Phase 1: Workers in Frontline Health Facilities shall be done based on the location of their health facility of assignment.
   b. For the eligible population with multiple affiliations (ex: health care worker in multiple hospitals), they shall choose only one health facility as their intended site for vaccination.
5. Masterlisting of UPs and essential personnel shall be based on their command. Masterlisting of the general population shall be based on the LGU where the vaccinee is residing in.
6. The province/HUC/ICC health office shall provide a status report and updated consolidation masterlist to their respective CHD every Friday.

7. After completion of masterlisting in a health facility, the Chief of Hospital or Head of Facility shall submit physically signed endorsement of all workers in the facility for phase 1 vaccination to the respective local government unit copy-furnish the CHD. The endorsement should indicate those who have and consented and who have not.
8. CHDs shall compile and store all signed and attested masterlists of all LGUs and health facilities, and scan copies saved according to the following format: Region-Health facility name, i.e., NCR-SAN LAZARO HOSPITAL. The document shall be saved in Portable Document Format (PDF) and be uploaded to the bit.ly link provided for their respective region.
9. Consistent with actions necessary for Universal Health Care, LGUs are instructed to initiate profiling the health status of their population now and generate a masterlist of population with comorbidities and other important information that will be necessary to implement the National Deployment and Vaccination Plan. Health profiling through Electronic Medical Records consistent with DOH standards is recommended.
10. Complete masterist including patient list, full demographics, and full health profile is required prior to actual vaccine administration. Phased submissions shall guide local and national planning of the vaccine deployment plan.

d. Masterlisting the Vaccination Workforce

LGUs shall develop masterlists of the vaccination workforce by Municipality/CC/HUC/ICC using the following minimum data fields:

Table 12. Minimum data fields required for the masterlisting of the vaccination workforce.

Data Set	*Definition*	*Type*	*Format*
heathfacility_name	Name of health facility	String	NHFR or freetext
healthfaiclity_LGU	Province/ HUC/ ICC of employer	String	PSGC, Dropdown
Last name	Surname/Last Name	String	Freetext
First name	First Name/Given name	String	Freetext
Middle name	Middle Name	String	Freetext
Suffix	Suffix	String	Dropdown
Position	Position or designation of the	String	Freetext
Team	Team category 01 - Vaccination Team 02 - AEFI/ AESI Composite Team	String	Dropdown
Role	Role in the vaccination team 01 - Screening and Assessment 02 - Health educator	String	Dropdown

	03 - Vaccinator 04 - Documentor/ Recorder 05 - AEFI Monitoring 06 - Others		

Local governments and CHDs shall determine the vaccination workforce and vaccination site/post, compliant to standards set in the National Deployment and Vaccination Plan. Initial list of these sites shall be submitted to the CHD by *January 31, 2021*.

2. Microplanning

Microplanning is a "bottom-up" planning process carried out to determine local needs and gaps and to ensure smooth and satisfactory vaccine implementation. This is one of the key activities to ensure the planning of the vaccination campaign lays out all operational aspects of the activity at the municipal/city and barangay levels. It is the translation of the national and regional macroplan to the local situation. Microplanning is one of the tools that health workers use and endorsed by the NIP to ensure that immunization services reach every community.

The microplanning activity has been tailored fit for COVID-19 vaccines taking into consideration diverse vaccine portfolios and the complexities of COVID-19 vaccine development.

The following are the objectives of microplanning:

1. To ensure that campaign objectives are reached and immunization strategies are well implemented at the service delivery points (health facilities and LGUs).
2. To ensure that adequate resources are mobilized and in place with expected results to be accomplished on time.
3. To anticipate the challenges and maximize use of limited resources in an efficient manner in the context of the COVID-19 pandemic.

The microplanning shall be done by the LGUs, specifically by municipalities and cities, and shall commence at once after masterlist and/or training has been obtained by the LGU.

It is paramount that microplans get validated at each level as data are collected. This calls for effective supervision of the development of each microplan. Therefore, microplans are submitted in the following order: for municipalities and component cities, to the Provincial Health Offices (PHO) copy furnished Provincial DOH Offices (PDOHO), then the PHO to the CHDs; and for HUCs and ICCs, directly to the CHDs.

Once microplans from C/MHO level reach the province, they get aggregated and the provincial coordinators add province-specific costs (supervision, meetings, transport) are incorporated, before forwarding the plan up to the regional and national level. The microplan must be updated as frequently as possible.

A readiness assessment tool shall be used to assess and monitor the implementation of the plan. This can also be https://tinyurl.com/covidvaccineRA or see Annex A. Also, a microplanning template in excel form is accessible in this link: https://tinyurl.com/microplanningc19.

Here are the critical steps in microplanning:

Critical Step 1: Determine the number of eligible population for COVID-19 vaccination in your area.

The number of eligible population can be culled out in the CEIR and shall be readily accessible to LGUs. The DOH shall provide specific guidelines on who among the priority population shall be vaccinated on a certain period of time depending on the vaccine supply and certain geographical area.

a. Utilize data gathered during the masterlisting and profiling in determining the number of eligible population for COVID-19 vaccination.
b. Once the type of vaccine to be deployed in your area is determined, work closely with the DOH CO and CHD in determining the final eligible population based on the inclusion and exclusion criteria as provided in the DOH guidelines.
c. Ensure that data in the CEIR are complete. And triangulate the accuracy of the profiling data with existing data available in the LGU.
d. Determine the eligible population per municipality/city.
e. Then, disaggregate the eligible population by barangay and/or implementing unit.

Here is a sample form in determining the eligible population in the area:

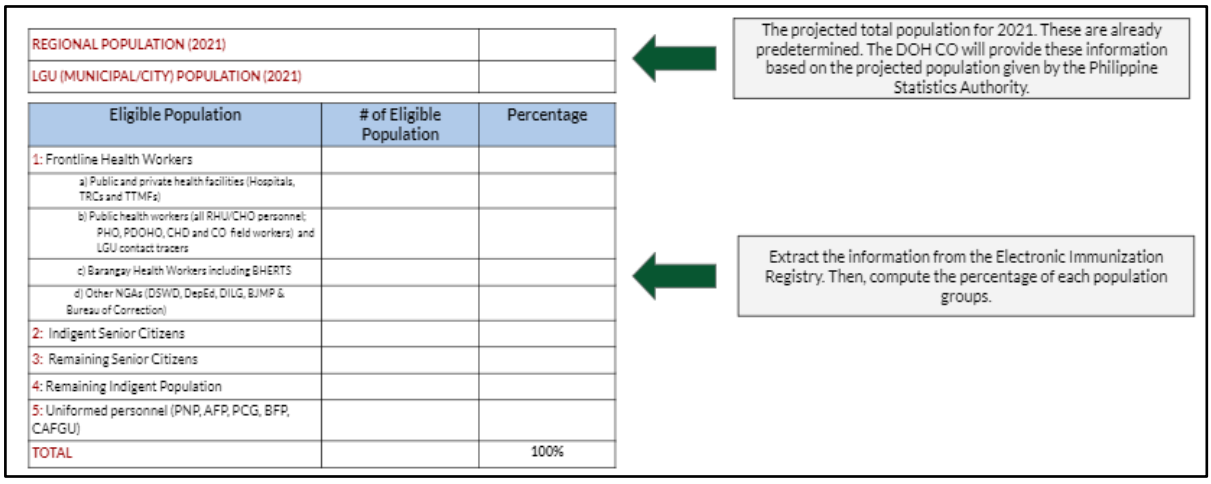


Figure 11. Sample form in determining the eligible population.

Table 13. Disaggregated eligible population by barangay / health facility.

Eligible Population	*Barangay /HF 1*	*Barangay /HF 2*	*Barangay/ HF 3*	*Barangay/ HF 4*	*TOTAL*
1: Frontline Health Workers					
a) Public and private health facilities (Hospitals, TRCs and TTMFs)					
b) Public health workers (all RHU/CHO personnel; PHO, PDOHO, CHD and CO field workers) and LGU contact tracers					

c) Barangay Health Workers including BHERTS					
d) Other NGAs (DSWD, DepEd, DILG, BJMP & Bureau of Correction)					
2: Indigent Senior Citizens					
3: Remaining Senior Citizens					
4: Remaining Indigent Population					
5: Uniformed personnel (PNP, AFP, PCG, BFP, CAFGU)					
TOTAL					*100%*

Criteria Step 2: Identify the implementing units in your area, and the number of vaccination sites/posts, and plot in your operational spot map.

a. For COVID-19 vaccination, the fixed-post vaccination strategy shall be used (discussed extensively in the succeeding section of this chapter). Implementing Units are defined as establishments authorized to conduct the vaccination activity. On the other hand, vaccination sites/posts are areas within the implementing units where the vaccination administration proper is conducted. The following shall be utilized as implementing units:
    i. Medical centers, hospitals and infirmaries (private and public)
    ii. Rural Health Units
    iii. Health facilities of other government agencies (e.g. AFP hospitals and facilities, BJMP/BuCor health facilities, and DepEd clinics)
    iv. Private clinics
b. The implementing units may have several vaccination sites/posts within its vicinity, e.g. a medical center can have several vaccination sites/posts within its vicinity.
c. Identify the implementing units as categorized on the table below and quantify the vaccination sites/posts per implementing unit. If possible, determine how many vaccination teams and AEFI/AESI composite teams can be accommodated in a vaccination post/site.
d. Plot in an operational spot map.

Table 14. List of Implementing Units and Vaccination Sites/Posts.

Implementing Units		*# of Vaccination Sites/Posts*
● Hospitals (government)	a.	
	b.	
● Hospitals (private)	a.	
	b.	
● Rural Health Units	a.	
	b.	
● Health Facilities of other agencies	a.	
	b.	

● Private Clinics	a.	
	b.	
TOTAL		

Here are several points in making an operational spot map:

a. LGUs may utilize this link to map out facilities (except for private clinics) in their area: https://nhfr.doh.gov.ph/rfacilities2list.php. The LGUs need to closely work with the private sector in mapping out private clinics.
b. In addition to mapping of implementing units and vaccination sites/posts, the map may include the following:
    i. Roads/tracks (to determine distance of communities of eligible population to implementing units).
    ii. geographical landmarks and features (to determine geographical barriers)
    iii. Areas with migrant workers, urban poor, ethnic minorities, new rural settlements and groups in movement or unrest.

Critical Step 3. Identify the number of supervisors, vaccination teams, AEFI/AESI composite teams and other personnel needed and available for the vaccination activity.

The guidelines on the composition of the vaccination workforce are detailed in the succeeding section of this chapter.

a. Utilizing the information on the number of eligible population to be vaccinated in a round, compute the required vaccination workforce, taking into consideration the duration of the vaccination activity round. e.g. 50,000 (eligible population) ÷ 100 (numbers of vaccinees to be vaccinated in a day) ÷ 14 (duration of the vaccination campaign) = 36 teams.
b. After determining the teams, determine the number of personnel required per team.
c. Coordinate closely with the health facilities and engage the health professionals and enjoin them to participate in the vaccination activity (see Table X below).

Table 15. List of vaccination workforce, teams and personnel.

COMPOSITION		*# of Teams / Individuals Required*
Vaccination Team		
2	For Screening and Assessment:	
1	As Health Educator:	
1	As Vaccinator:	
2	As Documenter/Recorder:	
AEFI/AESI Team		

1	As Monitor/Responder:	
1	As Surveillance Personnel:	
Supervisor:		

Critical Step 4: Assign vaccinees and teams to an implementing unit / vaccination post/site.

a. Determine the eligible population to be vaccinated in the implementing unit / vaccination post/site.
    i. Assign frontline health workers and uniformed personnel to health facilities where they are employed/deployed.
    ii. For frontline workers or uniformed personnel employed/deployed in an agency without any health facility, assign them to RHUs and CHOs.
    iii. For senior citizens and indigent population, assign them to the health facility nearest to their residence.
b. Allocate vaccination workforce based on the number of eligible population assigned to the implementing unit / vaccination site/post.
    i. In close coordination with health facilities, the LGU may reallocate vaccination workforce of health facilities to vaccination posts with a high number of eligible population assigned.

Table 16. Recommended vaccinees under the Eligible Priority Group A that particular implementing units can cater.

Operational Guidelines
● The following may be catered by *Medical Center / Hospital / Infirmary (both private and public):* ○ Frontline Health Workers, as defined in the DOH guidelines, in medical centers/hospitals/infirmaries, Treatment Rehabilitation Centers (TRCs), Temporary Treatment and Monitoring Facilities (TTMFs) ○ Senior Citizens ○ Indigent Population ○ Vaccination Team
● The following may be catered by *Rural Health Units:* ○ Frontline Health Workers employed/deployed/assigned in the public health sector, as defined in the DOH guidelines; Barangay Health Workers and Barangay Health Emergency Response Teams, employees manning close-setting facilities and long-term care facilities, e.g. orphanage, home for the aged, women's crisis centers, among others; and social workers providing social amelioration and social services in the communities; and LGU-hired/deployed/designated or DILG-hired contact tracers; Senior Citizens ○ Indigent Population ○ Uniformed personnel from the Philippine National Police, Bureau of Fire Protection, Philippine Coast Guard ○ Vaccination Team
● The following may be catered by *Private Clinics:* ○ Frontline Health Workers, as defined in the DOH guidelines, working in private clinics ○ Senior Citizens ○ Indigent Population

○ Vaccination Team
● The following may be catered by *Health Facilities of Government Agencies:* ○ Frontline Health Workers employed/deployed/designated/assigned in health facilities managed by the Department of Education, Armed Forces of the Philippines, Bureau of Jail Management and Penology, Bureau of Corrections; frontline workers, as defined in the DOH guidelines, employed/deployed/designated/assigned in BJMP and BuCor ○ Uniformed personnel from the AFP, CAFGU ○ Vaccination Team

Table 17. Sample for the assignment of vaccinees and vaccination workforce to vaccination posts/sites.

Bara-ngay	*Vaccination Post*	*Eligible Population assigned to vaccination posts*	*No. of Vaccination Teams required*	*No. of Available Vaccination Teams*	*Gap*	*No. of Composite Teams required*	*No. of Available Composite Teams*	*Gap*	*No. of Supervisors required*	*No. of available supervisors*	*Gap*
B1	RHU 1	5,467	8	4	4	8	6	2	3	2	1
	Private Clinic 1	600	1	1	0	1	1	0	1	1	0
B2	Hospital 1										
	DepEd Clinic 1										

Critical Step 5: Estimate the vaccine requirement and ancillary supplies needed

a. Develop a budgeted cold and logistics plan
b. Determine the logistics required for the implementing units and vaccination posts. The following are the minimum required.

Table 18. Vaccines and logistics required.

Logistics	*Formula*
Vaccines	● Still to be determined: Eligible population ÷ __ (___doses per via) x ___ (wastage factor) = Total # of COVID-19 vaccine vials
Diluents	● Still to be determined
AD syringes	● Still to be determined
Mixing syringes	● Still to be determined
AEFI /AESI kits	● At least one AEFI/AESI kit per composite team
Safety Collection Boxes (SCBs)	● Total ADS + Total Mixing syringes)/100 x1.1 (WF) = Safety Box Quantity Requirement
PPEs	● *Face mask*: Total HR x 2 masks/day x 7 days x 2 rounds; *Face Shield:* Total HR x 1 face shield
Alcohols, cottons	● *Alcohol:* 1 bottle of alcohol/HR per day x 7 days x 2 rounds; 2 *cotton balls* per vaccinee x 2 rounds
Vaccine carriers and ice	● 1 vaccine carrier per 1 Vaccination Team

packs	
Vaccine refrigerators	● Still to be determined
Thermal Gun, BP Apparatus, Stethoscope, Pulse Oximeter	● 2 set per 1 Vaccination Team
Immunization cards	● 1 immunization card per vaccinee
Campaign Forms and Checklists	● 1 set per team/day
Cot beds	● 1 bed per composite team
Ambulance	● 1 ambulance per implementing unit

Critical Step 6: Identify gaps in cold chain capacity

Determine the cold chain capacity and identify gaps. Coordinate closely with the CHDs on the logistics to be provided by the national and regional health offices.

a. *Refrigerators:* make an inventory of refrigerators and freezers specifying model, manufacturer, number, energy source and the net vaccine and coolant-pact storage capacity.
b. *Electrical System:* check electrical system for reliability, accessibility, quality and security.
c. *Vaccine Carriers:* Evaluate number of cold boxes, vaccine carriers and coolant-packs. Conduct an inventory of existing equipment at each implementing unit.
d. *Temperature Monitoring:* Assess the number and condition of thermometer/temperature monitoring devices, temperature monitoring sheets.

Critical Step 7: Ensure timely delivery of vaccines and ancillary logistics

a. Develop a delivery and distribution plan for vaccines and ancillary logistics.
b. Coordinate with CHD on the delivery of vaccines and ancillary logistics that the National Government will provide.
c. Consider in the delivery and distribution plan the timeline for the LGUs to deliver vaccines and ancillary logistics to implementing units.
d. Coordinate with the CHD or CO on the direct delivery of certain vaccines to implementing units.

Table 19. Sample Delivery Plan.

	Quantity	Date of Delivery
Vaccines		
Diluents		

AD syringes		
Mixing syringes		
AEFI Kits		
Safety Collection Boxes		
Face Masks		
Face Shield		
Alcohol		
Cotton		
Campaign Forms and Checklists		
Others		

Table 20. Sample Distribution Plan.

Vaccination Post/Site	*# Vaccines*	*# AD Syringes*	*# Mixing Syringes*	*# Diluents*	*# AEFI Kits*	*# Safety Collection Boxes*	*# Face Masks*	*# Face Shields*	*# Alcohols*	*# Cottons*	*Others*
Hospital 1											
Hospital 2											
RHU 1											
RHU 2											

Critical Step 8: Prepare a Daily Vaccination Session Plan (daily itinerary)

a. Plot the activities or assignment of each implementing unit / vaccination post on a daily basis. Include in the plan:
   i. Number of teams required daily
   ii. Expected number of vaccinees to be vaccinated per day
   iii. Transportation mechanism for the vaccinees and the teams, ensuring physical distancing is considered in computing the transportation sitting capacity required
   iv. Resources needed for the vaccination post, and its quantity.

Table 21. Sample daily vaccination session plan.

Date of Immunization Schedule	*Vaccination Posts*	*Assigned Vaccination Teams and Composite Teams*	*Eligible population*	*Daily Target to be Vaccinated*	*Transport mechanism for teams*	*Transport mechanism for vaccinees*	*Resources needed with quantity*
March 15	Hospital 1	Team 1 upto Team 3	Frontline Health Workers	300	3 hired vans	none	vaccines (#) syringes (#) Safety collector boxes (4) Vaccine Carriers (3) Ice Packs (12) and etc

March 18	Hospital 2	Team 6-10	Senior Citizen in the AM Indigent Population in the PM	500	8 vans	10 jeepneys	vaccines (#) syringes (#) Safety collector boxes (6) Vaccine Carriers (5) Ice Packs (20) and etc

Critical Step 9: Develop a communication plan for community advocacy, social mobilization, partnership and engagement

a. Determine the following elements of the Demand Generation and Risk Communication microplan (see sample plan below):
   i. Activities
   ii. Indicators
   iii. Target
   iv. Baseline
   v. Timeframe
   vi. Responsible person/unit
   vii. Budgetary requirements
   viii. Funding source

Table 22. Sample demand generation and communication plan.

Activities	Indicators	Target	Baseline	Time frame	Responsible person/unit	Budgetary requirements	Funding Source
BEFORE THE MASS IMMUNIZATION CAMPAIGN							
1. Briefing and feedback with LCEs, city administrator, LGU HEPOs, public information officer, DRRMO, and other key local officials	100% of target key local officials are briefed on the COVID-19 vaccination campaign						
2. Dialogues and/or capacity building with local partners and local leaders							
a. Barangay chairmen, BHWs, BHERTs, and other barangay officials	100% of target barangay chairmen, BHWs, BHERTs and other local officials are oriented and/or capacitated on the COVID-19 vaccination campaign						
b. Community-based leaders and representatives of community-based organizations *(homeowners associations, senior citizens, women's groups, transport groups, youth groups, indigenous peoples)*	80% of target community-based leaders and representatives from community-based organizations oriented and/or capacitated on the COVID-19 vaccination campaign						

c. Representatives of Faith-based groups	80% of target representatives of faith-based groups oriented and/or capacitated on the COVID-19 vaccination campaign						
d. NGOs, CSOs, civic, and other organizations operating in the city	80% of representatives NGOs, CSOs, and other organizations given oriented and/or capacitated on the COVID-19 vaccination campaign						
e. local medical societies and networks	80% of target representatives of local medical societies and networks oriented and/or capacitated on the COVID-19 vaccination campaign						
f. private elementary and high school teachers	80% of target representatives of private elementary and highschool teachers oriented and/or capacitated on the COVID-19 vaccination campaign						
3. Development, production, and/or dissemination/posting of communication materials							
a. Development and/or printing of communication materials	# of communication materials developed						
b. Distribution and posting/installation of streamers, posters, and other communication materials *(consider public markets, transport terminals, ports, health facilities, day care centers, commercial areas)*	# of streamers or posters installed # of flyers distributed						
4. Awareness-raising activities							
a. Announcements via local public address system(s) - *e.g. mobile public address system, community megaphones*	# of announcements made						
b. Awareness-raising activities for eligible population *(group orientation; announcements; barangay assemblies;*	# of activities conducted						

townhall meetings; online Q&A sessions)							
c. Awareness raising and engagement via the mass media and social media platforms *(e.g. Facebook, Twitter, Instagram, Youtube)*	# of activities conducted						
d. Awareness-raising activities for hard-to-reach or special populations *(e.g. areas with security issues, relocated populations, mobile and transient families, homeless)* - Identifying hard-to-reach or special populations - Conduct of local strategies to reach hard-to-reach or 'special' populations	# of awareness-raising activities for 'special' populations conducted						
e. City-level launching or kick-off activity - Form committee; assign tasks; coordinate with national task group for simultaneous launch - Prepare programme or activity plan, with budget; speeches or talking points - Send invitations; coordinate logistics support - Conduct kick-off activity	# of city-level kick-off activities conducted						
5. Pre-campaign monitoring *(check for visibility of communication materials e.g. streamers; awareness of parents/ caregivers about the campaign; activities conducted by local officials and partners in support of the campaign)*	# of pre-campaign monitoring activities conducted						
a. Documentation of pre-campaign activities *(e.g. video, photo)*	Type of documentation used *(video, audio, photo, narrative)*						
b. Coordination meetings on advocacy and social mobilization	# of coordination meetings conducted						
DURING THE MASS IMMUNIZATION CAMPAIGN							
1. Monitor the progress of immunization activities; check for possible issues including refusals, rumours, misinformation; apply corrective actions, if needed	# of monitoring activities conducted						

2. Continuing social mobilization activities *(add details below; some awareness-raising activities during pre-campaign period may be continued until end of the campaign period and/or when all children have been immunized)*							
AFTER THE MASS IMMUNIZATION CAMPAIGN							
1. Post-campaign assessment meetings and other activities	# of post-campaign assessment meetings and other related activities conducted						
2. Meetings with local partners to report on campaign accomplishment and to thank them for their support; agreements to maintain/sustain the partnership	# of meetings conducted						
3. Preparation and submission of campaign documentation report(s)	# of reports submitted						

Critical Step 9: Prepare a supervision and monitoring plan and schedule.

a. Ensure that supervisors and monitors are identified. Coordinate with implementing units to identify their vaccination team supervisors and/or implementing unit supervisors (see section on vaccination workforce).
b. Assign them to areas, especially areas needing technical assistance and support. If human resource is scarce, prioritization of areas shall be determined for the deployment of supervisors.
c. Map the areas needing supervisory work.

Table 23. Sample form for supervision and monitoring plan.

Region/Province: _____ LGU: _____
Implementing Unit: _____ Date: _____

Name of Supervisor / Monitor	Team Number and Name of VT Leader	Name of Vaccination Posts and Implementing Units	Mode of Transportation	Start Date	End Date	Contact Number	
						VT Leader	Supervisor
Rosana delos Santos	Team 1 - Carlos Reyes	PGH 3 vaccination posts	Van	March 19	June 19	0917 789 6534	0915 422 5623
Judith Dulay	Team 2 - AJ Cruz	Pasig RHU 1 1 vaccination posts	Van	March 19	June 19	0998 567 2317	0923 673 6423

Critical Step 10: Prepare an AEFI/AESI management, surveillance and response plan

a. Determine how many AEFI/AESI kits are required per vaccination post.
b. Ensure that each composite team has the following emergency equipment:

- BP apparatus
- Stethoscope
- Penlight
- Cot Bed / Stretcher

c. Identify AEFI/AESI referral facility for each composite team, and identify contact person in the referral facility and his/her contact numbers.
d. Ensure that an emergency transport vehicle is on standby in the vaccination post.

Table 24. Sample from for AEFI preparation.

Vaccination Posts	*No. of Composite Team Assigned*	*No. of AEFI/AESI Kits*	*Emergency Equipment Needed*	*Referral Facility*	*Contact Person*	*Contact Details*	*Assigned Emergency Transport Vehicle*
RHU 1	3 Teams (Team 1-3)	3 Kits (with complete items)	Cot Bed / Stretcher: 6 BP: 3 Stet: 3 Pen light: 3	Pasig City General Hospital	Dr. Juan Dela Cruz	0917 569 3455	RHU Ambulance Plate No. TG 3485
Hospital 2							

Critical Step 11: Develop a waste management plan

Details on what to prepare and what to plan are extensively discussed in the last section of this plan. The required management of wastes may vary depending on the type of vaccines. The waste management plan should be extensively laid out based on the recommendation of manufacturers. For a minimum, the following steps must be undertaken:

a. Designate safe temporary storage for immunization wastes generated daily
b. Schedule and designate key responsible persons for waste management, waste transport and waste storage and destruction (if necessary).
c. Identify healthcare waste treatment and final disposal facility

Table 25. Sample form for immunization waste management plan.

Vaccination Post/ Implementing Unit	*Disposal Facility*	*Contact Person and Contact Number*	*Schedule*

3. Mapping of Vaccination Workforce, Implementing Units and Vaccination Sites/Posts

During the pre-implementation phase, it is essential that decision-makers such as the Local Chief Executives (LCEs), planning officers and health officers, among others, are familiar and adept with the guidelines in determining the vaccination workforce, implementing units and vaccination sites/posts.

The Vaccination Workforce

For the COVID-19 vaccination campaign, a diverse set of professionals and personnel, both from the public and private sector, shall be utilized as part of the vaccination workforce.

As more doses of vaccines become available during 2021- 2022, there will be a need to expand the pool of skilled workforce to administer vaccines and to deliver the program. In particular, standalone general practice private clinics and pharmacists can and have successfully delivered very significant numbers of flu vaccines and can offer enhanced capacity for this program subject to agreement. This vaccination program will also require significant increases in the number of administrative and support staff, in this regard there may be opportunities to leverage the broader public service to achieve this.

Thus, to ensure that sufficient workforce is available, the National Government shall engage and include other professionals such as teachers, counsellors, pharmacists, medical and allied health professionals and interns; and the private sector, as part of the vaccination workforce.

These are the minimum set of vaccination workforce needed:

Table 26. Recommended composition of the vaccination and AEFI composite teams, and other personnel needed in the implementing units.

Team/Other Personnel needed	*Composition*
Vaccination Team (6)	(2) for screening and assessment: Physician/Nurse/Midwife (1) as health educator: Allied Professionals/ Volunteers from partner agencies (e.g. teachers, social workers, medical students, etc) (1) as vaccinator: Physician/Nurse/Midwife of RHU/Pharmacist (certified by PRC) (2) as documentor/recorder and vital signs-taker: Midwife/BHW/Health Staff / Volunteers from partner agencies (e.g. teachers, social workers, medical students, etc)
AEFI Composite Team (2)	(1) to monitor and provide response: Paramedic/Nurse/Midwife (1) to conduct surveillance: Surveillance Officer/ Nurse/Midwife/Pharmacist
Supervisors/Monitors	(1) Vaccination Team Supervisor: preferably a physician, for at least three (3) vaccination teams (1) Implementing Unit Level Supervisor: for the entire implementing unit (1) LGU Level Supervisor: for the entire LGU Internal Monitors and Independent Monitors

Other personnel needed in the implementing units	Cold Chain and Logistics Officer/s Local Officials (barangay captains) Security Personnel (PNP) Drivers Safety Officers (Barangay Tanods, among others)
Other personnel needed in community/health facilities	Social mobilizers: BHWs and hospital staff (HR) Navigators/Transport: BHWs and Local Officials, Health Facility Management

The following are the roles and responsibilities of each team and personnel:

Table 27. Roles and responsibilities of the vaccination workforce.

Teams and Personnel	*Roles and Responsibilities*
1. Vaccination Team	● Man the vaccination administration area in the vaccination post/site ● Ensure that the vaccination administration procedure has been conducted efficiently and correctly ● Ensure that reports and information are encoded truthfully and submitted timely
a. Personnel assigned as documenter and recorder	● Man the registration area ● Ensure that documents and identification presented by the vaccinee are valid ● Ensure that all information and data are encoded in the data management system ● Assist other team members, especially on vital signs taking ● Submit daily coverage, refusals and deferrals to the C/MHO
b. Personnel assigned as health educator	● Man the health education area ● Ensure that equipment and IEC materials are available during the vaccination post/area ● Provide information to vaccinees, particularly on the benefits of vaccination, the possible adverse reactions, and how to seek help if with adverse reaction, either by answering their queries, or providing them with IEC materials ● Facilitate the signing of the informed consent ● Coordinate with social mobilizers and navigators for those who were deferred and those who refuse on-site.
c. Personnel assigned for screening and assessment	● Man the screening and assessment area ● Conduct physical examination and take the history of present illness (if applicable) and record in the CEIR ● Provide clearance for the vaccinee to be vaccinated. Those deferred for vaccination shall be coordinated with the social mobilization team for follow-up and shall be provided with a possible vaccination schedule
d. Personnel assigned as a vaccinator	● Man the vaccine administration area ● Follow the step-by-step procedure of vaccine administration as recommended by the manufacturer and as guided by the immunization protocols ● Completely fill-up the immunization card and encode the needed information to the data management system ● Dispose syringe and vials accordingly
2. AEFI/AESI	● Man the post-vaccination area in the vaccination post/site

Composite Team	● Ensure that the vaccinee is monitored and observed for any adverse reaction in the 1st hour after vaccination ● Provide immediate intervention and response for vaccinees experiencing adverse reactions on-site and refer them accordingly and timely
a. Personnel assign to monitor and provide response	● Monitor and observe the vaccine for any adverse reaction in the 1st hour after vaccination ● If the vaccinee has any adverse reactions, provide immediate intervention/treatment ● Refer vaccinee/s with adverse reaction/s to appropriate AEFI/AESI referral health facilities in a timely manner ● Provide the vaccinee with information on what signs and symptoms he/she should watch for at home and where he/she should proceed to for treatment
b. Personnel assign for surveillance	● Monitor and observe the vaccine for any adverse reaction in the 1st hour after vaccination ● If the vaccinee has any adverse reactions, conduct surveillance investigation ● Follow-up the vaccinee/s for any adverse reaction/s at home
Supervisors and Monitors	Supervisors ● Supervise and oversee the vaccination activity ● Address concerns and coordinate accordingly ● Ensure timely submission of reports Monitors ● Monitor and evaluate the quality of vaccination implementation ● Provide feedback to VOCs
a. Vaccination Team Supervisor	● Visit Vaccination Teams at least once a day for supportive supervision using the Supervision Checklist ● Compile vaccination team reports, analyze them and report to higher level ● Review team performance and undertake corrective actions if needed
b. Implementing Unit Level Supervisor	● Visit Vaccination Teams with Team Supervisors, at least once a day for supportive supervision using the Supervision Checklist ● Compile and review vaccination team reports, analyze them and report to higher level ● Review team performance and undertake corrective actions if needed ● Communicate daily with Coordination team in the VOC
c. LGU Level Supervisor	● Visit implementing units 1-2 weeks prior to the campaign to monitor progress in preparedness. ● Support training and microplanning activities ● Review submitted reports, compile and analyze health center level data
d. Monitors and Independent Monitors	● Visit vaccination sites and complete monitoring forms ● Monitor the vaccination implementation and ensure that it is based on the guidelines set by DOH ● Participate in meetings of the coordination team ● Assist in troubleshooting, as needed

The following are the pertinent operational guidelines on the vaccination workforce:

a. The Local VOCs and City/Municipal Health Officers shall be responsible in mapping and identifying the vaccination workforce and in assigning them to vaccination sites/posts, in coordination with the implementing units.
b. One vaccination team shall be complemented with at least one AEFI/AESI composite team.
c. In minimum, three (3) or more vaccination teams and three (3) or more AEFI/AESI composite teams shall be assigned in a vaccination post/site.
d. Each vaccination team shall have a target of 100 vaccinees per day.
e. A supervisor shall oversee at least 3 vaccination teams and 3 AEFI/AESI composite teams.
f. At least one (1) Safety Officer is designated for every vaccination post. He/She shall ensure that minimum health standards are implemented and observed at all times.
g. The LGUs shall develop a contingency plan to ensure availability of sufficient number of vaccination workforce available considering the following:
    i. Human resource assigned for the COVID-19 pandemic response shall NOT be utilized as part of the vaccination workforce.
    ii. Possibility of COVID-19 infection among the vaccination workforce.
    iii. Services offered in health facilities shall not be hampered because of the vaccination campaign. If so, disruption must be kept to a minimum.
    iv. Possibility of vaccinated health workers experiencing adverse reaction, either mild or severe, after vaccination.

The Implementing Units and Vaccination Sites/Posts

A permanent fixed-post vaccination strategy shall be used in the conduct of the COVDI-19 vaccination campaign. As defined in the National Immunization Program, permanent fixed-posts are posts located at health facilities where there is sufficient capacity and equipment to immediately respond and refer AEFI/AESI cases, and where sufficient health human resources are available.

Therefore, the following shall be utilized as implementing units:

a. Medical centers, hospitals and infirmaries (private and public)
b. Rural Health Units
c. Health facilities of other government agencies (e.g. AFP hospitals and facilities, BJMP/BuCor health facilities, and DepEd clinics)
d. Private clinics

The LGUs shall ensure that all implementing units, including private health facilities, adhere to the protocols required for an implementing unit / vaccination posts/sites. No implementing unit shall be allowed to conduct vaccination activity without compliance to the protocols required of a vaccination post.

4. Human Resource Management and Training

Introduction of a new vaccine requires training activities on components of the National Deployment and Vaccination Plan and compliance with vaccine administration standards. These activities should be geared to personnel at all levels participating in the vaccination program.

The national training plan shall target:

- National and departmental coordinators of areas directly or indirectly related to vaccine introduction (e.g., information system, communication, cold chain, surveillance, etc), who will facilitate the vaccination processes at the district/municipality and local levels.
- Vaccination workforce who will directly or indirectly conduct the vaccination

Training in specific components of the plan should include participation by representatives of the scientific community, social security, and other relevant departments to standardize knowledge regarding the use of the new vaccine.

The COVID-19 Vaccine Deployment and Vaccination Program will be delivered by skilled and trained staff working in a variety of delivery locations. All staff working in the program will receive training relevant to their role in the team and service.

Training programs will be delivered through blended learning: on-line, and when required, in person. In addition to the specialist clinical training required for vaccinator staff, induction and orientation training will be provided for all staff working in implementing units.

Training Curriculum

In keeping with the guidance provided for the introduction of new vaccines, a training package is developed by DOH, together with WHO and Unicef. The training package will include a presentation slide deck and instructional job aids. The training will cover a total of nine (9) main topics including 1) Microplanning, 2) Masterlisting and Data Management, 3) Logistics and Cold Chain Management, 4) Risk Communication and Social Mobilization, 5) Addressing the Psychological Barriers to COVID-19 Vaccination, 6) Vaccine Administration, 7) Vaccine Safety, Surveillance and Response, and 8) Waste Management and Reverse Logistics and a module on 9) Training Skills and managing virtual training that shall capacitate trainers on the use of technology and virtual platforms not only for training activities but also online/ virtual activities. During the training, a review of the Standard Operating Procedures will be conducted.

Training Execution

Vaccination experts from the WHO, United Nations Children's Fund (UNICEF) and the DOH will provide the initial training and post-training support for the Core of Trainers. The DOH trainers will in turn conduct cluster-based Training of Trainers (TOT) for the 5 identified clusters: North Luzon, South Luzon, Visayas, North Mindanao and South Mindanao who in turn will organize regional training teams. The regional training teams will be responsible for training vaccinators from the local implementing units. These teams will also be responsible

for post-training supervision of the vaccinators. Relevant implementing partners will also be leveraged to provide training support where necessary. The table details the roles and responsibilities of the training teams at the different levels of the government.

Table 28: Roles and responsibilities of the training teams.

Level of Training Team	*Roles and Responsibilities*
WHO, UNICEF and DOH vaccination experts and trainers	● Develop/ Co-Develop the training materials ● Conduct the initial ToT for the Core Trainers ● Provide post training support to the Core trainers
DOH Cluster trainers	● Identify regional training teams Conduct TOT for the regional training teams ● Work with the regional training teams to develop regional training plans ● Provide oversight for the cascading of the trainings within each region ● Monitor the standards of and the implementation of training for the local implementing units. ● Conduct monitoring and evaluation of the training activities
Regional training teams	● Conduct training needs assessment ● Develop regional training plan ● Conduct trainings for the local implementing units ● Conduct post training supportive supervision, observation and mentoring for the local implementing units ● Implement quality improvement as needed based on gaps identified during the post training support activities

The following dates of training are:

Table 29. Training schedule.

Dates of Training	*Training*	*Training Participants*
December 29-30, 2020	Core of Trainer's Training	Designated DOH Core Trainers from DOH central office Designated trainers from: ● DOH Centers for Health Development Metro Manila ● Medical staff from other national government implementing agencies (DILG (BFP, PNP, BJMP), DSWD, DepEd, DND (AFP), DOJ (BuCor), DOTr (PCG))
January 12-13, 2021	NCR and Luzon Training	Designated trainers from: ● DOH Centers for Health Development

January 14-15, 2021	Visayas and Mindanao Training	● Selected government and private hospitals ● Provincial Health Officers ● Medical staff from other national government implementing agencies (DILG (BFP, PNP, BJMP), DSWD, DepEd, DND (AFP), DOJ (BuCor), DOTr (PCG))
January 20-21, 2021	BARMM Training	
January 22-31, 2021	Training of Implementing Units	● Provincial and local health units ● Remaining hospitals and other health facilities

Post-training supportive supervision

After training of the trainers, the DOH Core Trainers shall continue to support the trainers through post-training supporting supervision or coaching/mentoring sessions. Since this is a new vaccine and vaccination program, a more hands-on approach shall be implied. A training kit was created which contains the different training materials and updates about the program. The DOH core trainers assigned to 5 Clusters (N. Luzon, S. Luzon, Visayas, N. Mindanao and S. Mindanao) shall assist the trainers in their training activities and will look into the following areas:

1. Use of updated and standard training reference materials.
2. Planning and conduct of training.
3. Capacitating the target number of vaccinators and composite teams.
4. Readily addressing issues and concerns of the trainees
5. Continuous coordination with different implementing agencies and institutions.
6. Ensuring that the different implementing agencies are capacitated on the COVID-19 Immunization Program Implementation.

They shall virtually monitor and address issues and concerns encountered. Field monitoring may be conducted as necessary. The post training supervision and monitoring shall be conducted alongside with the DOH regional trainers and partner implementing agency focal persons.

5. *COVID-19 Vaccine and Cold Chain Capacity Inventory and Logistics Management*

The purpose of the vaccine “cold chain” is to maintain product quality from the time of manufacture until the point of administration by ensuring that vaccines are stored and transported within the recommended temperature ranges. Vaccine potency, meaning its ability to adequately protect the vaccinated patient, can diminish when the vaccine is exposed to inappropriate temperatures. Once lost, vaccine potency cannot be regained. It is essential that all those who handle vaccines and diluents know the temperature sensitivities and the recommended storage temperatures for all the vaccines.

In the pre-implementation phase, in order to maintain a reliable vaccine cold chain and logistics management at the LGU level, the following key procedures shall be observed:

a. Receive vaccines logistics requirement for the vaccination campaign.
b. Count ALL vaccines and logistics (syringes, SCBs, re-sealable plastic, among others) received to ensure NO short shipment.
c. Check the vaccine label and ensure that it is intact.
d. Store vaccines and diluents within the required temperature ranges at all sites/levels. Keep vaccines in appropriate vaccine refrigeration equipment. Keep all COVID-19 vaccine vials together in the same cold chain equipment at all times.
e. Label storage equipment containing COVID-19 vaccines properly.
f. Use a temperature monitoring device to ensure temperatures remain according to the recommended temperature.
g. Pack and transport vaccines to and from implementing units according to recommended procedure. Transport vaccines to immunization sessions in a vaccine carrier, correctly packed using coolant packs that have been properly prepared.
h. Keep vaccines and diluents within recommended cold chain conditions during vaccination sessions. During the vaccination sessions, fit a foam pad (if available) at the top of the vaccine carrier.

The LGU and in implementing units, one person shall be in-charge of logistics and cold chain management. An alternate shall also be identified to take over if the in-charge is absent. Their responsibilities shall include:

a. Checking and recording vaccine temperatures twice daily; in the morning and at the end of the session or day.
b. Properly storing vaccines, diluents and ice packs.
c. Handling preventative maintenance of the cold chain equipment.

6. Preparation of Vaccination Sites/Posts

A few weeks or days prior to the conduct of the vaccination activity, the LGUs and implementing units shall ensure that all vaccination posts/sites are prepared and fully equipped.

The vaccination post/site shall comply with the minimum health standards and shall have sufficient equipment for disinfection and sanitation. The dimension of the vaccination site/post shall be taken into consideration possible crowding in the post-vaccination area. It is recommended that implementing units shall utilize rooms of the health facilities for the vaccination activity, such as conference rooms, auditoriums, theaters, health facility gymnasiums, among others. If these types of facilities are not available, the implementing units can put up tents or temporary buildings within the vicinity of the implementing unit, such as in facility grounds, parking lots, and open spaces, among others.

The vaccination post/site shall have the following areas (as shown in Figure x):

1. Waiting Area. The waiting area shall be prepared for vaccinees waiting for their vaccination turn.
2. Vaccination Area: The vaccination area shall have at least three (3) vaccination teams and three (3) AEFI/AESI composite teams. Each area shall have several sanitation areas

for each vaccination team. The following areas, arranged in sequential order, shall be set in placed:

a. Registration Area: An area where the vaccinee's information and documents are checked and submitted. Each vaccination team shall have their respective areas in the registration area. Equipment needed to scan the QR code should be available in this area.
b. Health Education Area. There shall be one health education area for the whole vaccination site/post. In this area, IEC materials, such as pamphlets, leaflets and brochures shall be made available. Also, a projector or a TV shall be set up in this area, or the least, a flipchart, for health education purposes.
c. Screening Area. Since the screening procedure may take longer compared with other areas, it is advised that at least two screening stations per team shall be set up. Equipment needed to scan the QR code should be available in this area.
d. Vaccination Area. Each vaccinator shall have his/her own area. The vaccination area should have an accessible cold chain equipment to store the vaccines in the vaccination post/site.

3. Post-vaccination Monitoring Area. Since the observation of vaccinees post-vaccination will take 30 minutes to one hour, it is expected that there might be pooling or crowding of vaccinees in this area. Thus, this area must be spacious enough to accommodate all vaccinees and to allow observance of physical distancing measures. In addition, equipment needed for AEFI response must be available and accessible.

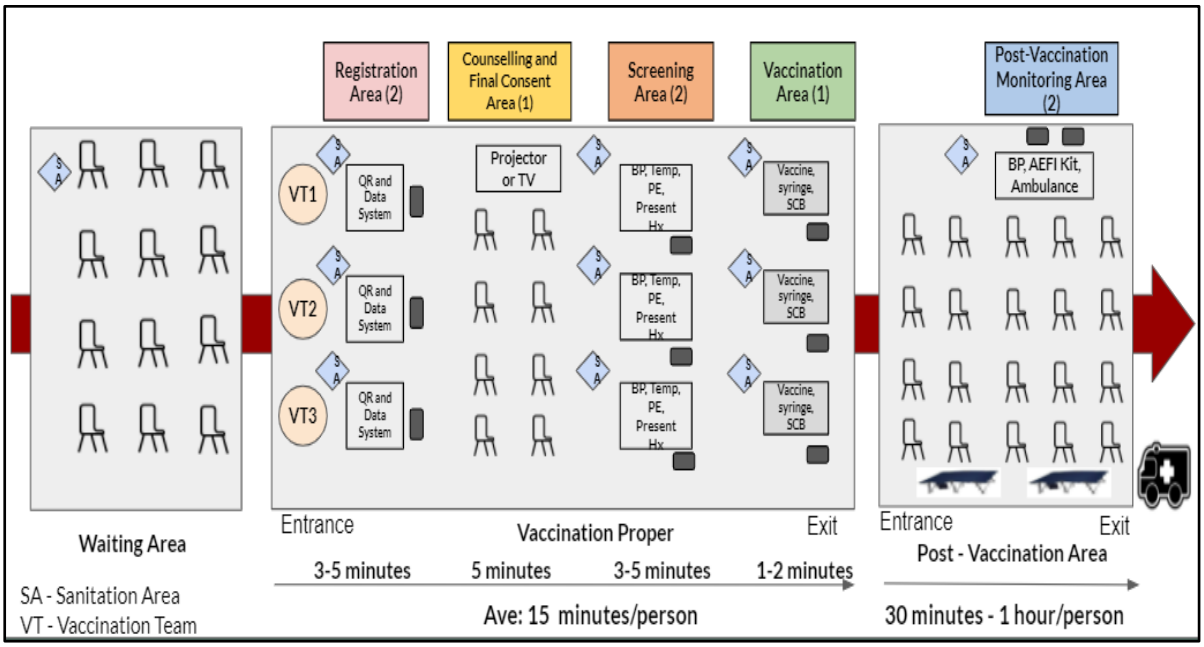


Figure 12. Vaccination site/post lay-out.

The following equipment is needed in the vaccination site/post.

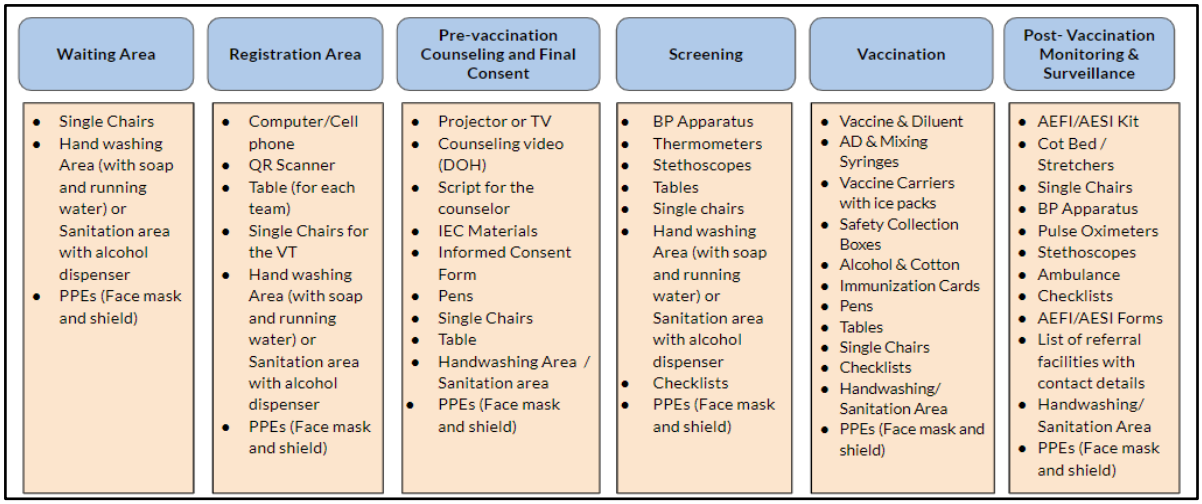


Figure 13. Equipment required in the vaccination site/post.

Implementation Phase

Mobilizing the eligible recipients

During the vaccination activity, eligible recipients who have successfully registered for vaccination shall proceed to the assigned vaccination posts/sites based on the schedule provided or they may be fetched from assigned pick-up points through previously arranged transport mechanisms. BHWs, local officials and other personnel may also do house-to-house visits to mobilize eligible recipients who have successfully registered for the vaccination, so that they can proceed to the assigned vaccination site (see Figure 12).

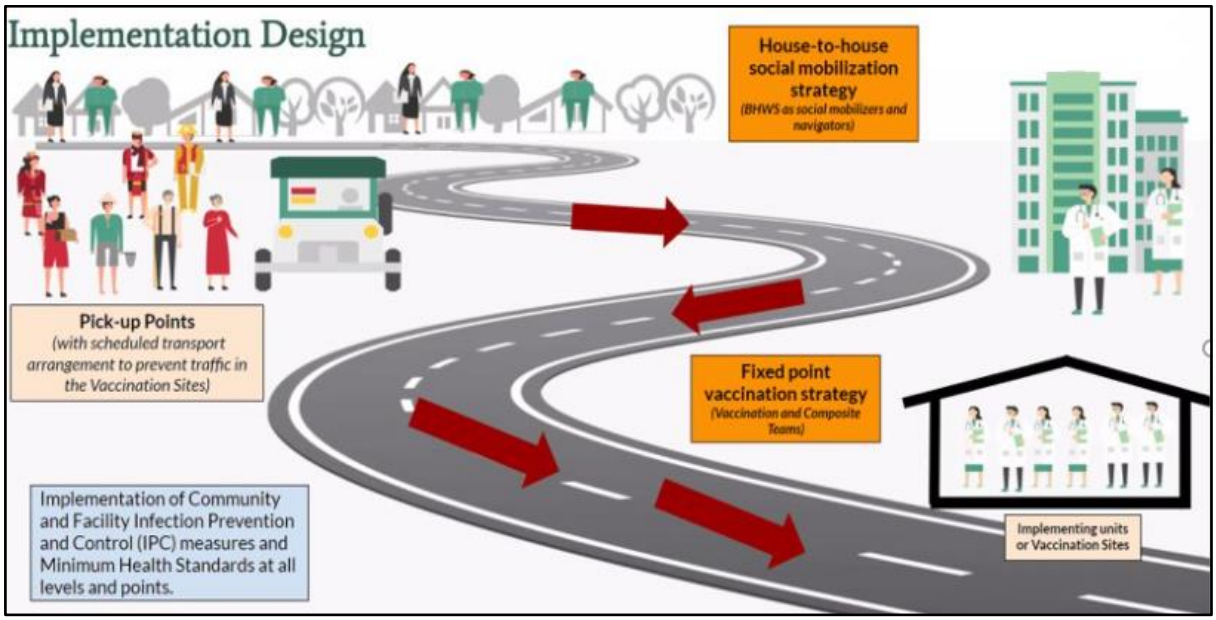


Figure 14. Illustration of the mobilization of eligible recipients for the actual COVID-19 vaccination.

Intra-campaign Vaccine Cold Chain and Logistics Management

Daily during the vaccination campaign round, the preparation of vaccines and logistics is a very important activity to be undertaken by the LGU/health facility supervisor and cold chain manager.

The following steps shall be undertaken every vaccination day:

1. Before every vaccination activity, prepare the vaccine carriers and the ice packs.
2. In each vaccine carrier, arrange the frozen ice packs exactly as recommended on the manufacturer's instruction on the inside of the lid. Do not cover the frozen ice packs in paper.
3. Prepare re-sealable plastic bags and an extra one for opened/used vials (after the vaccination day).
4. Place 20 vaccine vials in one re-sealable plastic bag. The number of vaccines to be used per vaccination team shall be determined prior to the activity.
5. Put the resealable plastic with the vaccines in the middle of the vaccine carrier to protect them from damage due to condensation.
6. Daily issuances of vaccines should be recorded in the distribution and collection form acknowledged by the vaccination team leader / supervisor.
7. At the end of each vaccination day, all vials (unopened, fully or partially used) shall be placed in resealable plastic bags and returned to the same health facility where they received the vaccines in the morning. The facility supervisor shall record the vials received at the end of each vaccination day.
8. Health facilities / vaccination distribution points must then keep the unopened usable vials in the cold chain. The vaccines can be used for the next day.
9. All opened or unusable vials contained in resealable plastic by twenties (20s) must be kept in a sack and be picked up by the CHD at the end of the vaccination round for disposal.

Table 30. The vaccine distribution and collection form.

Vaccine Distribution and Collection Form

Region:_____ Province:_____ Municipality:_____ Date (mm/dd/yyyy):_____

Name of VT/Barangay/ City/ Municipality/ Province	Target	Number Immunized	Vaccine Distribution					Empty / opened vials	Unopened vial returend (in Vials)	Total (in Vials)	Name of Vaccinator	Contact Number	Signature
			Vaccine Issued		Additional Vaccine Issued		Total Vaccine Received (in Vials)						
			Quantity (in Vials)	Lot/ Batch No.	Quantity (in Vials)	Lot/ Batch No.							

Vaccination Administration

Prior to the vaccination, the vaccinee will be provided with a vaccination date and time schedule, and an immunization card with a QR code, which he/she will bring to the vaccination post, to ensure smooth implementation of the vaccination activity and avoid congestion in the vaccination site/post. No walk-in vaccination shall be accommodated since vaccines allocated for the day are sufficiently allocated for the projected number of vaccinations to be conducted in a day. However, a walk-in eligible recipient shall be scheduled and provided with an immunization card with a QR code immediately, and advised accordingly.

Upon arrival at the vaccination site/post, the vaccinee shall wait for his/her turn in the waiting area. Upon entry in the waiting area, the vaccinee's temperature will be checked. The Safety Officer shall ensure that physical distancing measures shall be implemented at all times at the waiting area.

Each vaccinee shall be assigned to a specific vaccination team. When his/her turn arrives, he/she will proceed to the vaccination area, and in a stepwise approach, he/she will proceed from the registration area, health education area, screening area and lastly, to the vaccination area.

At the registration area, the vaccinee shall present his/her immunization card with QR code and shall be scanned. The profile of the vaccinee shall be retrieved in the computer system and the vaccinee's identity shall be verified by presenting his/her government ID (eg. driver's license, PRC license, PhilHealth ID, UMID, Passport, etc). Other relevant documents shall be presented at the registration.

The vaccinee shall then be directed to the Health Education Area where health educators shall present IEC materials and answer any question the vaccinee may have regarding the COVID-19 vaccine. Once all questions are answered, the vaccinee shall be asked to sign the Final Consent form.

At the Screening Area, the personnel assigned shall scan the patient's QR code and conduct history-taking and physical examination to ensure the eligibility of the vaccinee. Using both the CEIR and screening form hard copy, the health worker shall update the vaccinee's profile and determine whether or not he/she is qualified to receive the vaccination.

The vaccinee shall then be directed to the Vaccination Area where the vaccine shall be administered. Once vaccinated, the QR code shall be scanned and the vaccination details (e.g. date of vaccination, vaccine manufacturer, batch number, lot number, name of vaccinator and signature) shall be recorded in the CEIR and immunization card.

After vaccination, the vaccinee shall be observed for adverse reactions for 30 minutes to one hour at the post-vaccination monitoring area. The post-vaccination monitoring area must be closely linked with an identified referral health facility. After an hour, once cleared, the vaccinee shall be provided with instructions about the possible adverse reaction that the vaccinee might experience and the location of facilities where he/she can proceed should he/she experience adverse reactions.

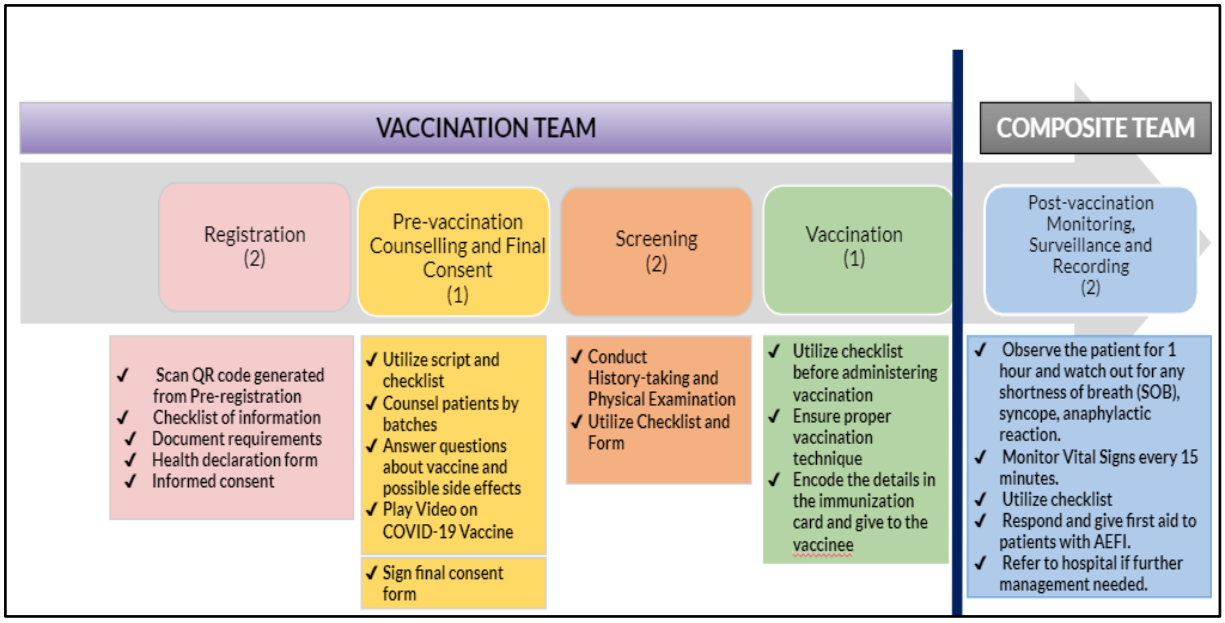


Figure 15. The vaccine administration flow.

A checklist detailing the steps to be followed by the vaccination and AEFI/AESI composite teams shall be placed in each designated area. In the vaccination area, a specific checklist for each type of vaccine shall be provided. As of January 18, 2021, information on vaccine administration of Pfizer and Moderna vaccines are available. In the checklist, the following steps are detailed:

Registration Area:

1. Ask the vaccinee to sanitize hands and get his/her temperature.
2. Scan QR Code or Register ID number.
3. Verify the vaccinee's identity with any government-issued ID (contains photo, birthday, signature) or passport.
4. Remind the vaccinee to follow the minimum health standards within the vicinity.
5. Direct the vaccinee to the Health Education and Final Consent Area.

Health Education and Final Consent Area:

1. Group the vaccinees (even those from other teams) to at least 6-12 individuals.
2. Play a DOH Explainer Video to the Group.
3. Encourage the vaccinee to ask questions and clarifications and address issues that he/she may have.
4. Explain to and educate vaccinee on COVID-19 Vaccine - what it is, how it protects, administration and possible side effects.
5. Explain to the vaccinee that he or she may opt to receive the 2nd dose from another facility provided that the 2nd dose is the same brand as the 1st dose.
6. Instruct patient on post-vaccination care:
    a. Put ice pack / ice on the injection site for 15 minutes 3x a day, in the first 24 hours after vaccination. Report any AEFI to the clinic/hospital.
    b. For any serious AEFI, proceed immediately to the nearest Emergency Room.
7. Provide educational materials (pamphlets with FAQs) at suitable reading levels to the

vaccinee and available in vaccinee's local language.

8. Provide Vaccine Information Statements (VIS) or Emergency Use Authorization (EUA) forms, if required.
9. Ask vaccinee to sign the *Final Consent Form*.
10. Direct the patient to the Screening Area.

Screening Area:

1. Scan QR Code
2. Conduct history-taking
    - ❑ Focus on the present history *(past history and co-morbidities are gathered during pre-registration and profiling)*
    a. Is the vaccinee currently experiencing the ff symptoms or have experienced the ff in the past 14 days?
        - ❑ Fever
        - ❑ Headache
        - ❑ Cough
        - ❑ Colds
        - ❑ Sore throat
        - ❑ Shortness of breath or Difficulty in breathing
        - ❑ Chest pain
        - ❑ Abdominal pain
        - ❑ Changes in bowel movement
        - ❑ Loss of taste/smell
        - ❑ Fatigue/weakness
        - ❑ Others: _____
    b. Is the vaccinee on any blood thinner or any medication that affects the immune system?
    c. Has the vaccinee received any vaccination in the past 4 weeks?
    d. Has the vaccinee experienced any serious reaction after receiving a vaccine?
    e. Has the vaccinee previously received a COVID-19 Vaccine?
    If yes, specify: _____
    f. For women: Is the vaccinee pregnant/ breastfeeding or is there a chance she could become pregnant during the next month?
3. *Conduct Physical Examination*
    a. Take the Vital Signs
        - ❑ Heart rate: _____ beats/min (N: 60-100 bpm)
        - ❑ Respiratory rate: _____ breaths/min (N: 12-20 bpm)
        - ❑ Blood pressure: _____ (N: < 120/80)
        - ❑ Oxygen saturation: _____ % (N: 95-100%)
    b. Perform Cardiovascular Examination
        - ❑ Normal rate and rhythm

❑ (+) Murmurs

❑ (+) Irregular heart rate and rhythm

c. Perform Respiratory Examination

❑ Clear lung fields

❑ Adventitious breath sounds, specify: _____

Vaccination Area (Pfizer Vaccine):

Prepare the Vaccine

1. Follow aseptic technique. Perform hand hygiene before vaccine preparation, between patients, when changing gloves (if worn), and any time hands become soiled.*
2. Remove vaccine from the freezer or refrigerator. Allow vaccine to come to room temperature. Vials can be held at room temperature for up to 2 hours before mixing. After 2 hours return unmixed vials to the refrigerator.
3. Before mixing, check the expiration dates of the vaccine and diluent. *NEVER use expired vaccines or diluent.*
4. With the vaccine at room temperature, *gently invert the vial 10 times. Do not shake the vial.* If the vial is shaken, discard the vaccine. The vaccine is a white to off-white in color and may contain opaque particles. *Do not use it if liquid is discolored.*
5. Using a new, sterile alcohol prep pad for each vial, wipe off the stoppers of the diluent and vaccine vials.
6. Using a 21-gauge (or narrower) needle, withdraw 1.8 mL of 0.9% sodium chloride (normal saline, preservative- free) into a mixing syringe. After use, discard diluent vial and remaining diluent.
7. *Do NOT use bacteriostatic normal saline or other diluents to mix the vaccine.*
8. Inject 1.8 mL 0.9% sodium chloride (normal saline, preservative-free) diluent into the vaccine vial.
9. Using the mixing syringe, remove 1.8 mL of air from the vaccine vial to equalize the pressure in the vaccine vial.
10. *Gently invert the vial containing vaccine and diluent 10 times.* The vaccine will be off-white in color. Do not use if discolored or contains particulate matter. Do not shake. If the vial is shaken, discard the vaccine.
11. Note the date and time the vaccine was mixed on the vial.
12. Keep mixed vaccine at room temperature (2ºC to 25ºC [36ºF to 77ºF]) and administer within 6 hours. Discard any unused vaccine after 6 hours. Do not return to refrigerator or freezer storage.

Administer the Vaccine

1. Scan the QR Code and verify the patient's identity (e.g. name and birthday).
2. Perform hand hygiene and aseptic technique.
3. Ensure staff has the correct PPE before administering vaccines.
4. Choose the correct equipment, including the correct needle size. Use a new, sterile needle and syringe for each injection.
5. Cleanse the stopper on the vial of mixed vaccine with a new, sterile alcohol prep pad.

Withdraw 0.3 mL of mixed vaccine into the syringe. Ensure the prepared syringe is not cold to the touch.

6. Remove any air bubbles with the needle still in the vial to avoid loss of vaccine. Use the same needle* to withdraw and administer the vaccine, unless contaminated or damaged.
7. Administer the vaccine immediately by intramuscular (IM) injection in the deltoid muscle.
8. Update the vaccinee profile system with: date of vaccination, COVID vaccine manufacturer, batch number, lot number, name of vaccinator.
9. Fill up the patient's immunization card with vaccinee's date of vaccination, COVID vaccine manufacturer, batch number, lot number, name of vaccinator.
10. Direct patient to Post-vaccination Monitoring Area.

Vaccination Area (Moderna Vaccine):

1. Scan the QR Code and verify the patient's identity (e.g. name and birthday).
2. Perform hand hygiene and aseptic technique.
3. Visually inspect each dose of the Moderna COVID-19 Vaccine in the dosing syringe prior to administration. The white to off-white suspension may contain white or translucent product related particulates. During the visual inspection,
    - Verify the final dosing volume of 0.5 mL.
    - Confirm there are no other particulates and that no discoloration is observed.
    - *Do not administer if the vaccine is discolored or contains other particulate matter.*
4. Administer the Moderna COVID-19 Vaccine intramuscularly.
5. Update the vaccinee profile system with: date of vaccination, COVID vaccine manufacturer, batch number, lot number, name of vaccinator.
6. Fill up the patient's immunization card with vaccinee's date of vaccination, COVID vaccine manufacturer, batch number, lot number, name of vaccinator.
7. Direct patient to Monitoring Area.

Post-Vaccination Monitoring Area:

1. Monitor and record patient's vital signs every 15 minutes for 30 minutes to one hour post-vaccination.
2. Play DOH videos and provide information to the vaccinee during the observation period.
    a. Instruct the vaccinee on possible adverse reactions and when, how, and where to report if he/she manifest signs and symptoms.
    b. Provide information on post-marketing surveillance.
3. Observe the patient and watch out for any symptoms of shortness of breath, syncope and anaphylactic reaction, or any reaction as stipulated by the manufacturer.
4. Respond and give first aid to vaccinee for possible AEFI/AESI.
5. Refer vaccinee to hospital for further management needed.

Infection Prevention and Control (IPC), Injection Safety, Management of Health Care Waste and Reverse Logistics

All throughout the implementation phase, infection prevention and control measures must be practiced. Table 32 shows minimum standards for IPC that must be practiced during the vaccination.

Table 31. Minimum infection prevention and control measures during COVID-19 vaccine administration

Aspect of vaccine administration	*Minimum IPC measures*
Vaccination post	● Open or well-ventilated areas ● Frequently disinfected areas ● Spacious enough to implement physical distancing, crowd control measures ● Limit number of vaccinees within the vaccination area to <24 individuals at a given time.
Vaccination Team and Composite Team, and other personnel in the vaccination site	● Wear face mask and face shield ● Practice hand hygiene before and after procedure/vaccine ● Limit contact between vaccinator and vaccinee to less than 15 minutes ● Daily self-monitoring for COVID-19 symptoms ● Log-in upon entering and exiting a vaccination area on a daily basis
Vaccinees	● Wear face mask and face shield ● Frequently practice hand hygiene ● Abide to physical distancing guidelines

Injection Safety

In addition to the IPC measures, injection safety must also be ensured during the vaccination. Injection safety is the safe handling of all injection equipment, routine monitoring of the availability and use of safe injection equipment and correct disposal of contaminated injection equipment.

The following injection safety guidelines shall be implemented:

1. Follow proper infection control practices and maintain aseptic technique during the preparation and administration of vaccines (e.g., perform hand hygiene).
2. Never administer vaccines from the same syringe to more than one patient, even if the needle is changed.
3. Never enter a vial with a used syringe or needle.
4. Do not use vaccines packaged as single-dose or single-use for more than one patient.
5. After use, immediately put syringes and needles in a puncture-proof sharps container.
6. Close safety boxes when they are ¾ full and lock boxes in a secure area.
7. Know how syringes are stored and destroyed at your facility.

Disposal of Immunization Wastes

Wastes generated at the health care facilities after vaccination may pose harm and risks to the health care workers and communities if not properly managed. Health Care Waste Management (HCWM) is a process that helps in ensuring the proper management of health care waste from the point of generation until disposal.

Department of Environment and Natural Resources (DENR) AO 2013-22 categorized health care waste under the following subclassifications of miscellaneous wastes (Class M):

- Pathological or Infectious Waste (Waste No. M501)
- Pharmaceuticals and Drugs (Waste No. M503)

Understanding the health care waste management system, in general, requires proper planning and implementation of managing wastes generated in the nationwide COVID-19 vaccination, considering the complexity of the nature of the vaccines. Proper handling, storage, collection and disposal of the wastes shall be followed to ensure protection of the environment and the general public.

The health care facility or implementing unit shall identify personnel as part of the COVID-19 Vaccine Waste Team. The existing HCWM Committee of the health facility may also serve as the Team. The Team shall develop a COVID-19 Waste Vaccination Plan and implement the said plan. The plan shall include activities, resources needed, including budget, responsible person/s or unit/s, and timelines. The Team shall be responsible that the vaccinators follow the guidelines on the proper segregation or sorting, handling and disposal of the waste. The Team shall ensure that all collected wastes in the temporary storage areas of the HCF are properly collected and disposed either on-site or offsite.

The COVID-19 vaccination may generate the following types of waste:

1. Hazardous wastes: these include the contaminated sharps such as syringes and needles, infectious empty vials, and blood soiled cotton
2. Non-hazardous wastes: the plastic wrapper, paper and cotton.

Guidelines on waste segregation and management are as follows:

1. Proper segregation of the waste at source or onsite shall be strictly followed.
2. Sharps such as syringes and needles shall be placed in a safety collection box for temporary storage onsite and fill with chemical disinfectant when ¾ full.
3. Empty vaccine vials and used syringe barrels shall be considered infectious. The wastes shall be placed in a separate waste bin lined with yellow plastic bad and with cover.
4. Both bins and plastic liners shall be preferably of the same color for the type of waste intended to be placed. This is to avoid confusion and poor segregation.
5. The recommended thickness of the plastic liners is 0.07 mm (ISO 7765 2004). Plastics used for either containers or bags should be chlorine-free. Not all plastic bags can withstand temperatures of 121ºC, and some can melt during an autoclave process.
6. Proper tagging of plastic liners before placing on the waste bin is to be strictly implemented. The tag of the plastic liner shall indicate the following: a) name of the

health care facility or implementing unit; b) area of the health care facility or implementing unit where the waste was generated (or the source); c) type of waste and the weight and date of collection on-site, or date and time of closure of the container; and d) name of the person filling out the label.

7. Containers should be large enough for the quantity of waste generated at that location during the period between collections;
8. All filled waste containers shall be collected only by designated staff and brought to the temporary storage area of the health care facility or implementing unit. The collected plastic container shall be tied tightly.
9. All non-hazardous wastes shall be placed in separate waste bins together with the general waste.

Guidelines on waste collection and transport are as follows:

1. The collection and transport practices shall be designed to achieve an efficient movement of waste from point of generation to storage or treatment while minimizing the risk to the personnel.
2. The general service personnel shall be assigned for the collection of wastes from the waste bins going to the on-site storage area of the health care facility or implementing unit.
3. Infectious and general waste should be collected daily (or as frequently as required).
4. Waste bags should be filled to no more than three-quarters full. Once this level is reached, they should be sealed ready for collection. Plastic bags should never be stapled but may be tied or sealed with a plastic tag or tie.
5. Sharp containers should be collected when three-quarters full.
6. Upon waste collection, the personnel must ensure that the waste bags and containers are properly labeled.
7. Replacement bags or containers should be available at each waste collection location so that full ones can immediately be replaced.
8. Transport of the collected waste must be done using wheeled trolleys/carts or wheeled bins.
9. Hazardous and non-hazardous waste should always be transported separately.
10. Infectious waste can be transported together with used sharps wastes.
11. The trolleys shall be disinfected after every use.
    a. Can be cleaned and disinfected daily using 4-5% concentration of sodium hypochlorite (NaClO).

Guidelines on central storage are as follows:

1. All collected and transported waste materials shall be stored in the designated central storage area of the health care facility.
    a. There shall be separate storage area for hazardous and non-hazardous wastes.
2. Hazardous waste should always be stored in enclosed rooms.
3. The storage place must be identified as an infectious waste area by using the biohazard sign.

Guidelines on treatment and disposal systems. The following options for treatment and disposal of all hazardous waste during vaccination may be applied:

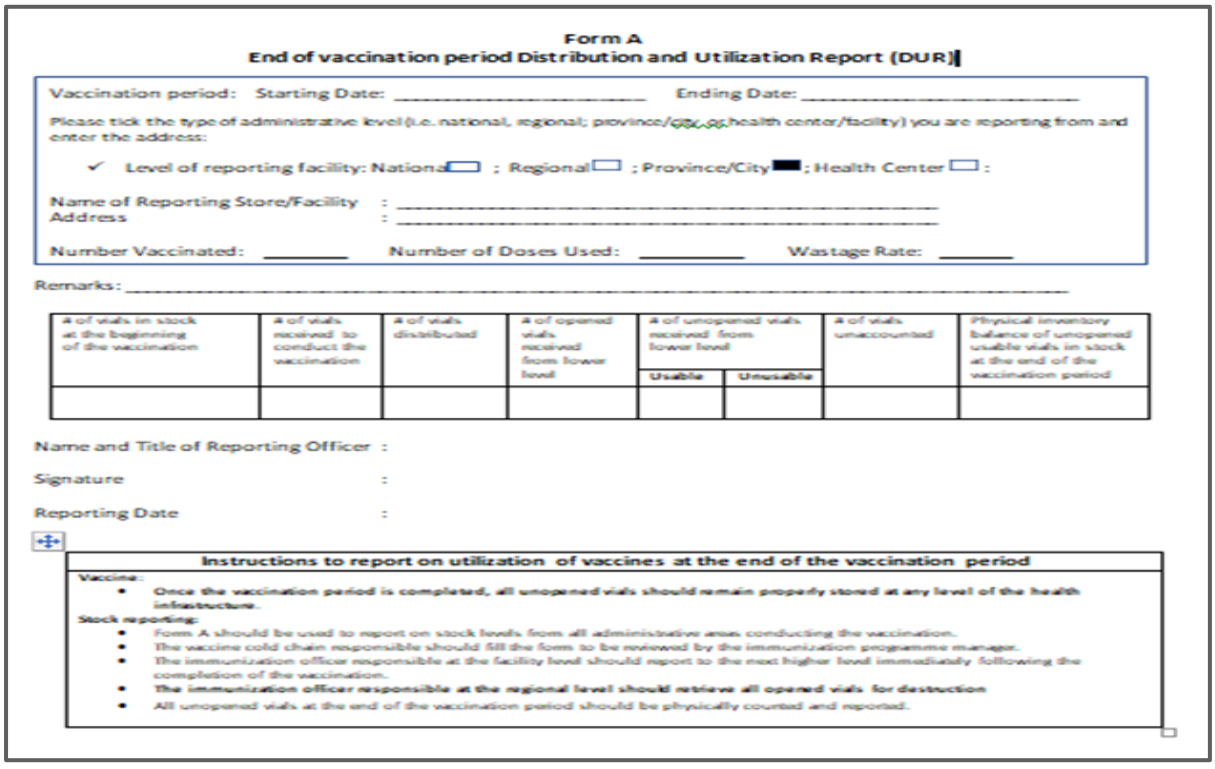
a. Onsite system. The health care facilities or implementing units may construct concrete vault within its premises to serve as the final disposal for the syringes and vials. The vault must be constructed of concrete walls and slabs with a minimum size of 1m X 1m X 1.8m.
b. Offsite system. The health care facilities or implementing units may avail the service of a DENR-accredited waste transporter to transport all the hazardous waste generated during the vaccination to the final treatment and disposal facility.

Lastly, the estimated volume or amount of waste generated particularly the hazardous waste must be recorded.

Reverse Logistics

The following are reverse logistics guidelines:

1. Empty and unopened vials should be returned daily by the Vaccination Team to the implementing unit or RHU/CHO for consolidation.
2. At the end of each vaccination period, accounted empty/opened vials should be kept in a safe and secured place in the health facility.
3. Unopened usable vials should remain stored at required temperature.
4. Properly accomplish Form A to await pick up by the CHD for destruction.



Form A
End of vaccination period Distribution and Utilization Report (DUR)

Vaccination period: Starting Date: _____ Ending Date: _____

Please tick the type of administrative level (i.e. national; regional; province/city; or health center/facility) you are reporting from and enter the address:

✓ Level of reporting facility: National ☐ ; Regional ☐ ; Province/City ■ ; Health Center ☐ :

Name of Reporting Store/Facility : _____
Address : _____

Number Vaccinated: _____ Number of Doses Used: _____ Wastage Rate: _____

Remarks: _____

# of vials in stock at the beginning of the vaccination	# of vials received to conduct the vaccination	# of vials distributed	# of opened vials received from lower level	# of unopened vials received from lower level		# of vials unaccounted	Physical inventory balance of unopened usable vials in stock at the end of the vaccination period
				Usable	Unusable		

Name and Title of Reporting Officer :

Signature :

Reporting Date :

Instructions to report on utilization of vaccines at the end of the vaccination period

Vaccine:
- Once the vaccination period is completed, all unopened vials should remain properly stored at any level of the health infrastructure.

Stock reporting:
- Form A should be used to report on stock levels from all administrative areas conducting the vaccination.
- The vaccine cold chain responsible should fill the form to be reviewed by the immunization programme manager.
- The immunization officer responsible at the facility level should report to the next higher level immediately following the completion of the vaccination.
- **The immunization officer responsible at the regional level should retrieve all opened vials for destruction**
- All unopened vials at the end of the vaccination period should be physically counted and reported.

Figure 16. Form A: End of vaccination period distribution and utilization report.

Computation and Terms

1. Calculate vaccine wastage rate: (number of vaccine doses used - number of eligible population) / number of vaccine doses used x 100 = vaccine wastage rate (%)
2. "Vaccine doses used" includes doses used for immunization and all doses discarded or lost for any reason (including expiry, indication of heat exposure, missing inventory, cold chain failure, freezing or discarding of open vials of vaccine at the end of a session or campaign activity).
3. The wastage rate is the percentage of vaccine doses that are wasted - in other words, doses that are not used for immunization and are discarded or lost for any reason.

Retrieval of vials from the field

1. The vaccination team should return vials in re-sealable plastic bags (a maximum of 20 vials per resealable plastic bag).
2. Supervisors should count collected empty vials at the end of vaccination day.
3. Empty vial retrieved should be well accounted and documented.

Vials accountability

Unaccounted vials should be:

1. reported to the supervisor.
2. reason/s for the unaccountability should be stated.
3. investigated with the support of the LGUs.
4. Incident report should be prepared and endorsed by the following: NIP, RHU, LGUs and submitted to overseeing VOC.

Disposal of COVID-19 vaccine vials

These are the basic principles:

1. A detailed vial collection and destruction plan should be developed.
2. Destruction of the vials should be in accordance with national regulations.
3. Used/opened vials should be inactivated prior to destruction. The recommended methods are:
    a. Inactivation by autoclaving, boiling, chemical inactivation, encapsulation or incineration.
    b. Destruction and disposal by transporting to the waste facility or burying.

Chapter 7: Assessment, Evaluation and Monitoring

The post-implementation phase starts right after the first dose of vaccine is administered. This phase has two components: the AEFI surveillance and response, and pharmacovigilance.

Vaccine Safety Monitoring, and Management of Adverse Events Following Immunization

The role of vaccine safety monitoring during COVID-19 vaccine introduction is to facilitate the early detection, reporting, notification, investigation and analysis, and feedback of Adverse Events Following Immunization (AEFIs) and Adverse Events of Special Interest (AESI), to ensure appropriate and timely case management and response. These activities shall assist vaccinees and ensure them of prompt and timely response should an AEFI occur.
The AEFI surveillance entails:

- Timely detection of serious AEFIs/AESIs to provide up-to-date and accurate data that can be shared with relevant stakeholders for appropriate response;
- Generation of data to characterize the safety of the COVID-19 vaccines in use;
- Identification, investigation, assessment and validation of safety signals and recommendation of appropriate public health interventions or other interventions; and
- High quality safety surveillance and maintenance of public and stakeholder confidence in vaccines and immunization

The WHO defines *Adverse Event Following Immunization* (AEFI) as any untoward medical occurrence which follows immunization, and which does not necessarily have a causal relationship with the usage of the vaccine. If not rapidly and effectively dealt with, AEFIs can undermine confidence in a vaccine and ultimately have dramatic consequences for immunization coverage and disease incidence. Based on consultations with experts and the latest data from published clinical trials as of 16 January 2021, the following are the identified AEFI from various brands of COVID-19 vaccination and must be reported.

Table 32. List of Adverse Events Following COVID-19 Vaccination of Selected Candidate COVID-19 Vaccine.

Manufacturer	*University of Oxford and Astrazeneca*						*BioNTech and Pfizer*	*NIAID and Moderna*	*Novavax*		
*Adverse Events**											
Age	18-55		56-69		>70+			>18			
									Mild	Moderate	Severe
Pain at injection site	75%	64%	63%	54%	34%	22%	84.1%	92.0%	45% 39%	0% 12.5%	0%
Redness	7%	11%	12%	12%	11%	11%	9.5%	10.0%	0%	0%	0%
Swelling	7%	7%	12%	12%	14%	14%	10.5%	14.7%	0%	0%	0%
Tenderness	87%	75%	83%	76%	64%	62%		19.8%	36% 45.8%	16% 29.2%	0% 4.2%
Warmth	27%	25%	22%	32%	27%	14%					
Itch	14%	25%	22%	18%	14%	11%					

Induration	7%	7%	12%	12%	11%	11%							
Feverish	58%	22%	27%	32%	22%	20%							
Fever	39%	7%	12%	12%	7%	7%	14.2%				15.5%	4.2%	
Chills	50%	27%	27%	27%	14%	7%	31.9%				45.4%		
Joint Pain	48%	17%	35%	36%	27%	20%	23.6%				46.4%	8.0%	4.2%	8.3%
Muscle Ache	67%	52%	56%	44%	32%	32%	38.3%				61.5%	24% 37.5%	8% 8.3%	- 8.3%
Fatigue	87%	69%	69%	61%	56%	48%	62.9%				70%	28% 25%	12% 16.7%	0% 8.3%
Headache	78%	45%	69%	54%	56%	34%	55.1%				64.7%	28% 41.7%	4% 16.7%	4% -
Nausea/ Vomiting	41%	20%	31%	40%	20%	17%	1.1%				23%	12.5%	4%	
Diarrhea							11.1%	10. 4%	8.2%	8.3%				
Need for antipyretic							27.8%	45. %	19.9%	37.7%				
Malaise	56%	43%	46%	27%	39%	25%	0.5%					20% 12.6%	8% 16.7%	0% 8.3%

Manufacturer	*University of Oxford and Astrazeneca*	*BioNTech and Pfizer*	*NIAID and Moderna*	*Novavax*
Serious Adverse Events Event-based*	0.7% (84/12021)	0.4% (n=10841) 18-55 0.8% (n=7960) >55	1.0% (n=147)	
	haemolytic anaemia in the control group Neuroinflammatory disorders Transverse myelitis which is likely to be idiopathic, short segment, spinal cord demyelination Fever higher than 40°C Deaths Road traffic accident, blunt force trauma, homicide, and fungal pneumonia	*<u>Related to vaccine:</u>* ● 1 Lymphadenopathy ● 1 Shoulder injury due to incorrect administration ● Unsure ● Appendicitis ● Facial paralysis (Bell's palsy) ● G51.0 7,400 ● Ventricular arrhythmia ● I47.0 12,200 ● pain in the lower back/extremities/and radicular paraesthesia *<u>Coincidental</u>* *Active group* ● 1 Anaphylactoid reaction (related to bee sting) ● 1 Drug hypersensitivity (doxycycline) ● T78.2 Anaphylaxis 7600 *Placebo group* ● 1 Anaphylactoid reaction due to ant bite ● 16-17 years old ● 1 facial bone fracture ● Deaths ● 7 deaths (2 active 4 placebo) ● Due to pre-existing diseases including aortic rupture	● Lymphadenopathy 1.1% ● Hypersensitivity:1.5% (injection site rash and injection site urticaria) ● 3 cases of Bell's palsy ● Facial swelling ● Intractable nausea and vomiting in a participant with prior history of severe headache and nausea requiring hospitalization.	
Special population	Elderly: safety data limited in >65, no dosing adjustments Pediatric: no data available	● Pregnancy: very limited ● Elderly: no specific safety concern ● Immunocompromised: on stable ART for 6 months, ● Pediatric: limited participants	● For use in individuals 18 years of age and older ● Elderly >65 ● No notable differences in the safety profiles	

As can be seen on the table above, the AEFIs are divided into two groups. Minor AEFIs are local or systemic signs and symptoms that easily resolve within a few days without medical intervention and do not pose a potential risk to the health of the vaccinee. On the other hand, serious AEFIs are events that cause a potential risk to the health/life of a vaccinee leading to hospitalization, disability/ incapacity or death. A thorough investigation and retrieval of medical records are critical to determine whether the adverse event has been caused by the vaccine, immunization error or from programmatic errors.

In addition to AEFIs, Adverse Events of Special Interest (AESIs) arising from COVID-19 vaccination must also be reported. The Council for International Organizations of Medical Sciences (CIOMS) VII defines AESI as a scientific and medical concern specific to the sponsor's product or program, which can be serious or non-serious, and for which, ongoing monitoring and rapid communication by the investigator to the sponsor could be appropriate. Such an event might require further investigation in order to characterize and understand it. Depending on the nature of the event, rapid communication by the trial sponsor to other parties (e.g. regulators) might also be warranted. While AESIs are also considered important in surveillance and response, the STG has yet to formalize the list of AESIs that are deemed reportable. The following are AESIs being considered:

Table 33. Adverse Events of Special Interest relevant to COVID-19.

Body System	Diagnoses
Immunologic	Enhanced disease following immunization, cytokine release syndrome related to COVID-19 disease†, multisystem inflammatory syndrome in children (MIS-C)
Respiratory	Acute respiratory distress syndrome (ARDS)
Cardiac	Acute cardiac injury including: • Microangiopathy • Heart failure and cardiogenic shock • Stress cardiomyopathy • Coronary artery disease • Arrhythmia • Myocarditis, pericarditis
Hematologic	Coagulation disorder • Deep vein thrombosis • Pulmonary embolus • Cerebrovascular stroke • Limb ischemia • Hemorrhagic disease • Thrombotic complications
Renal	Acute kidney injury
Gastrointestinal	Liver injury
Neurologic	Guillain Barré Syndrome, anosmia, ageusia, meningoencephalitis
Dermatologic	Chilblain-like lesions, single organ cutaneous vasulitis, erythema multiforme

* COVID-19 disease manifestations associated with more severe presentation and decompensation with consideration of enhanced disease potential. The current listing is based on Safety Platform for Emergency Vaccines (SPEAC) D2.3 Priority List of Adverse Events of Special Interest: COVID-19.[5]

† Cytokine Release Syndrome related to COVID-19 disease is a disorder characterized by nausea, headache, tachycardia, hypotension, rash, and/or shortness of breath.[6]

In the context of the COVID-19 vaccination program, any health event that has occurred after vaccination must be reported and considered as AEFI, pending proper professional consultation/case classification.

AEFI surveillance shall be performed by the Surveillance Officer (stimulated passive surveillance) every two (2) weeks for the first two (2) months, then monthly for one year. This is to ensure that no health event relevant to COVID-19 shall be experienced by the recipient per incubation period of the disease.

Passive surveillance requires empowering and reinforcing the vaccinee to report any health event post-vaccination. There are two advantages to passive surveillance: 1) it may lower healthcare system burden since minor cases are catered by lower level health facilities, while

higher level health facilities concentrate on treating serious AEFIs only, 2) the detection and reporting of all AEFIs, especially minor ones, will allow greater chance of detecting minor clusters of AEFIs, which will, in turn, be reported as part of global knowledge on vaccines.

Figure 17 shows the process flowchart for AEFI surveillance and response for COVID-19 vaccination. Following vaccination, the Surveillance Officer shall follow-up the vaccinee, and rematch him/her with his/her pre-existing conditions. If the Surveillance Officer identified additional findings, he/she shall provide immediate appropriate treatment and facilitate transfer to an identified referral facility, if necessary. If there are no additional findings, he/she shall check for AEFIs and classify the vaccinee as one of the following: (1) well (no AEFI), (2) minor AEFI and (3) serious AEFI.

In addition, the vaccinee can also report his/her signs and symptoms (self-reporting) by, a) calling the VOC Call Center, b) filing a report to FDA through the pharmacovigilance system or directly to the vaccine manufacturer, or c) reporting online (a system, similar to the of COVIDKaya, shall be set up). These mechanisms shall be aligned with the masterlisting and profiling data to ensure continuity of data and harmonization through the overarching Vaccine Information Management System (VIMS).

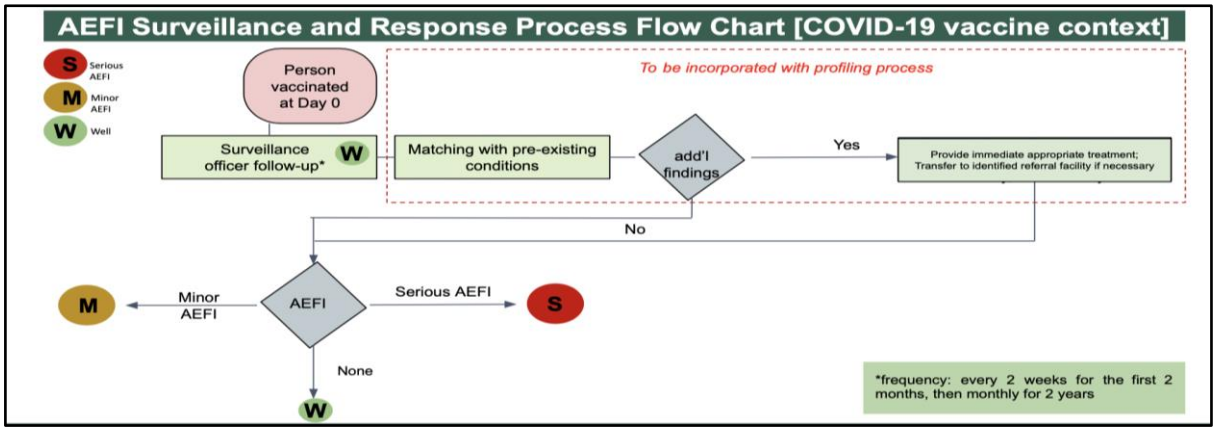


Figure 17. Process flowchart for AEFI surveillance and response in the context of COVID-19 vaccine administration.

The Surveillance Officer, as part of the AEFI/AESI Composite Team assigned in the post-vaccination monitoring area, shall provide information to the vaccinee on existing procedures and protocols in identifying and reporting AEFIs, especially serious cases.

For the routine follow-up for the vaccinee, the Surveillance Officer shall be stationed in the facility as part of the Human Resource/Administrative Department of the facility equipped with the necessary information communication technology equipment for performing its follow-up function to vaccinees. Methods of following up may be stratified phone calls, facility announcements/ memorandums, through notes upon receipt of documents/salary papers by the facility, etc.

For minor AEFIs detected through self-report or SSO assessment, QR code verification must be done by the responsible health facility. If the vaccinee with minor AEFI was deemed in need of medical assistance, he/she must be promptly referred to the identified health facility for

management. If there is no need for medical assistance, he/she must be given medical advice, followed by an updating of the QR profile (Figure 18).

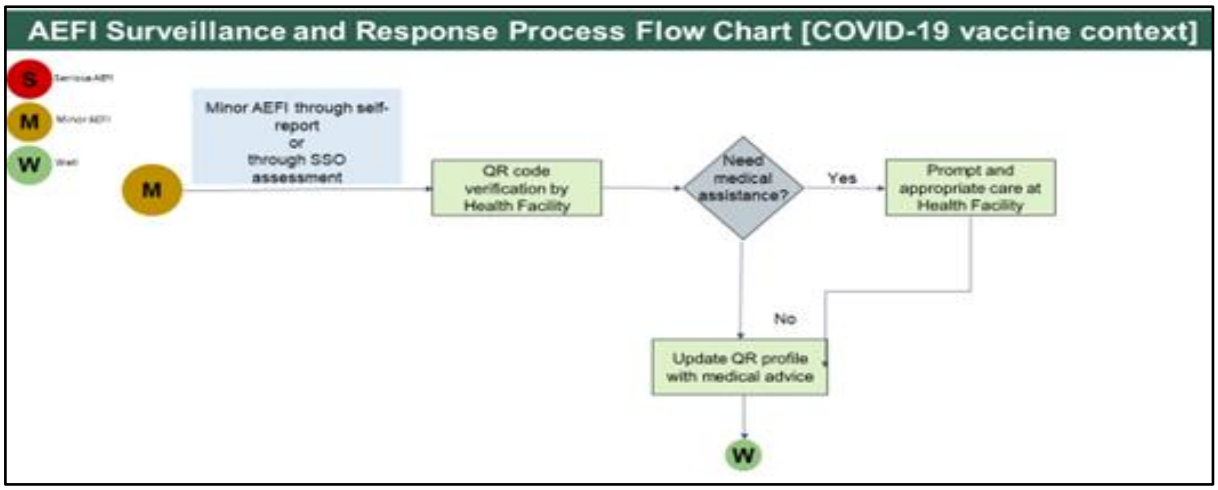


Figure 18. Process flowchart for responding to minor AEFIs of COVID-19 vaccine.

Serious AEFIs should further be investigated and reported through the Event-based Surveillance Reporting System. All serious AEFIs must be given prompt and appropriate care at a health facility, followed by investigation of the case and submission of data to the AEFI database. During investigation, initial causality assessment shall be done by the Regional AEFI Committee (RAEFIC). Based on this assessment, the final causality assessment shall be done by the National AEFI Committee (NAEFIC). Based on the final cause determined, the NAEFIC shall provide recommendations to the Epidemiology Bureau, Food and Drug Administration, National Immunization Program and Centers for Health Development for appropriate action. Response at the regional level shall also be assisted by the National AEFI Response Team. If the vaccine recipient does not recover and dies, further investigation of the death shall be conducted (Figure 19).

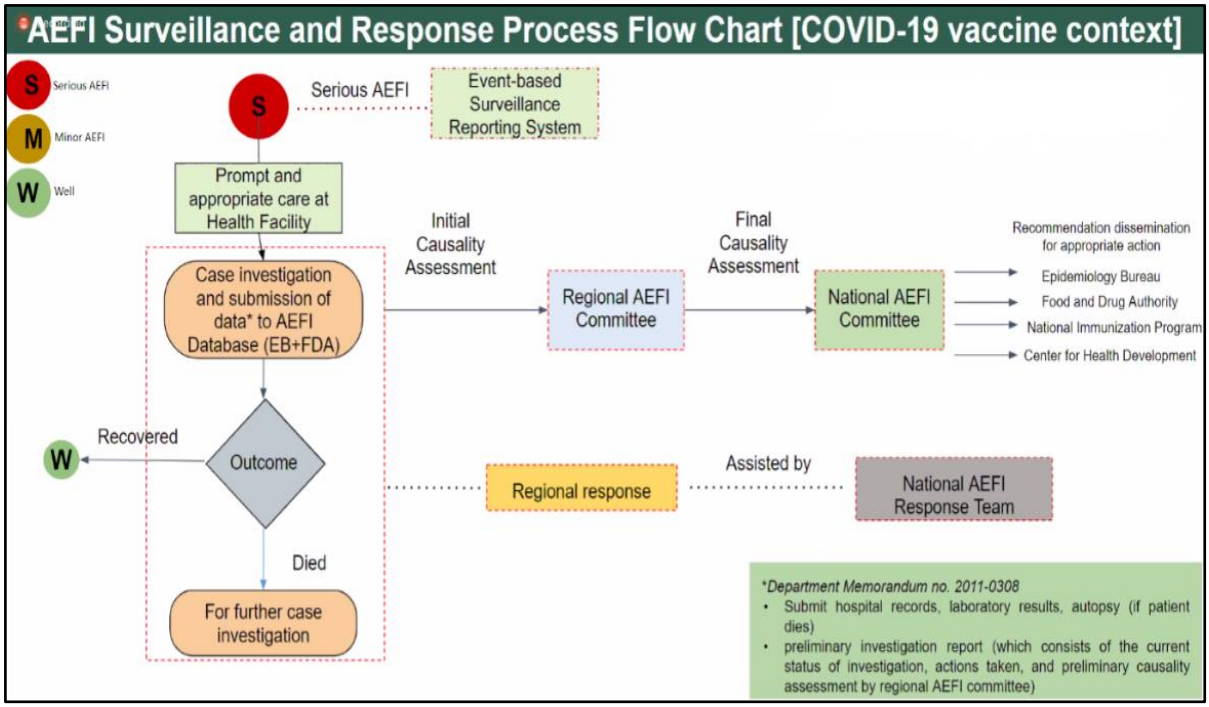


Figure 19. Process flowchart for responding to serious AEFIs of COVID-19 vaccine.

Additionally, the WHO recommends safety surveillance activities for all countries introducing COVID-19 vaccine, regardless of AEFI surveillance capacity. These are summarized in Table 35 below.

Table 34. WHO-recommended safety surveillance activities for all countries introducing COVID-19 vaccine regardless of AEFI surveillance capacity.

Objective	*Recommended AEFI surveillance activities*
Strengthen routine passive AEFI surveillance reporting systems for the management of increased frequency or severity of AEFI reports (mild, moderate and severe)	● Conduct training on identification and reporting of AEFI for health care professionals. ● Update, print and distribute AEFI surveillance tools. ● Use both vaccine tracking information and passive AEFI reporting information to perform vaccine-specific safety analyses. ● Review and adapt processes for timely reporting, review and data sharing nationally, regionally and globally (e.g. uploading data to global databases such as the WHO VigiBase) ● Develop clear standard operating procedures (SOPs) for the coordination process between the NRA, NIP/EIP, and other institutions with responsibilities for AEFI surveillance. ● Consider coordination of activities with Public Health Emergency Units. ● Consider setting up AEFI committees at subnational as well as national level, particularly in large countries
Investigate potential AEFIs causing concern, such as clusters, serious events, programmatic errors, community concerns	● Prepare investigation teams and train them for AEFI investigation activities that are relevant in the population being vaccinated. ● Update, print and distribute AEFI investigation tools to obtain information on specific outcomes. ● Ensure the collection and storage of all relevant data to help make a causality assessment (AEFI reporting and investigation forms, clinical case record, laboratory reports, autopsy reports, etc.)

Perform systematic causality assessment of AEFIs causing concern	● Constitute an National AEFI committee to review and respond to AEFI safety signals and public concerns or contact the WHO Country or Regional Office or send email to gvsi@who.int for assistance. ● Provide training on causality assessment processes using WHO causality assessment guidelines for members of the National AEFI committee. ● Ensure regular updates to the Committee members on COVID-19 vaccine development and safety data, including safety reports from ongoing phase III clinical trials or any events reported in clinical trials. ● Foster and use the committee's expertise to identify AEFI cases in need of further investigation, such as AESIs. 5. Anticipate an increased number of AEFI reports that will need to be reviewed and consider including AEFI committees at subnational as well as national level, particularly in large countries.
Use AEFI and disease surveillance data to detect potential safety signals or clustering of events	● Regularly review and report AEFI surveillance data, particularly those relevant to AESIs or other conditions identified during pre-licensure COVID-19 vaccine clinical trials. ● Explore the use of disease surveillance data to complement AEFI surveillance systems for the detecting of AESIs, if indicated. ● Consider use of early signal detection methods, especially for certain AESIs.
Prepare comprehensive plans to respond rapidly to any COVID-19 vaccine-related event	● Outline roles and responsibilities of key stakeholders (including the private sector) for the implementation of safety surveillance activities and responding to vaccine-related events. ● Keep stakeholders up to date with COVID-19 vaccine safety information. ● Communicate with WHO regions and globally and share data on outcomes of AEFIs and AESIs in a rapid, timely and regular manner.
Address concerns of healthcare professionals and maintain community confidence. (Link to communication module to be added)	● Create and share a COVID-19 vaccine safety communication plan with relevant stakeholders. ● Train and support personnel at all levels to address concerns that may arise before, during and after COVID-19 vaccine introduction. ● Develop, print, and distribute messages concerning the safety COVID-19 vaccines

Note: Objectives and Recommendations were adapted from the WHO COVID-19 Vaccines Safety Surveillance Manual: Module on Establishing surveillance systems in countries using COVID-19 vaccines, 2020.

Serious AEFIs and AESIs are events that result in death, are life-threatening, require in-patient hospitalization or prolongation of existing hospitalization, result in persistent or significant disability/incapacity, or cause congenital anomalies or birth defects. If serious AEFIs or AESIs occur, all documentation generated during the management of the event, including hospitalization, should be appended to the investigation form and submitted as a dossier to the NAEFIC for causality assessment. The risk communication team should be made aware of the occurrence as soon as possible.

Specific protocols for investigating deaths following COVID-19 vaccination shall be defined. Guidance on investigating deaths following vaccination are provided in the global guidelines on AEFI surveillance. Deaths of individuals who received COVID-19 vaccines, including those classified as AESI, shall be included in the protocol for investigating deaths following COVID-19 vaccination.

Coordination with stakeholders reporting COVID-19-related deaths as well as COVID-19 vaccination-related deaths should be established. Protocols that were developed for investigating COVID-19 related deaths could be adapted in the investigation of COVID-19 vaccination related deaths. If indicated, tissue samples should be collected for in-depth pathologic, virologic and genetic testing. If an autopsy is not done, a complete verbal autopsy using standard protocol should be conducted and the findings documented and sent to the national AEFI committee.[5]

Safety Surveillance and Response

Enabling Policies and Guidelines

The guiding principles for Safety Surveillance and Response is based on the World Health Organization (WHO) Strategic Advisory Group of Experts on Immunization (SAGE) Values Framework for the Allocation and Prioritization of COVID-19 vaccination published last September 2020.

Existing policies for AEFI surveillance and response such as Administrative Order (AO) No. 2016-0006, or the *Revised Guidelines on Surveillance and Response to Adverse Events Following Immunization* details the general and specific guidelines on performing AEFI surveillance and response. For case management and support, AO No. 2016-0025, or the *Guidelines on the Referral System for Adverse Events Following Immunization (AEFI) of DOH Programs* can be used as reference. Furthermore, the AEFI Manual of Procedures published last 2014 by the DOH provides the overall operational guidelines for AEFI surveillance and response.

Other supportive administrative issuances include the following:

(1) Department Memorandum (DM) No. 2011-0308, or the *Strengthening Adverse Events Following Immunization (AEFI) Surveillance and Response at all levels* (Annex 7-D) is an important policy prior to the Data Privacy Act of 2013. The policy requires health facilities to submit all medical records of those referred for AEFI cases. However, the DM requires amendment and alignment with RA 11332, or the *Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act* and its *2020 Revised Implementing Rules and Regulation* wherein AEFI is listed as one of the immediately notifiable diseases were notification is required at all levels within 24-48 hours upon identification and detection.

(2) DM 2020-0459 or the *Reiteration on the Implementation of AO No. 2016-0006, and AO No. 2016-0025,* reiterated the role of DOH EB and its regional counterparts on AEFI surveillance.

Restructuring of the National AEFI Committe*e* through DPO No. 2020-2996 as an independent expert panel for causality assessment of serious AEFI cases. The NAEFIC members include

[5] Adapted from WHO COVID-19 Vaccines Safety Surveillance Manual: Module on Establishing Surveillance Systems in countries using COVID-19 vaccine

pediatric infectious diseases experts, vaccinology experts, forensic pathology experts, immunologist and allergologist among others. Technical resource persons can also be invited (e.g. adult infectious disease experts).

To support the NAEFIC, the National AEFI Response Team through DPO No. 2020-2772 was created with the composing of the following: EB, DPCB, FDA, HPB, RITM, HEMB.

Regulatory provisions requiring manufacturers to implement risk management plans and collect and report COVID-19 vaccine safety data to the NRA

The Risk Management Plan (RMP) provides a detailed description of the risk management system for a certain product. It is a set of pharmacovigilance activities and interventions designed to identify, characterize, prevent or minimize risks relating to pharmaceutical products including the assessment of the effectiveness of those interventions.

Before a drug product is authorized, the FDA requires submission of the Risk Management Plan (RMP) as part of the company's obligation on the use of their product. Specific pharmacovigilance requirements and obligations are stipulated in FDA Circular No. 2020-003 *Guidelines for Pharmaceutical Industry on Pharmacovigilance*.

The RMP contains important information with regards to the safety of the product such as product overview, safety specification (important identified risk, important potential risk and missing information), the proposed pharmacovigilance plan, and proposed risk minimization measures. Routine pharmacovigilance activities include collection and reporting AEFI to the FDA, signal detection and updating of significant information as well as reporting action taken by other regulatory agencies in other countries. Other than routine is an additional pharmacovigilance activity which may include non-clinical studies, clinical trial or non-interventional studies aiming to further identify and characterize the risks of the product.

For the purpose of transparency and risk minimization, the summary of the RMP and its updates may be uploaded in the FDA website as reference in immunization programs. The FDA shall ensure availability of these information. Information related to the risk of vaccines shall be coordinated to the TG for Demand Generation and Communication for proper communication and dissemination. Dissemination fora shall be scheduled in order to inform all relevant stakeholders on the prerequisites and foreseen processes related to risk management plans.

Any other policies deemed necessary in order to properly implement the COVID-19 vaccine immunization plan will be developed and crafted in relation to AEFI surveillance and response.

As part of the preliminary regulatory measure, the FDA Circular 2020-036 on the *Guidelines on the Issuance of Emergency Use Authorization for Drugs and Vaccines for COVID-19* stipulated the need of the market authorization holder to have a comprehensive pharmacovigilance system for their product following the system or protocol of a registered

drug or biological product which includes assistance to the national initiatives on AEFI surveillance and response system.

AEFI Surveillance Cycle

In order to contextualize the operational guidelines from AEFI to have a special focus on COVID-19 vaccination, the components of the AEFI Surveillance Cycle based on the World Health Organization (Figure 13). Guidance for establishing AEFI surveillance systems shall be illustrated for the succeeding activities.

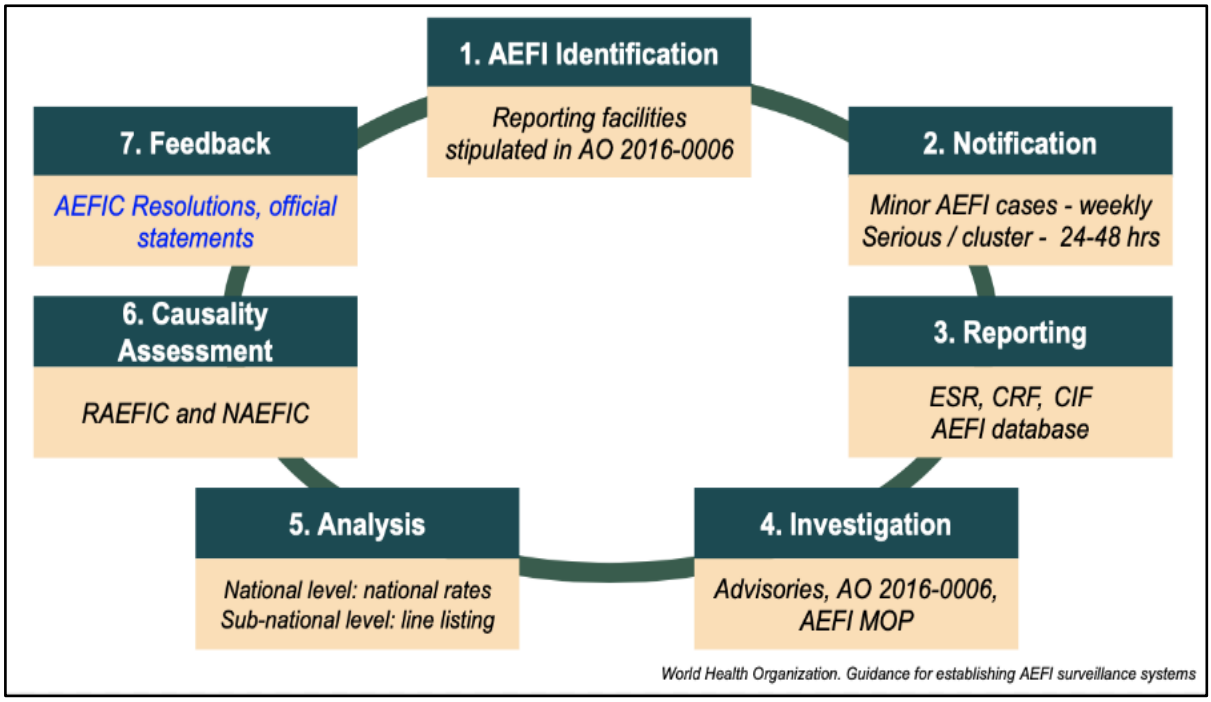


Figure 20. AEFI Surveillance Cycle.

Table 35. The AEFI Surveillance Cycle components.

AEFI Surveillance Cycle components	*Main points*
1. Identification	• Health care providers, vaccinators and personnel from the field • Individuals who received the vaccination • Researchers, sponsors, investigators and laboratories involved in clinical studies or field trials • Vaccine manufacturers and distributors
2. Notification	• Minor AEFI cases reported weekly to the higher ESU level. (shift to daily for COVID-19 vaccine)

	● Serious AEFIs and clusters of minor AEFIs are reported within 24 to 48 hours simultaneously to higher level ESUs and the EB for case investigation.
3. Reporting	● Minor AEFI through Case Report Form and Vigiflow ● Serious AEFI through Case Investigation Form and Vigiflow
4. Investigation	● Only serious AEFI and clusters of minor AEFIs needed to be investigated ● SOP on handling Serious AEFI cases needed to be filled up and submitted to EB as soon as possible ● Case Investigation Form within 24-48 hrs
5. Analysis	● Daily bulletin
6. Causality Assessment	● All serious AEFI cases or clusters of minor AEFI should have comprehensive AEFI investigations and for endorsement to RAEFIC and forwarded to NAEFIC ● For those regions without RAEFIC, AEFIs are forwarded directly to NAEFIC for causality assessment
7. Feedback	● All final resolutions shall be issued by the NAEFIC ● RAEFIC resolutions shall be based on the approved official documents of NAEFIC for dissemination ● Risk communication before, during, and after AEFI cases shall be made. ● Post-incident evaluation shall be spearheaded by RAEFIC. ● CHDs to monitor and evaluate RAEFIC / NAEFIC recommendations

In line with the components of the AEFI Surveillance Cycle: *AEFI identification* relies on the ability and initiative of AEFI reporting units/facilities to proactively identify AEFI whether it would be a minor or serious case. With this, a series of orientation sessions and refresher courses on vaccinators and officers in disease reporting units shall be informed that any health event that has occurred after vaccination must be reported and considered as AEFI pending proper professional consultation/case classification. In line with this, training modules shall be developed including FAQs on the vaccine which will be guided by WHO partners.

AEFI notification and reporting currently has a working system in place through Event-based Reporting System wherein all AEFI cases must have an accomplished ESR form submitted to the higher level Epidemiology and Surveillance Units weekly, whereas all serious AEFI cases must be notified to all higher level ESUs and EB within 24-48 hours. Training modules shall also be developed to ensure the alignment of reporting of AEFI of a novel vaccine to the existing system.

The development of training modules shall be based on existing manuals and guidelines; the list of manuals includes the following but are not limited:

a. DOH AEFI Manual of Procedures
b. DOH Event-based Surveillance (ESR) Manual
c. DOH Philippine Integrated Disease Surveillance and Response (PIDSR)

d. WHO Causality Assessment Manual 2nd edition
e. WHO Global Safety Surveillance Manual
f. WHO COVID-19 Safety Surveillance Manual
g. WHO National Vaccine Development Program

The National AEFI Committee (NAEFIC) conducts a systematic review of data about AEFI case(s) to determine the likelihood of causal association between the event and the vaccine(s) received. The readiness of the Regional AEFI Committee (RAEFIC)s were assessed through DM 2020-0415, wherein most of the regions have functional RAEFICs. As part of the follow-up action, regions needing further technical assistance shall accomplish a needs assessment tool through DM 2020-0508.

In coordination with WHO, training materials for COVID-19 vaccination include Instructor-led and Online self-learning. Some of the materials may be accessed from:

a. WHO e-Learning Course on AEFI Investigation e-Learning course: Investigating Adverse Events Following Immunization (AEFI) (vaccine-safety-training.org)
b. Causality assessment algorithm and WHO e-tool: http://gvsi-aefi-tools.org/
c. Global Vaccine Safety – E-learning course on Vaccine Safety Basics WHO | E-learning course on Vaccine Safety Basics
d. COVID-19 technical resources: page:https://www.technet-21.org/en/topics/covid-19

AEFI Reporting uses the current Event-based Surveillance Reporting and Philippine Integrated Disease Surveillance and Response (PIDSR) reporting system. However, with the novel vaccine pressing a concern on interagency operability of current systems and data sharing, a comparative evaluation of the Excel format utilized during the Measles-Rubella-Oral Polio Vaccine Supplemental Immunization Activity (MR-OPV SIA) and VigiFlow was done (Table 36). Based on the Center for Disease Control criteria for surveillance, VigiFlow, which is currently being recognized as the global standard, managed by WHO and Uppsala Monitoring Center, shall be used as the National COVID-19 AEFI Surveillance System. Moreover, the AEFI template was recently added and training of national and sub-national level staff was already performed. Moving forward, more simulation exercises to ensure smooth usage of the VigiFlow shall be the next priority along with providing access to the determined reporting units.

Table 36. Comparative evaluation of excel format and VigiFlow.

Criteria adapted on CDC Evaluation of Surveillance Systems	*Current System (Excel Template)*	*VIGIFLOW*	*REMARKS*
Simplicity: refers to both the structure and ease of operation of surveillance system			

Ease of navigation and data entry and uploading of documents.	User friendly, simple and beginner level. Advantage is familiarity with Excel interface. AEFI excel template was based on the core variables of Case Report Form and Dengvaxia vaccine AEFI reporting template.	Fields are easy to understand. Some fields have drop-down options. There is a navigation panel for ease of jumping to specific parts of the report. MedDRA and WHO Drug coded. However, no uploading capability.	The current excel template is currently being used by the RESUs which are the main AEFI surveillance system at the moment. Navigation of VigiFlow will require additional orientation training which should be scheduled early January 2021
Feasibility of training schedule with the current timelines for COVID-19 vaccination	One training session was sufficient for RESUs to be able to submit the accomplished tool weekly	Online training (recorded) is available on the UMC website. The FDA PV team may also provide training for new users. VigiFlow Training Materials https://www.who-umc.org/global-pharmacovigilance/vigiflow/training-materials/english/	The Excel tool is self-explanatory and will not be overwhelming. Training schedules for Vigiflow must be set immediately as well as the targeted people to access VigiFlow to preserve data integrity.
Time spent with maintaining the system, collecting, transmitting, analyzing case information, and preparing and disseminating surveillance reports	Data cleaning of 50 AEFI cases (line listing and sending to regions for verification) and generating statistics as draft AEFI surveillance report takes one man day Bottleneck processes include time to verify and sending of reports by the regions and LGU level	No maintenance is necessary. Collecting and transmitting of data is real time. Reports may be downloaded into excel or pdf files.	The maintenance of the system for excel heavily relies on the national data managers. Whereas, for vigiflow, it is the accepted system in the WHO setting and global level. Familiarization and data encoding may bear more time for Vigiflow
Minimum technical requirement of the device (PC/Laptop)	Downloaded and saved into a local PC drive/laptop with Microsoft Excel application (93 version and above) for encoding.	Computer (laptop or PC) and internet connection are the minimum requirements. No local installations, back-ups or maintenance are necessary. No off-line functionality.	Main advantage of excel: off line functionality
Flexibility: observing how a system responded to a new demand			

Able to accommodate, for example, COVID-19 vaccine (novel vaccine), changes in case definitions, and variations in reporting sources	The system is adept to be incorporated to any vaccine with minimal edits on the needed variables specifically for COVID-19 vaccine. Currently limited platform for global data sharing. Used through google sheets / excel.	May be accommodated in the global level through the UMC. COVID-19 vaccine is coded into WHODrug.	Revising specific variables for COVID-19 to fit national needs is easier in AEFI excel. Data sharing for global level is already set up in Vigiflow
Acceptability: willingness of individuals and organizations to participate in the surveillance system			
Participation rates among internal and external stakeholders/partners	All the RESUs and CHDs are responsive and able to comply with the weekly submission of their accomplished Excel Templates.	Hospitals who regularly report to the FDA were given VigiFlow accounts and are already using the system in reporting. Pharmaceutical Companies have a system that generates reports in E2B xml files which are then uploaded to the VigiFlow either manually by the FDA or directly through eReporting for Industry. Health care professionals, non-health professionals & patients may report through the eReporting system.	A consensus on the national level must be built to roll out the specific database that the facilities and ESUs will use
Completeness and timeliness of reporting accompanied with seeking technical support in troubleshooting	There are only some regions that submitting complete and on time reports Data submissions of RESUs and CHDs every week then followed by data verification and validation by EB. There are incomplete and delayed submissions in some regions.	There are several fields that are needed for a report to be submitted to the VigiFlow such as the minimum mandatory information. Reports submitted are received real time by the FDA. Technical support in troubleshooting may be provided by the FDA PV Team. Real time reporting that may have pressing concerns on accurateness and accountability of data submitted.	Due to the nature of excel reporting, there are great instances wherein incomplete data are submitted. No mechanism is set to have minimum data requirements. Validation mechanism of reports submitted to FDA should be strengthened in the regional and national level.

Sensitivity: ability to be detected by the surveillance systems and to detect epidemics *Predictive value positive: proportion of persons identified as having cases who actually do have the condition under surveillance*			
Confirmation of cases reported through the surveillance systems (Event-based Surveillance Reporting and AEFI system)	The current system is cross validated with Event-based Surveillance System and RESU for confirmation of cases	Cases are presented in line list coded in MedDRA terminologies Pilot testing of the AEFI Vigiflow shall commence in January 2nd week of 2021	
Quality of data: clarity of surveillance forms, complete surveillance forms and appropriate data management			
Completeness of WHO core variable for AEFI reporting	Additional variables needed can be easily integrated in the Excel Template. Although based on the WHO core variables for AEFI, it may be tailored to fit contextual purposes	VigiFlow are made for reporting adverse reactions including adverse events following immunization. To adapt the current situation on COVID-19, UMC is currently developing the VigiFlow system to enhance the core variables for AEFI reporting. The target release of these developments is on the 2nd week of January. https://www.who-umc.org/media/165550/using-vigiflow-for-data-collection_covid-19.pdf	Vigiflow current has a Demo version specifically targeting AEFI reporting AEFI excel was enhanced to fit the HWO Core Variables for AEFI reporting
Data gathered are easily converted, merged and integrated to the platform	Manually performed by data managers	see above	Vigiflow is adept to perform data analysis of the entries In AEFI excel, the data managers and data analysis team will have to manually calculate and compute.

Able to produce meaning analysis, Evaluation, and assessment; or only with desired variable/s	Manually performed by data managers therefore able to tailor the needed analysis given that sufficient variables are present	Minimum required information is necessary to successfully save and submit a report. https://www.who-umc.org/global-pharmaovigilance/vigiflow/vaccine-surveillance-in-vigiflow/	Both platforms contain necessary variable in order to perform minimum required analysis
Timeliness: reflects the speed or delay between steps in a surveillance system			
Ability to support the 24-48 hr reporting from ESU to EB for serious/clusters of minor AEFIs	It can also supports the 24 – 48 hours reporting from ESU to EB.	Real-time submission. Once the report is saved, it is readily available for the higher levels (regional or national level) to view or edit the report.	AEFI excel template relies heavily on the timeliness of submission by stakeholders In vigiflow, the same scenario but with real time reflecting submission
Timeliness of producing reports (i.e. daily reports)	Can produce daily reports. Weekly reports are drafted within a day. Delayed data submissions of RESUs and CHDs are included in the next report.	Once a report is submitted, it is ready to be generated.	
Traceability: ensure appropriate platform access on the national and sub-national levels *Security/Confidentiality of the Data*			
Can the end user update the submitted information?	Yes, the end user can update the submitted information and leave a remarks regarding to the information that was being updated The end user has a direct access to the Excel Template and can update all the information previously encoded.	Reports submitted through the VigiFlow may be updated/edited anytime.	Both types of reports may be easily edited and updated

Is it traceable? (shows the name who updated the information and the date it was edited)	Yes, there is column for the name of encoder and column for date encoded. It can also use the REMARKS column for any update information. Includes the name of the encoder and date encoded. The name who updated the information and the date it was edited may be included in the remarks column. It is manually determined rather than system generated There is no user login for better traceability function	Yes. The date and name of the person who last edited the report is reflected in the report.	Traceability of whom edited is more seen in Vigiflow
Ability to have predefined data platform access per ESU level (only authorized personnel able to view and/or edit the data)	It can access down to the municipal, provincial and regional level. The interface is easy to use. However, it may be still prone to errors when not cascaded properly to the lower level ESUs. Platform access is dependent on the capabilities of ESUs and persons-in-charge	The VigiFlow has 3 level options to view/edit reports. Viewing or editing data depends on the level of access given to a specific accounts.	Platform access mechanism is yet to be set on Excel template unlike in Vigiflow

Due to the nature of the novel vaccine and the inclusion of adult population on the list of vaccinees, series of trainings and encoding workshops will be conducted. The personnel involved in the encoding of reports shall be formalized through an issuance of database logger in order to preserve data integrity and traceability of surveillance reports. Accountability of the surveillance officer is also included in the training since data shared through the database will be disseminated to global level for our country to participate and have access also to the latest updates on the possible signals of AEFI for the novel vaccine.

Continuous harmonization of the surveillance platform is also on its development in terms of linking the registry or the vaccinee profile with the AEFI. A unique identifier code shall be its interoperability mechanism to link with the AEFI system. In order not to overload the health system to all AEFI cases (minor and serious), a self-report mechanism for minor AEFI cases shall also be developed which may be adapted to the current COVIDKAYA self-reporting platform. The automated linkage of unique identifier code shall be enhanced within the next

weeks during pre-testing of the system. Furthermore, the AEFI surveillance and response systems are in the process of interlinking through using a single database platform with both EB (PIDSR) and FDA as national data managers. As mentioned, VigiFlow training, especially on AEFI reporting form which was recently added in the system was cascaded to the national and subnational staff. Furthermore, meetings with the Uppsala Monitoring Center pharmacovigilance team were already performed in order to provide inputs on the improvements on the system and enhance the applicability of the tool esp in data security, accessibility, data management in the Philippine Health system.

Strengthening *AEFI investigation* procedures requires series of orientation and capacity training on the needs and actions of the *AEFI investigations team* (Epidemiology and Surveillance Unit, EPI Coordinator/Cold Chain Manager, Food and Drug Regulation Officer, Health Promotion Officer) on conducting field investigations for AEFIs. Moreover, enhancing the appropriate case management and program support to those affected by serious AEFI or AEFIs needing professional assistance is critical for service delivery.

In terms of *response*, the NART which is a composite team of DOH offices serves as the link to every office in responding to emergency situations. To streamline the *referral system*, for AEFI cases and optimize the use of medical care services at a national level for a unified NART response, the One Hospital Command System (OHCS) shall be utilized (i.e. DO No. 2020-0653 - *Guidelines in the Creation of the One Hospital Command System*, and DO. No. 2021-0004 - *Delineation of Functions of Hospital Oversight in Alignment with Universal Health Care*). Further, the OHCS can be supported by the Health Care Provider Network under AO No. 2020-0019 - *Guidelines on the Service Delivery Design of Health Care Provider Networks*.

The Health Emergency Management Bureau along with the help of Field Implementation and Coordination Team shall be the forefront offices in coordinating and determination of ambulance services and designation of public and private facilities as AEFI referrals subject to the funds of PhilHealth through case rates, or the Quick Access Fund of the National Agencies/Regional Offices. For case management, costing estimates were calculated for minor and serious AEFI cases with the projections for minor AEFI at 2% and serious at 0.16 per 100,000 doses (based on the National serious AEFI rates as per WHO and DOH assessment in 2013). Scenario-based analyses were calculated based on the % population of vaccinees at 20%, 60%, and 70%.

As for the *AEFI analysis*, the current templates on vaccine surveillance reports are being enhanced pending the important data needed to be analyzed specifically for COVID-19 vaccine. Currently, the following variables considered in the recently concluded MR-OPV SIA Phase 1 campaign includes the following:

- National and regional AEFI rates per 100,000 doses
- Profile of cases (age, sex, region, most common signs and symptoms)
- Rates of signs and symptoms per 100,000 doses
- Narrative profile of deaths

Feedback and risk communication before, during and after the vaccination program is critical in order not to cause mass hysteria and public panic on COVID-19 vaccine. Thus, it is recommended that the Health Promotions Bureau will handle this matter appropriately.

In terms of the *surveillance flow*, the interim proposal is status quo which states that for HCW, senior citizens, and indigents on AEFI reporting system through health facilities and ESUs; as for NGAs: geographical jurisdiction to respective ESUs (Figure 21).

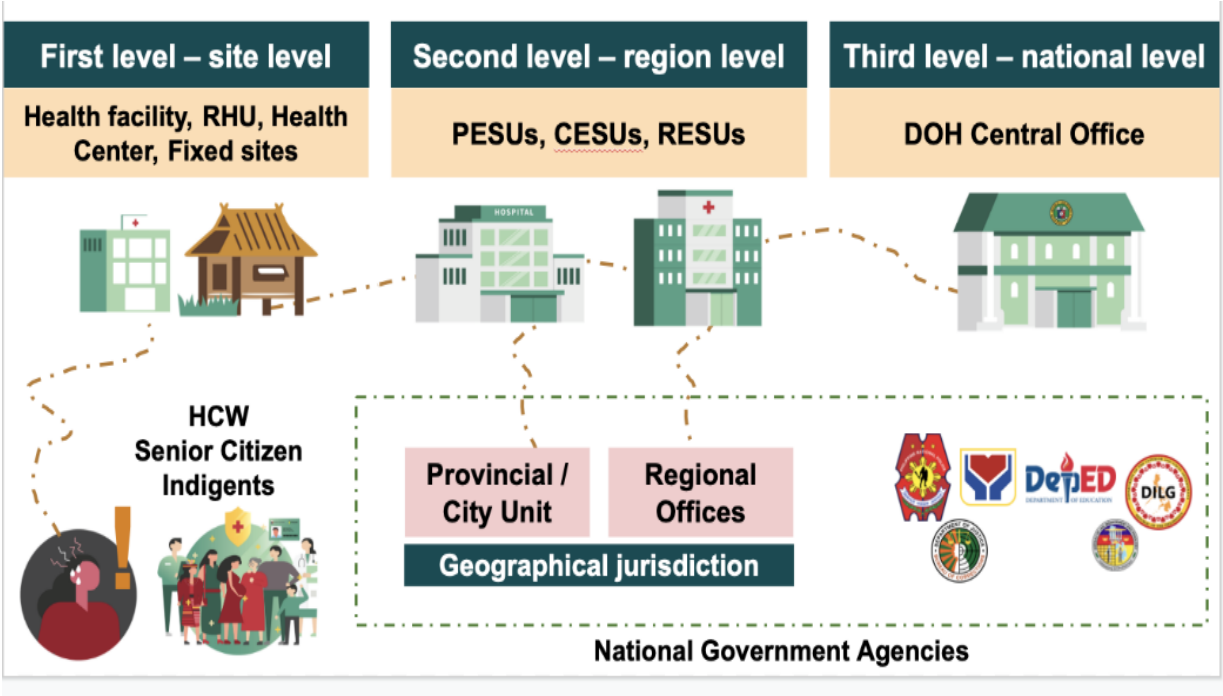


Figure 14. Surveillance referral flow.

Identify and secure channels of data sharing mechanisms to share COVID-19 vaccine safety data and findings with relevant regional and international partners: The International Health Regulation (IHR) National Focal Point shall make the necessary coordination mechanism with global and international partners in accordance with IHR guidelines and procedures. The IHR shall manage all communications and relay to relevant offices, task groups, in charge of the query and shall consolidate all opinions and answers of the offices for their official reply.

The IHR National Focal Point acts as the international Liaison Officer for COVID-19 surveillance and manages all communications of the AEFI surveillance with international partners. The team shall respond within 24 hours upon receipt of any query.

The FDA, as a member of the WHO Programme for International Drug Monitoring, shall share relevant cases of AEFIs to the global database of adverse drug reaction to facilitate data sharing and analysis of data in the global context.

Monitoring and Evaluation Framework, and Reporting Mechanism

Prior to vaccine introduction, listing the various stakeholders, their roles and responsibilities in handling end-to-end COVID-19 vaccine safety issues will help to shorten the response time during a crisis and ensure that there is a harmonized approach to routine activities and managing a crisis and unexpected events.

As COVID-19 vaccines are being introduced, there will likely be an intense demand for data by different stakeholders, to meet the key anticipated needs of these different stakeholders, the COVID-19 Vaccine Deployment and Vaccination Program monitoring system for COVID-19 vaccines has been designed to be able to:

- Measure equitable uptake and coverage over time by geography, population groups, and risk groups.
- Monitor to what extent national policies to prioritize at-risk groups and settings (e.g. hospital and long-term care facilities) are effectively implemented.
- Provide a personal vaccination record/certificate for any health, occupational, educational and travel purposes (as per national policies).
- Ensure that the necessary records and documentation are in place for use in surveys, safety monitoring, disease surveillance and vaccine effectiveness studies.
- Ensure that individuals can be monitored for the full course, in the likely case that a multidose schedule is required, to reduce the incidence of drop-outs.

The main indicators to measure progress with COVID-19 vaccines are similar to any vaccine introduction:

Vaccine uptake: The number or proportion of people vaccinated with a certain dose of the vaccine in a certain time period (e.g. during a month or year). If expressed as a percentage, an alternative term to be used is vaccination rate.

Vaccination coverage: The vaccinated proportion of a target population, which is similar to uptake, but considers vaccination in previous time periods. Over time, coverage can be constructed by accounting for uptake in previous time periods (weeks, months, years), depending on the duration of protection of the vaccine. For the year of introduction (2021), uptake and coverage can be used interchangeably.[6]

[6] Adapted from the WHO Interim Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines, 16 November 2020

Table 37. Dimensions for disaggregating vaccine uptake and coverage .

Disaggregation	Definition	Use
Vaccine product	By each vaccine product in use in a country	• Calculate uptake and coverage with a last recommended dose • Evaluate protection in a population, given differences in effectiveness • Evaluate vaccine safety issues that are specific to the different products in use
Geography (required)	By district, province, state etc.	• Monitor equitable distribution across regions in a country
Sex (required)	By sex of the vaccinated person	• Monitor equitable distribution by sex
Age group (required, at a minimum younger than 60, 60–69, 70–79, 80+)	By age group of the vaccinated person according to national policy for vaccine prioritization	• Age is a risk factor for severe COVID-19. Monitoring uptake among specific age groups is required to evaluate whether prioritization policies are implemented
Occupation (optional, where feasible)	By prioritized occupational group: definition/ characteristics to be decided at the country level by national health experts/NITAGs.	• Occupation is a risk factor for transmission of CoV-SARS-2, and country policies will need to ensure that essential frontline workers are protected first • Evaluate whether prioritization policies are implemented
Other risk factors (optional, where feasible)	Among people with co-morbidities or other risk factors for COVID-19 such as pregnancy	• Evaluate whether prioritization policies are implemented *Note:* this may not be feasible in all countries; foresee challenges disaggregating doses as well as establishing targets for these at-risk groups
Context (optional, where feasible)	In long-term care facilities, prisons, universities and schools	• Evaluate whether these strategies are implemented
Other equity dimensions (optional, where feasible)	By socioeconomic, ethnic, linguistic, religious, or any socially disadvantaged populations	• Monitor equitable distribution across different populations in a country *Note:* this may only be feasible to measure using surveys

Continuous monitoring for situational awareness throughout the COVID-19 Vaccination Program is crucial for a successful outcome. Prior to receiving COVID-19 vaccine, jurisdictions should establish procedures for monitoring various critical program planning and implementation elements, including performance targets, resources, staffing, and activities.

To provide situational awareness for higher officials and the general public throughout the COVID-19 vaccination response, the following dashboards will be available:

- Weekly COVID vaccination dashboard
- COVID-19 vaccine distribution planning, tracking, modeling, and analysis application

Evaluation of COVID-19 vaccine introduction

Based on the World Health Organization's "Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines", evaluation of COVID-19 vaccine introduction pertains to the "post-evaluation following the introduction of COVID-19 vaccines to assess vaccine effectiveness impact and identify any improvements to the COVID-19 vaccination process". This may cover (a) assessment of the impact of the specificities and novelty of the COVID-19 vaccines on the immunization program and how these will input to the further optimization of the vaccine deployment, (b) assessment of vaccine effectiveness and impact after introduction into populations, and (c) documenting the lessons learned from deployment and vaccination operations.