

NATIONAL STANDARDS IN INFECTION CONTROL FOR HEALTHCARE FACILITIES *(Revised Edition)* **2009**



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National Center for Health Facility Development
Department of Health
Philippine Hospital Infection Control Society (PHICS), Inc.
Manila, 2009

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National Center for Health Facility Development
Department of Health
Philippine Hospital Infection Control Society (PHICS), Inc.
Manila, 2009



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY



MESSAGE

Sustaining health care services in the Philippines is an uphill but necessary process. The challenges ahead, such as the high cost of health care services that requires special technical expertise, may prove to be prohibitive. Hence, our road map needs to be paved with strategies, plans, structure, regulations, policies and legal mandates with which to carry out our ideal future state in hospital management and operations. For this reason, the National Center for Health Facility Development (NCHFD) produced a set of health/hospital facility manuals that serve as guide and standard reference for hospital management, service providers and support staff to inject quality in their day-to-day operations at various aspects of work and service delivery points in the hospital.

While our initiatives are focused on addressing the disparities between public and the private hospital facility performance as well as rural-urban inequities, we need to ensure that the key dimensions of quality care are at the forefront of our core objectives.

We envision our approaches to be sustained by (1) informed and empowered individuals, families and communities; (2) competent and responsive health practitioners; (3) effective and efficient health care organizations; and (4) supportive health systems. All these through a sector-wide approach to health care.

Let us all constantly engage in more functional partnerships with our health care delivery networks, and in mutually fulfilling relationships with our hospital personnel in order to gain more meaningful achievements that will make our hospital system a real force to improve the health of the Filipino people.


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



Republic of the Philippines
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OFFICE OF THE SECRETARY



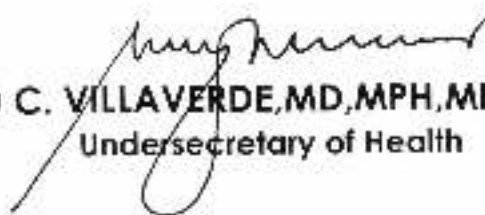
MESSAGE

To operate successfully in today's globally competitive environment, a health facility must consistently deliver high quality, cost effective care to its clients. Improving health care quality and enhancing each patient's experience of care require attention not only on health system design but also on every process of patient care.

The goals and objectives stated at each carefully crafted Hospital Manual are reflective of the fundamental principles in the delivery of a continuum of quality care that is expected to operate efficiently and effectively.

Outstanding evidence-based medical care and management practices are born out of resource-rich as well as resource-challenged health systems. Most positive changes are achieved with the judicious and appropriate use of current capabilities of health facilities. In a low-resource environment, quality care can be achieved without compromising the life and safety of patients.

Thus, we enjoin every health facility worker from the top management to the frontline and support services to seriously study, discuss among themselves and implement this set of hospital facility/hospital manuals in the best way appropriate to their setting, always keeping in mind human dignity—their own and their clients'—in executing more effective, efficient and responsive health care and management systems.


MARIO C. VILLAVARDE, MD, MPH, MPM, CESO I
Undersecretary of Health



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FOREWORD

In line with the thrust of the Department of Health on Health Service Delivery and Good Governance under Formula One for Health (F1), the National Center for Health Facilities Development (NCHFD) formulates policies and develops standards for the establishment, development, management and operations of health facilities in the country. The NCHFD assumes the technical leadership and coordinates the health facility development initiatives of government and its partners. Efforts to improve the health service delivery and determine the critical areas for continuing quality improvement that ensure patient-centered quality care have been our utmost priority.

Health workers and Health Facility/Hospital Administrators have been continuously confronted with a wide range of issues, new trends and technologies in various health care settings. The development of more relevant and responsive policies and guidelines for patient-centered quality care attunes our health systems to this dynamic environment.

The National Center for Health Facilities Development (NCHFD) proudly endorses a set of Manuals for health facilities/hospitals. These Manuals are outputs of Technical Working Groups composed of experts in various fields of health facility management and quality patient care. The Manuals considered Philippine settings while maintaining consistency with international standards. Each of the following individual manuals is best used in conjunction with the other Manuals in the set:

1. Manual of Organization and Management of the Administrative and Finance Service for Hospitals
2. Hospital Property and Supply Management Manual
3. Hospital Nursing Service Administration Manual
4. Hospital Pharmacy Management Manual
5. Hospital Nutrition and Dietetics Service Management Manual
6. Manual for Medical Social Workers Fifth edition

7. Manual of Standards for Infection Control in Health Care Facilities
8. Quality Management Systems in Clinical Laboratories
9. Manual of Standards and Guidelines on the Management of Hospital Emergency Department
10. Revised Organization and Staffing Standards for Government Hospitals

The standards and guidelines recommended in this set of Manuals will assist the Administrators and Clinical Practitioners achieve quality services through timely access, efficiency, effectiveness, safety and patient-centeredness in health facility/hospitals.

The above mentioned Manuals will serve as standard reference materials for DOH health facilities/hospitals to aid administrators and clinical practitioners in the management and operations of the various services that directly and indirectly contribute to patient safety and quality patient care. These Manuals are also recommended for use in the health facilities/hospitals of the Local Government Units, the military, the PNP, the private sector and the academe.


CRISELDA G. ABESAMIS, MD, FPSP, CESO III
Director IV



MESSAGE

Infection control is one of the most important strategies to achieve quality patient care. To promote quality care, healthcare facilities and healthcare providers must conform to standards required by regulatory agencies. Standards are set of prerequisites that need to be fulfilled by any facility to be accredited. In infection control, there are standards required to prevent and reduce occurrence of healthcare-associated infection. All healthcare facilities should establish an Infection Control Program with an organizational structure to manage it; a surveillance system that will provide data as basis for decision making, available guidelines, policies and procedures to serve as reference to staff and hospital-wide education and training on basic concepts principles and updates on infection control. The standards in infection control for healthcare facility are formulated to provide administrators, managers and staff a ready reference on how to establish a successful infection control program. The Infection Control Committee under the office of the chief of the institution manages the program and is headed by trained, committed and dedicated senior member of the staff. The leader carries out the vision of the program making all of its component functions well, even with limited budget. The team members give support to the program by enforcing implementation of policies in their areas making the system work hospital-wide.

It is our hope that through these standards, a more effective national infection control program can be achieved.

MELECIA A. VELMONTE, MD

Founding President

Philippine Hospital Infection Control Society (PHICS), Inc.



MESSAGE

The standardization of infection control practice in the Philippines reflects the maturity of infection control movement in the country. It took decades of experiences to reach this far. With the leadership of the Department of Health, these standards will have a great influence in the infection prevention strategies from health institutions down to the community/barangay level.

The "National Standards in Infection Control for Healthcare Facilities" will bridge the gaps in the practice of infection control nationwide. In reality, the risks of developing nosocomial or healthcare associated infections vary from hospital to hospital, whether it is primary, secondary or tertiary. Necessarily, approaches to infection prevention and control differ.

Since infection control is a very important component of quality patient care and involves participation of healthcare workers from different disciplines, a standardized approach will ensure a more systematic, evidence-based and cost-effective implementation of infection control programs. It will also promote the sharing of resources and experiences leading to a more relevant infection control practice.

Finally, this initiative is expected to be the basis of a national infection control program and policy. If this happens, infection control will truly spell the difference in quality patient care.

DOMINGA C. GOMEZ, RN

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- Philippine Society for Microbiology and Infectious Diseases (PSMID)
- Philippine Hospital Association (PHA), Inc.
- Department of Health, National Center for Disease Prevention and Control, Infectious Office
- Department of Health, National Epidemiology Center
- Department of Health, Bureau of Health Facilities and Services
- Philippine Health Insurance Corporation (PHIC), Inc.
- World Health Organization (WHO)
- National Children's Hospital
- Research Institute for Tropical Medicine
- San Lazaro Hospital
- Quirino Memorial Medical Center
- ADB-World Health Organization
- Philippine College of Surgeons
- Philippine College of Physicians
- Philippine Nurses Association (PNA), Inc.
- Pediatric Infectious Disease Society of the Philippines, Inc.
- Philippine Association of Medical Technologists
- Philippine Academy of Family Physicians
- Philippine Society of Critical Care Medicine
- Philippine Pediatric Society
- Philippine Council on Healthcare Accreditation Organization
- Philippine Medical Association
- Philippine Society for Quality Healthcare
- National League of Philippine Government Nurses Association, Inc.
- Association of Nursing Service Administrators of the Philippines
- Occupational Health Nurses Association of the Philippines, Inc.

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BACKGROUND/RATIONALE

More than 20 years have passed since the Office of Hospital Facility Services and Regulations of the Department of Health issued a Memorandum/Administrative Order requiring healthcare facilities to establish Infection Control Committees (ICC) in hospitals. In September 26, 1996 the revised rules and regulation governing registration and licensing of hospitals again reiterated that each should establish three (3) vital committees one of which is the Infection Control Committee (ICC). Since no implementing guidelines on minimum standards to make the committee function effectively were issued, many ICCs existed but did not provide a forum for multidisciplinary input, cooperation, and information sharing.

During the SARS outbreak in 2003, when there was no known treatment available, strict adherence to infection control guidelines and policies and procedures were the only recognized effective method to prevent and control the global spread of this most dreaded disease. Through the initiative of the World Health Organization (WHO) and the leadership of the Department of Health (DOH) in collaboration with Philippine Society of Microbiology and Infectious Diseases (PSMID), Philippine Hospital Infection Control Society (PHICS), Philippine Hospital Infection Control Nurses Association (PHICNA), SARS preparedness was assessed in DOH hospitals based on recommended infection prevention and control guidelines. Findings revealed flagrant deficiencies in knowledge, practice and policy compliance among healthcare providers. WHO and DOH realized the need to strengthen Infection Control programs nationwide to enhance preparedness of healthcare workers to be able to respond to threats of outbreaks of highly transmissible infectious diseases and more importantly, to prevent and reduce occurrence of healthcare-associated infections among patients.

To achieve an effective infection control program, infection control standards are needed by hospital administration for implementation and government regulating agencies for licensing and accreditation. To address this problem, a Technical Working Group (TWG) on Development of Standards in Infection Control for Healthcare facilities was organized. In



the formulation of this document the group considered resource limitation and consistency with international standards.

These standards will continuously be reviewed and updated to adapt to current realities in the local healthcare facility setting.

It is critical that healthcare facility administrators and staff be aware of, understand and apply these standards as they pertain to their respective roles, functions and responsibilities.



PART I

STANDARDS ON MANAGEMENT, STRUCTURE, FUNCTIONS AND RESPONSIBILITIES

1 STANDARDS ON MANAGEMENT, STRUCTURE, FUNCTIONS AND RESPONSIBILITIES

Each healthcare facility shall have a coordinated institutional infection control program. The program shall have sufficient designated personnel with clearly defined responsibilities, commensurate authority, clear lines of communication, and other resources to facilitate the effective prevention, detection and control of healthcare-associated infections among patients, staff and visitors.

STANDARD 1

There shall be an infection control management structure under the Office of Chief of Hospital with sufficient resources and clear lines of responsibility.

Requirements

- The Chief of Hospital/Healthcare Facility shall ensure effective implementation of infection control policies and availability of resources.
- The infection shall be managed by a multidisciplinary committee under the Office of the Chief of Hospital/Healthcare. Smaller healthcare facilities within the geographic area shall link with bigger facilities for infection control services through their designated representative.



STANDARD 2

There shall be a functional Infection Control Committee (ICC).

Requirements

- The ICC shall have defined goals, objectives, strategies and priorities to achieve an effective infection control program in the healthcare facility.
- The ICC shall perform the following functions:
 - Formulates/updates infection control policies, guidelines and procedures.
 - Ensures implementation of infection control policies, guidelines and procedures.
 - Ensures availability of resources and contingencies for infection control program.
 - Prepares, reviews and evaluates the progress and the effectiveness of the infection control programs.
 - Disseminates the necessary information and coordinates with medical, nursing, administration, other hospital committees and other appropriate government agencies.
 - Oversees the performance of the Infection Control Team (ICT).
 - Approves infection control training modules.
 - Defines the goals, objectives and priorities for all surveillance activities on healthcare associated infections, including time frame, areas, patient population to be studied and surveillance method to be used.



- The ICC shall be a multidisciplinary committee composed of:
 - The Chief of Hospital or the designated Chairperson
 - The Infection Control Physician (ICP)
 - The Infection Control Nurse (ICN)
 - Core members:
 - ≈ Administrative Officer or equivalent
 - ≈ Representatives from:
 - Clinical departments including Infectious Disease Section
 - Nursing Service
 - Microbiology Laboratory
 - Special and High Risk Units
 - Emergency Room
 - Operating Room
 - Dialysis Unit
 - Intensive Care Unit
 - Endoscopy Unit
 - Transplant Unit
 - Others
- Auxiliary Members / Representatives from:
 - ≈ Employees Health Service
 - ≈ Maintenance or Engineering Service
 - ≈ Pharmacy
 - ≈ Central Sterilization Unit
 - ≈ Dietary Service



- ≈ Linen and Laundry Service
 - ≈ Purchasing and Supply Department
 - ≈ Housekeeping Department
 - ≈ Linked Healthcare Facilities
 - ≈ Clinical Laboratory
 - ≈ Others as needed
- ▷ Each ICC member has specific duties and responsibilities (Refer to Annex 2).
- The ICC shall meet regularly at least quarterly and as needed with adequate documentation (e.g. Outbreaks of infection in the healthcare facility or from the community).
 - The Chief of Hospital/Healthcare Facility is informed about any outbreak of infection in the healthcare facility and coming from the community and in consultation with the ICT decides whether all members of the committee should meet.

STANDARD 3

There shall be an active and effective Infection Control Team (ICT).

Requirements

- The ICT is responsible for the day-to-day infection control activities. The ICT is supported by adequate clerical staff and has access to appropriate facilities to enable it to perform its duties.



- ICT effectively performs the following functions:
 - Conducts and documents surveillance activities.
 - Coordinates with the Infectious Disease Section, Microbiology Laboratory and Administration as well as other departments about known or suspected cases of notifiable/reportable infectious diseases, food poisoning and other significant infections such as Multi Drug Resistance Organism (MDRO).
 - Ensures adequate, accurate and timely reporting and feedback of information to concerned areas/unit.
 - Investigates and initiates appropriate responses to incidents or outbreaks of infections, assesses risks of infection and recommends allocation of resources for investigation, management and control.
 - Responds to urgent problems of infection control through a 24-hour emergency referral system.
 - Propose resource requirement for the program and any contingencies.
 - Gives advice on the procurement of medical equipment, drugs/medicines and supplies.
 - Participates in the planning and design of plant facilities critical to infection control, i.e. renovations, repairs, relocation of critical care areas.
 - Develops IC training modules, organizes the relevant education and training programs for all healthcare staff and encourages reflexive practice of infection control measures.
 - Monitors compliance to infection control policies, guidelines and procedures (Refer to Annex 5).
 - Recommends/proposes to ICC actions, which may have implications for infection control in the hospital.



- The ICT is composed of the Infection Control Physician (ICP), preferably an Infectious Disease Specialist/Hospital Epidemiologist, Infection Control Nurse (ICN), and Head of the Microbiology Unit/Section.
- The ICP is an active consultant who may also be the Chair or Co chair and has a minimum required training provided by accredited societies and has experience in infection control.
- The ICT shall report to the ICC.
- The ICT shall have direct access to the Microbiology Laboratory and facilities.

STANDARD 4

There shall be at least one (1) full time Infection Control Nurse (ICN).

Requirements

- Ideally, the ICN is a senior nurse with supervisory functions.
- The ICN has received training in infection control provided by an accredited training organization.
- The ICN coordinates all infection control activities with the ICC Chairperson as well as with the other areas in the healthcare facility (Refer to Annex 2).



PART II

STANDARDS ON GUIDELINES, POLICIES AND PROCEDURES

2 STANDARDS ON GUIDELINES, POLICIES AND PROCEDURES

There are written guidelines, policies, and procedures that address infection prevention, detection and control in the healthcare facility.

STANDARD 1

The Infection Control Committee initiates development, implementation, evaluation, review and updating of written guidelines, policies and procedures pertinent to the activities of that department/unit.

Requirements

- Guidelines and policies on all patient admissions/referrals, isolation and timely case reporting of highly transmissible and notifiable/reportable infectious diseases.
- Basic Infection Control Guidelines, Policies and Procedures on:
 - Hand Hygiene
 - Isolation Precaution
 - Decontamination, Disinfection, Sterilization; Disinfectants for specific medical equipment/items and areas.
 - Environmental Care and Healthcare Waste Management
 - Protection of Healthcare workers



- Infection Control Guidelines, Policies and Procedures on Prevention of Healthcare-associated infection:
 - Respiratory Care
 - In-dwelling Intravascular Device Care
 - Urinary Catheter Care
 - Wound Care
- Infection Control Guidelines and Policies on Housekeeping Procedures for:
 - Isolation Rooms
 - Regular Rooms/Wards
 - Special Areas and High Risk Units
 - Out Patient Department
- Infection Control Guidelines, Policies and Procedures for Specific Patient Care Areas
 - ICU/CCU
 - OR, DR, Nursery
 - Dialysis Unit
 - Burn Unit, Trauma Ward
 - Emergency Room
 - Transplant Unit
 - Dental Clinic



- o Endoscopy Unit
- o Oncology Unit
- Infection Control Guidelines, Policies and Procedures for Hospital Auxiliary Service Departments/ Units
 - o Laboratory
 - o Radiology
 - o Dietary
 - o Laundry
 - o Linen
 - o Pharmacy
 - o Sterile Supply Service
 - o Engineering and Building Service
 - o Patient transport facilities
 - o Mortuary care and management
- Guidelines, Policies and Procedures on Outbreak Investigation
- Infection Control Guidelines and Policies related to purchasing of medical equipment, drugs/medicines and supplies.
- Guidelines and Policies on Rational Antibiotic Use in coordination with Microbiology Laboratory and Pharmacy Drugs and Therapeutic Committee.
- Guidelines and Policies on Upholding Patient Confidentiality (Patient's Rights).



STANDARD 2

There is a written program for dissemination, implementation and monitoring of infection control policies, guidelines and procedures.

Requirements:

- These policies, and procedures are made known to all personnel through an administrative order/memorandum and during orientations and regular in-service trainings.
- There shall be evidences that all personnel received appropriate infection control trainings/ instructions.
- There shall be a standardized simple tool to monitor compliance.

(A standardized simple tool to monitor compliance is utilized to evaluate performance.)



PART III

STANDARDS ON MICROBIOLOGY SERVICES

3 STANDARDS ON MICROBIOLOGY SERVICES

There shall be access to a licensed microbiology section in a DOH licensed clinical laboratory that shall provide quality diagnostic and clinical services required for epidemiologic evaluation, effective surveillance and infection control.

STANDARD 1 (FOR HEALTHCARE FACILITIES WITH MICROBIOLOGY LABORATORY)

There is a document available to all users of the laboratory, which describes the organization, and scope of the laboratory services and standard operating procedures.

Requirements

The document describes:

- Availability of services during regular working hours, after office hours, public holidays and emergencies.
- Proper collection, handling, transport, processing and disposal of specimens.
 - Instructions on the appropriate specimens to be collected, the availability of request forms, appropriate containers, swabs, transport media etc.
 - Methods of labeling and details required to complete the request form (e.g., patient information data, relevant clinical information, the type of specimen and the examination required).



- Type and range of specimens routinely examined and those examined by special arrangement.
- Proper collection of appropriate specimen and isolation and identification procedures of potentially pathogenic microorganism to specie level. Interpretation of results and timely dissemination of information to concerned areas.
- Availability of reports, technical and clinical advice and procedures to access services.
- Quality control procedures (internal and external).
- Information on national reference laboratory for services not available within the microbiology laboratory of the healthcare facility.
- Guidelines, Policies and Procedures to be observed on safe handling, transport and disposal of specimens.
 - Biosafety and biohazard precautions.
 - Disinfection and sterilization of laboratory facilities.
 - Good microbiologic laboratory practices.
 - Personal Protective Equipment (PPE), Vaccination and the Prophylaxis required for laboratory personnel.
 - Safe Waste Management based on national guidelines.
 - Acceptable/recommended recycling methods for laboratory supplies.
- Identification and antibiotic susceptibility patterns of bacterial isolates to antimicrobial agents based on international standards.
- Results of screening tests for hospital staff and employees (e.g. stool culture for dietary staff).



- Monitoring of sterilization and disinfection procedures.
- Technical assistance for environmental sampling and cultures when indicated.
- Appropriate data storage, retrieval and communication facilities for tracking of specimen, tracing of report and preparation of surveillance information directly relating to infection control.

STANDARD 2 (FOR HEALTHCARE FACILITIES WITHOUT MICROBIOLOGY LABORATORY AND THE REFERRAL MICROBIOLOGY LABORATORY)

There is access to a DOH licensed clinical laboratory for microbiology services for healthcare facility without Microbiology Laboratory.

Requirements

- There shall be a Memorandum of Agreement with the referral microbiology laboratory which should include policies on patients' confidentiality, documents and information that the referral microbiology laboratory complied with the requirements of Standard 1.
- The referral microbiology laboratory shall provide information to the referring healthcare facilities on:
 - Availability of services during regular working hours, after office hours, public holidays and emergencies.
 - Proper collection, handling, transport, processing and disposal of specimens.
 - Instructions on the appropriate specimens to be collected, the availability of request forms, appropriate containers, swabs, transport media, etc.



- Method of labeling and details required to complete the request forms (e.g. patient information data, relevant clinical information, the type of specimen and the examination required.)
- Type and range of specimens routinely examined and those examined by special arrangement.
- Identification and susceptibility patterns of bacterial isolates to antimicrobial agents based on international standards.



PART IV

STANDARDS ON SURVEILLANCE

4 STANDARDS ON SURVEILLANCE

There is a defined program of surveillance and reporting of healthcare-associated and community acquired infection including the collection, analysis, dissemination, feedback and storage of data.

STANDARD 1

There shall be a defined surveillance program.

Requirements

- The Infection Control Committee (ICC) defines goals, objectives and priorities for all surveillance activities on healthcare-associated infections, including time frame, areas, patient population to be studied.
- The ICC sets the surveillance method to be utilized in achieving goals and objectives.
- The ICC shall adopt the universally accepted definitions of healthcare-associated infections.
- The surveillance forms shall be adapted and standardized.
- ICT collects, analyzes and reports the data to clinicians, administrators and others who could use them constructively as basis for intervention.
- The ICT uses the surveillance data for evaluation of the program, identifying problems, as well as revision of guidelines.



- The ICT coordinates with the microbiology laboratory in the development of a program for the surveillance of microorganisms, antibiotic resistance patterns as well as clustering of patient groups within their hospital network.
- The ICT may compare data with benchmark set by national/international bodies as well as with other institution for collaborative activities.

STANDARD 2

There is an efficient mechanism of reporting healthcare-associated and community acquired notifiable/reportable infections including significant outbreaks/ potential outbreaks to ICT, ICC and to the National Epidemiology Center, Department of Health (NEC-DOH).

Requirements

- There is an organized/systematic method/procedure of reporting Healthcare-Associated Infections (HAI) and Community-Acquired Infections (CAI) with potential for outbreaks.
- The ICC regularly reports their semi-annual infection rates, antibiotic resistance pattern to the clinicians, and administration.
- The ICC immediately reports to NEC-DOH through the Chief of Hospital any suspicion of potential outbreaks for their information and appropriate action following the NEC-DOH reporting system.



PART V

STANDARDS ON EDUCATION AND TRAINING

5 STANDARDS ON EDUCATION AND TRAINING

All healthcare staff including support services shall receive appropriate education and training on epidemiology, surveillance, prevention and control of healthcare-associated infections.

STANDARD 1

There are adequate resources available in the hospital for the required education and training activities.

Requirements

- There are adequate resources for education, skills building and training of healthcare staff and support/auxiliary services.
- There are available and accessible venues for teaching and training.
- There is access to up-to-date tools like audio-visual materials and/or relevant books and journals in infection control and hospital epidemiology at the infection control office.
- There is available budget to allow attendance of ICC members to infection control training, conferences, production of educational materials and related activities.
- There are continuing education opportunities within and outside healthcare facility.



STANDARD 2

There are infection control educational programs for the healthcare staff and support services focused on relevant topics appropriate for specific clinical setting.

Requirements

- There are institutional materials available for education and training which includes:
 - Epidemiology of Healthcare-Associated Infection
 - Basic Principles in Prevention and Control: Hand Hygiene, Isolation Precaution, Decontamination, Disinfection & Sterilization, Care of the Environment and Hospital Waste Management
 - Infection Control During Routine Patient Care
 - Infection Control in Special and High Risk Area
 - Infection Control in Hospital Ancillary Services
 - Healthcare worker: Infection Risks and Prevention
- There is involvement of the ICC/ICT in the orientation and continuing education of patients, students, trainees and other healthcare staff and other healthcare personnel.
 - There is involvement of the ICC/ICT in the course design and implementation of basic level training and continuing education of healthcare staff.
 - There is a basic course in infection control conducted regularly, at least twice a year and as needed and records of the attendance of all staff on these educational activities.



- There is a defined policy for teaching patients and the appropriate members of their families (e.g. watchers class) about the precautions relevant to the diagnosis of the affected/infected patients.
- There are mechanisms for information dissemination and assessment of knowledge and practices of healthcare staff on new guidelines and written policies on infection control practices, surveillance and observational studies.
- There are tools for knowledge assessment of infection control practices, and procedures (e.g. equipment disinfection methods, when and how to isolate patients, etc).
- The Infection Control Committee monitors and conducts periodic assessment of infection control practices.



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GLOSSARY OF TERMS

Auxiliary Workers refer to all support staff in the healthcare establishments aside from those in the ancillary services (i.e., institution workers, nursing attendants, dental aides, laboratory aides, etc.).

Decontamination refers to the removal of moist body substances from items as part of reprocessing and the sanitizing of items so that they are safer for handling before cleaning and disassembly by personnel.

Disinfection refers to the process that eliminates many or all pathogenic microorganisms on inanimate objects with the EXCEPTION of bacterial spores.

Endemic Infection refers to the habitual presence of an infection within a geographic area, may also refer to the usual prevalence of a given disease within such area.

Epidemic Infection refers to an outbreak in a community or region of a group of infections of similar nature, clearly in excess of normal expectancy and derived from a common or propagated source.

Hand Hygiene refers to a general term that applies to hand washing, antiseptic hand wash, antiseptic hand rub, or surgical antiseptics.

Healthcare waste management refers to the activities involved in the production, handling, treatment, conditioning storage, transportation and disposal of waste generated by healthcare establishments.

Healthcare worker refers to any person working in a healthcare facility, e.g., medical officer, nurse, physiotherapist, cleaners, psychologist.

Healthcare facility refers to a facility that employs healthcare workers and cares for patients or clients.

Infection Control Committee refers to a committee that provides a forum for multidisciplinary input, cooperation and information sharing. Representation includes management, physicians, other healthcare workers from clinical microbiology, pharmacy, sterilizing service, housekeeping, and training services.



Infection Control Team refers to those healthcare workers involved in carrying out the day to day infection control program including the yearly work plan for review by the Infection Control Committee.

Link Nurses refer to nurses who coordinate all infection control policies and activities to nursing units or station.

Nosocomial Infection or healthcare-associated infections refer to infection acquired in the hospital or healthcare facility.

Notifiable/Reportable Diseases refer to diseases that have been selected by DOH due to their tendency to occur in epidemic proportion.

Personal Protective Equipment (PPE) refers to a protective barrier, provided whenever necessary by reason of the hazardous nature of the process of the environment, chemical or radiological, or other mechanical irritants or hazards capable of causing injury or impairment in the functions of any part of the body through absorption, inhalation or physical contact. PPE reduces the risks of infection if used correctly. It includes gloves, mask, long sleeved cuffed gown, plastic apron, protective eyewear, and cap.

Sterilization refers to the reduction in microorganisms of more than 99.9%, or a decrease in microbial load, achieved by physical, chemical or mechanical methods or by irradiation.



ACRONYMS

BHFS	- Bureau of Health Facilities and Services
CAI	- Community Acquired Infection
CDC	- Centers for Disease Control
COH	- Chief of Hospital
DOH	- Department of Health
HCAI	- Healthcare-Associated Infection
ICC	- Infection Control Committee
ICN	- Infection Control Nurse
ICP	- Infection Control Physician
ICT	- Infection Control Team
MDRO	- Multi-Drug Resistant Organism
MRSA	- Methicillin-Resistant <i>Staphylococcus aureus</i>
NEC	- National Epidemiology Center
PHICNA	- Philippine Hospital Infection Control Nurses Association (PHICNA), Inc.
PHICS	- Philippine Hospital Infection Control Society (PHICS), Inc.
PPE	- Personal Protective Equipment
PSMID	- Philippine Society of Microbiology and Infectious Diseases



REFERENCES

Healthcare Waste Management Manual. Environmental and Occupational Health Office, National Center for Disease Prevention and Control, Department of Health, Manila, 2004.

Implementing Rules and Regulation on Chapter VII, Industrial Hygiene of the Sanitation Code of the Philippines Updated (P.D. 856), Department of Health, Manila, 1991.

Joint Commission on Accreditation of Healthcare Organizations, Chicago, USA, 2005.

Practical Guidelines for Infection Control in Healthcare Facilities, World Health Organization, Regional Office for South-East Asia and Regional Office for Western Pacific, 2004.

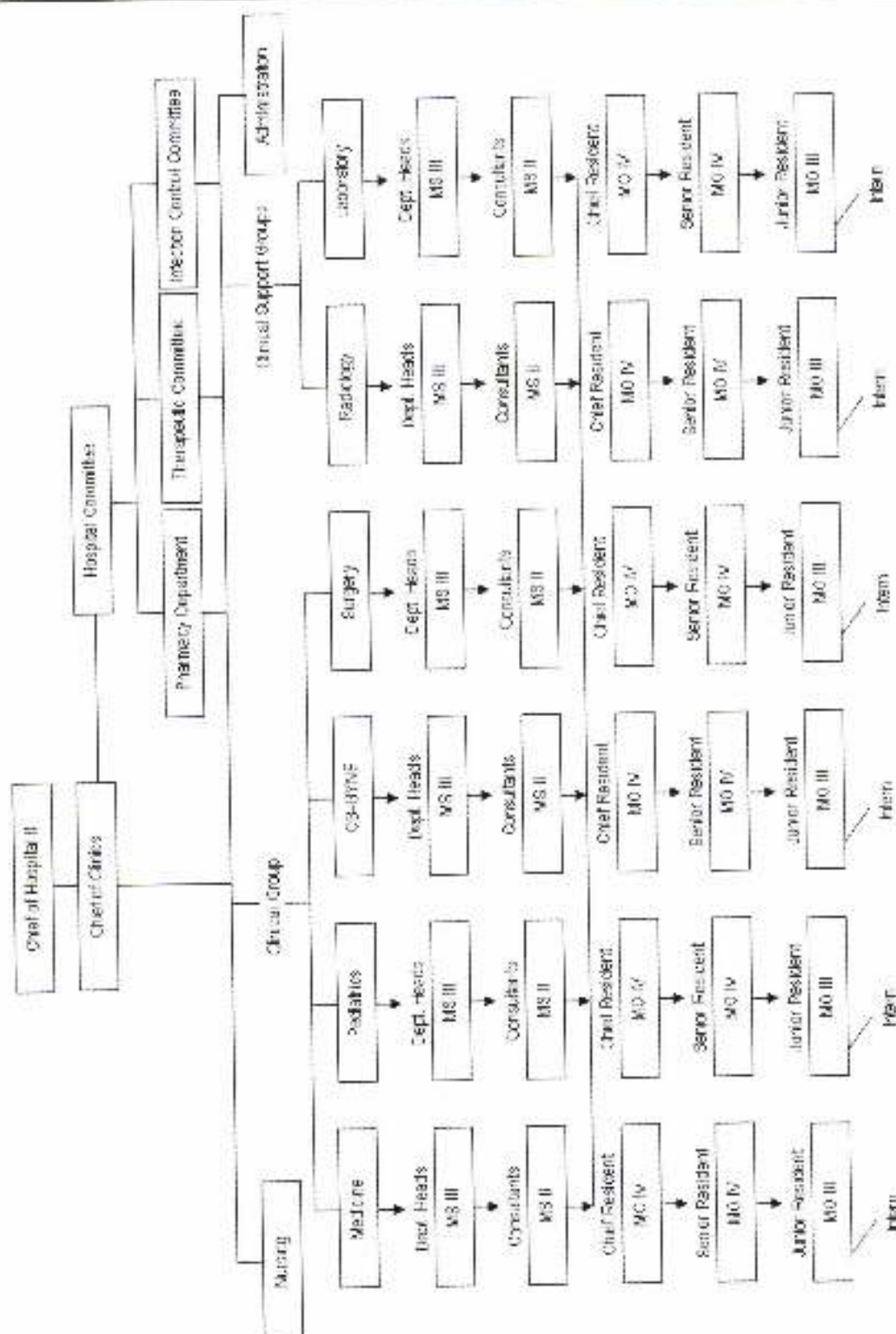
Revised Rules and regulations Governing the Registration, Licensure, and Operation of Hospitals in the Philippines, Department of Health, Manila, September 25, 1996.

Guidelines for Environmental Infection Control for Healthcare Facilities (Recommendation of CDC and HICPAC), 2003.

Benchbook on Performance Improvement of Health Services, Philippine Health Insurance Corporation-Policy Development Group, 2004.



ANNEXES



ORGANIZATION CHART



Annex 2

DUTIES AND RESPONSIBILITIES OF ICC CHAIR AND MEMBERS

POSITION	:	CHAIRMAN
REPORTS TO	:	HOSPITAL DIRECTOR AND MEDICAL DIRECTOR
SUPERVISES	:	INFECTION CONTROL TEAM AND ACTIVITIES

GENERAL DUTIES AND RESPONSIBILITIES

Plans, organizes, directs and controls all activities of the departments.

SPECIFIC DUTIES

- Takes a lead role in the effective functioning of the infection control team.
- Assists the hospital in drawing up annual plans, policies and long-term program for the prevention of hospital infection.
- Recommends to Hospital Management on all aspects of infection control in the hospital and on the implementation of agreed policies.
- Participates in the preparation of the tender documents for support services, and advises on infection aspects.
- Gets involved in setting quality standards with regards to prevention of healthcare associated infections and in the audit of infections.

QUALIFICATIONS

- Preferably a doctor with Infection Control Training certified by Philippine Hospital Infection Control Society, Specialist in Infectious Disease, Microbiologist, or Hospital Epidemiologist.



POSITION : INFECTION CONTROL NURSE

REPORTS TO : ICC CHAIRMAN

SUPERVISES : ALL NURSING STAFF, AND HEALTH CARE WORKERS

GENERAL DUTIES AND RESPONSIBILITIES

Coordinates and supervises all activities in hospital relevant to Infection Control.

SPECIFIC DUTIES

- Acts as coordinator to all hospital staff relevant to infection control
- Identifies healthcare associated (nosocomial) infections.
- Investigates type of infection and infecting organism.
- Participates in outbreak investigation.
- Conducts of surveillance of hospital infections.
- Participates in training of personnel.
- Assists in the development of infection control policies, reviews and approves patient care policies relevant to infection control.
- Ensures compliance with local and national regulations.
- Serves as liaison with other departments of the hospital.
- Provides expert consultative advice to staff health and other appropriate hospital program in matters relating to transmission of infections.
- Attends professional meetings and conferences on matters related to infection control.



- Regularly monitors infection control practices and compliance of health care worker.
- Monitors staff health in collaboration with the Employee Health Services Department to prevent hospital related infection among hospital staff.
- Serves as preceptor in nursing training program.
- Conducts research studies relevant to infection control.

QUALIFICATIONS

- Clinical Nurse specialist or at least Head Nurse with clinical and administrative expertise
- Good interpersonal and educational background
- Good communication skills
- With training in infection control

POSITION : MEDICAL TECHNOLOGIST

REPORTS TO : INFECTION CONTROL COORDINATOR AND ICT

SUPERVISES : LABORATORY STAFF

GENERAL DUTIES AND RESPONSIBILITIES:

Coordinates and implements the safe delivery and handling of laboratory procedures.

SPECIFIC DUTIES

- Handles patient and staff specimens to maximize the likelihood of microbiological diagnosis.
- Develops guidelines for appropriate collection, transport, and handling of specimen.
- Ensures laboratory practices meet appropriate standards.



- Ensures safe laboratory practice to prevent infection on staff.
- Performs antimicrobial susceptibility testing following internationally recognized methods, and providing summary reports of prevalence of resistance.
- Monitors sterilization, disinfection and the environment where necessary.
- Communicates the results to the infection control committee.

QUALIFICATIONS

- Licensed Microbiologist or Medical Technologist trained in microbiology
- Active experience of least 2 years
- Good communication skills
- With teaching ability
- Willing to undergo infection control training

POSITION : ADMINISTRATION REPRESENTATIVE

REPORTS TO : HOSPITAL DIRECTOR

SUPERVISES : ALL EMPLOYEES

GENERAL DUTIES AND RESPONSIBILITIES

Acts as liaison between ICC and administration, implements and executes policies.

SPECIFIC DUTIES

- Facilitates implementation, dissemination of ICC recommendations and policies.
- Ensures financial support for Infection Control Program.



- Identifies appropriate resources for programs to monitor infections and apply the most appropriate methods for preventing infections.
- Ensures education and training of all staff through support of programs on the prevention of infection, disinfection and sterilization techniques, etc.
- Ensures that infection control team has authority to facilitate program functions.

QUALIFICATIONS

- Registered Physician
- Preferably senior member of administration office
- With special interest on infection control

POSITION : CLINICAL DEPARTMENT REPRESENTATIVE

REPORT TO : INFECTION CONTROL CHAIRMAN AND ICT

SUPERVISES : HOSPITAL STAFF AND PATIENTS

GENERAL DUTIES AND RESPONSIBILITIES

Coordinates with ICT and directs hospital staff regarding infection control and related issues.

SPECIFIC DUTIES

- Provides direct patient care using practices which minimize infection.
- Supervises and monitors staff on implementation and compliance with infection control practices.
- Follows appropriate practice of hand hygiene.
- Works with the Infection Control Committee.



- Supports the Infection Control Team.
- Links with staff and with areas of clinical practice.
- Coordinates with ICT/ICC regarding implementation of policies and guidelines.
- Helps in surveillance and outbreak investigation.
- Advises the ICC on recent advances in medical procedures that have Infection Control implication.

QUALIFICATIONS

- Registered physician
- Preferably senior member of the hospital staff
- With special training or interest on infection control

POSITION : EMERGENCY ROOM INFECTION CONTROL REPRESENTATIVE

REPORTS TO : INFECTION CONTROL TEAM

SUPERVISES : EMERGENCY ROOM STAFF

GENERAL DUTIES AND RESPONSIBILITIES

Supervises all activities relevant to infection control practices and procedures in ER.

SPECIFIC DUTIES

- Supervises staff on implementation and compliance of infection control practices.
- Refers cases with infection control implications.
- Coordinates with the committee regarding implementation of policies and guidelines.



- Helps investigate local outbreak.
- Participates in surveillance.
- Monitors aseptic techniques, including hand hygiene and practice of isolation precaution.
- Limits patient's exposure to infections from visitors, hospital staff, other patients, or equipment used for diagnosis or treatment.

QUALIFICATIONS

- Licensed Physician or Registered Nurse.
- With ER experience at least 2 years.
- Demonstrates leadership ability to general management of the unit.
- Has good interpersonal relationship.
- Willing to undergo infection control training.

POSITION : ICU/CCU/HEMODIALYSIS IC REPRESENTATIVE

REPORTS TO : INFECTION CONTROL TEAM

SUPERVISES : ICU/CCU/HEMO STAFF

GENERAL DUTIES AND RESPONSIBILITIES:

Supervises all activities relevant to infection control practices and procedures in ICU/CCU/Hemodialysis.

SPECIFIC DUTIES

- Supervises staff on implementation and compliance of infection control practices.
- Refers cases with infection control implications.
- Coordinates with the committee regarding policies and guidelines.
- Helps investigate local outbreak.



- Participates in surveillance.
- Maintains hygiene, consistent with hospital policies and good nursing practice on the ward.
- Reports promptly to the attending physician any evidence of infection in patients under nurse's care.
- Limits patient exposure to infections from visitors, hospital staff, other patients, or equipment used in the diagnosis or treatment.

QUALIFICATIONS

- Registered Nurse
- With ICU/CCU/Hemodialysis experience at Emergency Room experience of least 2 years
- Demonstrate leadership ability to the general management of the unit
- Has good interpersonal relationship
- Willing to undergo infection control training

POSITION : OR/DR IC REPRESENTATIVE

REPORTS TO : INFECTION CONTROL TEAM

SUPERVISES : OR/DR STAFF

GENERAL DUTIES AND RESPONSIBILITIES:

Supervises all activities relevant to infection control practices and procedures.

SPECIFIC DUTIES

- Supervises staff on implementation and compliance of infection control practices.
- Refers cases with infection control implication.



- Coordinates with the committee regarding an implementation of policies and guidelines.
- Helps investigate local outbreak.
- Participates in surveillance.
- Maintains hygiene, consistent with hospital policies and good nursing practice on the ward.
- Reports promptly to the attending physician any evidence of infection in the patients under nurse's care.
- Limits patient exposure to infections from visitors, hospital staff, other patients, or equipment used in the diagnosis or treatment.

QUALIFICATIONS

- Registered Nurse
- With OR experience at least 2 years
- Demonstrate leadership ability to the general management of the unit
- Willing to undergo infection control training

POSITION : NEONATAL INTENSIVE CARE UNIT REPRESENTATIVE

REPORTS TO : INFECTION CONTROL COORDINATOR AND ICT

SUPERVISES : NICU STAFF

GENERAL DUTIES AND RESPONSIBILITIES

Supervises all activities relevant to infection control practices and procedures



SPECIFIC DUTIES

- Supervises staff on implementation and compliance of infection control practices.
- Refers cases with infection control implication.
- Coordinates with the committee regarding implementation of policies and guidelines.
- Helps investigate local out break.
- Participates in surveillance.
- Maintains hygiene, consistent with hospital policies and good nursing practice on the ward.
- Reports promptly to the attending physician any evidence of infection in the patients under nurse's care.
- Limits patient exposure to infections from visitors, hospital staff, other patients, or equipment used in the diagnosis or treatment.

QUALIFICATIONS

- Registered Nurse
- With NICU experience at least 2 years
- Demonstrate leadership ability to the general management of the unit
- Has good interpersonal relationship
- Willing to undergo infection control training



POSITION : NURSING REPRESENTATIVE (Link Head Nurses)

REPORTS TO : INFECTION CONTROL TEAM

SUPERVISES : NURSING STAFF AND NURSING AIDES/ORDERLIES

GENERAL DUTIES AND RESPONSIBILITIES

- Coordinates with NSO Infection control programs and policies to the nursing staff.
- Acts as link nurses between ICC and NSO.

SPECIFIC DUTIES

- Conveys to nursing staff the recommendations of Infection Control Committee for hospital-wide implementation.
- Participates in infection control committee activities.
- Promotes the development and improvement of nursing techniques, and ongoing review of aseptic nursing policies, with approval by the infection control committee.
- Develops training programs for members of nursing staff.
- Supervises the implementation of techniques for the prevention of infection in specialized areas such as the operating room, the intensive care unit, the maternity unit and newborn.
- Monitors nurses' adherence to policies.
- Ensures nurse education programs that include IC policies and procedures.
- Limits patient exposure to infections from visitors, hospital staff, other patients, or equipment used in the diagnosis or treatment.



- Maintains hygiene, consistent with hospital policies and good nursing practice on the ward.
- Reports promptly to the attending physician any evidence of infection in the patients under nurse's care.

QUALIFICATIONS

- Registered nurse.
- Minimum 2 years active practice.
- Good communication skills.
- Good interpersonal and educational skills.
- Willing to undergo infection control training.

POSITION : PHARMACIST

REPORTS TO : INFECTION CONTROL TEAM

SUPERVISES : PHARMACIST

GENERAL DUTIES AND RESPONSIBILITIES

Coordinates with ICC on matters related to Infection Control.

SPECIFIC DUTIES

- Obtains, stores and distributes pharmaceutical preparations using practices which limit potential transmission of infectious agents to patients.
- Dispenses anti infectious drugs and maintains relevant records (potency, incompatibility, conditions of storage and deterioration).
- Obtains and stores vaccines or sera, and making them available as appropriate.
- Provides the Anti microbial Use Committee and Infection Control Committee with summary reports and trends of anti microbial use.



- Participates in the development of guidelines for antiseptic, disinfectants, and products used for washing and disinfecting the hands.
- Communicates as needed, with the Infection Control Committee the Nursing Services, Pharmacy Services maintenance and other appropriate services.
- Advises the staff on appropriate indications for disinfectants, antiseptics and antibiotics.
- Keep record of cost and usage of antibiotics and disinfectants.
- Coordinates with Infection Control Committee on evaluation of disinfectants, antiseptics and antibiotics and other new products with IC implication.

QUALIFICATIONS

- Registered pharmacist
- Has leadership ability
- Good communication skills
- With teaching ability

POSITION : PULMONARY THERAPY REPRESENTATIVE

REPORTS TO : INFECTION CONTROL TEAM

SUPERVISES : PULMONARY STAFF

GENERAL DUTIES AND RESPONSIBILITIES

Coordinate with ICT on the infection control procedures and practices related to respiratory care and pulmonary therapy.

SPECIFIC DUTIES

- Advises the staff on appropriate infection control measures during use of respiratory equipments and gadgets and procedures.



- Coordinates with the ICC on the infection control practices to be observed by during respiratory care and therapy.
- Participates in the development of guidelines for antiseptic, disinfectants, and products used for washing and disinfecting the respiratory equipments.
- Monitors and maintains equipments.

QUALIFICATIONS

- College graduate of Pulmonary Therapy
- Good communication skills
- Has leadership ability
- With teaching skills

POSITION : CENTRAL SUPPLY ROOM REPRESENTATIVE

REPORTS TO : INFECTION CONTROL TEAM

SUPERVISES : CENTRAL SUPPLY STAFF

GENERAL DUTIES AND RESPONSIBILITIES

Control quality assurance, safety and sterility of equipment and supplies used on patients.

SPECIFIC DUTIES

- Collaborates with the Infection Control Committee and other hospital programs to develop and monitors policies on cleaning and decontamination of reusable, contaminated equipments.
- Oversees the use of different methods to monitor the sterilization process.
- Ensures technical maintenance of the equipment according to national standards and manufacturers' recommendation.



- Reports any defect to administration, maintenance, infection control and other appropriate personnel.
- Maintains complete records of each autoclave run, and ensure long-term availability to records.
- Collects or have collected, at regular intervals all outdated sterile units.
- Communicates, as needed with the infection control committee, the nursing services, the operating suite the hospital transport services, pharmacy services, maintenance and other appropriate services.
- Knowledgeable on appropriate and safe methods of disinfection and sterilization.
- Advises on quality assurance and safe practices.
- Implements policy on disinfection and sterilization.

QUALIFICATIONS

- College graduate with 5 or more years of experience in hospital work equivalent in service supplies
- Physically and mentally fit, with sound decision-making ability
- Communication skills and interpersonal relationship
- Interest and concern for people and accepts own limitations
- Preferably with leadership training to be able to lead and supervise



POSITION : X-RAY TECHNICIAN

REPORTS TO : INFECTION CONTROL TEAM

SUPERVISES : X-RAY STAFF

GENERAL DUTIES AND RESPONSIBILITIES

Maintains proper handling care and transport of infectious patients.

SPECIFIC DUTIES

- Maintains the proper techniques in transporting patient.
- Ensures that standard precautions are observed in all diagnostic procedures.
- Monitors and maintains staff health status exposed to highly infectious patients in and out of the department.
- Reports and coordinates diagnostic results with infection implications.

QUALIFICATIONS

- Registered X-Ray Technician
- Has leadership ability
- Good communication skills
- With teaching skill
- Active hospital experience at least 2 years



POSITION : DIETITIAN

REPORTS TO : INFECTION CONTROL COORDINATOR AND ICT

SUPERVISES : DIETARY STAFF

GENERAL DUTIES AND RESPONSIBILITIES

Implements infection control precautions and practices to prevent food-borne diseases and other illness related to food preparation and handling.

SPECIFIC DUTIES

- Ensures proper preparation, storage, delivery and handling of food.
- Monitors equipment used for food preparation, serving, processing and storage are cleaned and sanitized after use.
- Monitors compliance on infection control practices and procedures of food handlers.
- Maintains proper waste disposal /pest control.
- Issues written policies and instructions for hand hygiene, clothing, staff responsibilities and daily disinfection duties.

QUALIFICATIONS

- Registered dietitian
- Has leadership ability
- Good communication skills
- With teaching skills



POSITION : NUCLEAR UNIT REPRESENTATIVE

REPORTS TO : INFECTION CONTROL TEAM

SUPERVISES : NUCLEAR STAFF

GENERAL DUTIES AND RESPONSIBILITIES

Supervises all activities relevant to infection control and procedures

SPECIFIC DUTIES

- Coordinates with the Infection Control Team on infection control practices and precautions related to care of patients and disposal of radioactive elements.
- Monitors staff health status exposed to highly infectious patients.
- Ensures that standard precautions are observed in all diagnostic procedures.

QUALIFICATIONS

- Registered Physician
- With special interest in infection control
- Preferably Senior Nuclear Medicine Staff

POSITION : MAINTENANCE REPRESENTATIVE

REPORTS TO : INFECTION CONTROL TEAM

SUPERVISES : MAINTENANCE STAFF

GENERAL DUTIES AND RESPONSIBILITIES

Maintains and controls hospital quality equipment.



SPECIFIC DUTIES

- Tests and maintains efficiency of equipment with the infection control requirements (Autoclave).
- Monitors and maintains the water and electricity supplies.
- Installs and repairs existing equipment to meet required infection control standard.
- Practices standard precautions during performance of duties.
- Collaborates with other departments in selecting equipment and ensuring early identification and prompt correction of any defect.
- Inspects and regularly maintains plumbing, heating and refrigeration equipment, electrical fittings and air conditioning.
- Ensures environmental safety outside the hospital e.g. waste disposal and water source.
- Inspects, cleaning and regular replacement of the filters of all appliances for ventilation and humidifiers.
- Regularly inspects all surfaces, walls, floors, ceilings to ensure they are kept smooth and washable.

QUALIFICATIONS

- Licensed Engineer
- With good interpersonal relationship
- Has leadership ability
- With good communication and teaching skills



POSITION : HOUSE KEEPING SUPERVISOR

REPORTS TO : INFECTION CONTROL COORDINATOR AND ICT

SUPERVISES : HOUSE KEEPING SUPERVISOR

GENERAL DUTIES AND RESPONSIBILITIES

Implements a clean and safe environment.

SPECIFIC DUTIES

- Maintains and monitors hospital-wide cleanliness and sanitation.
- Coordinates with ICT on proper waste disposal and use of disinfectants.
- Monitors housekeeping practices with infection control implication.
- Implements cleaning and disinfection policies in the work place.
- Observes and practices the IC precautions during work.
- Classifies the different hospital areas by varying need for cleaning.
- Develops policies for appropriate cleaning techniques.
- Informs the maintenance services of any building problems requiring repair.
- Monitors and controls pest in the hospital.

QUALIFICATIONS

- Housekeeping Supervisor
- Willing to undergo training on Infection Control
- Hard working
- With teaching ability
- Environment conscious



POSITION : ADMITTING RECEPTIONIST

REPORTS TO : INFECTION CONTROL COORDINATOR AND ICT

SUPERVISES : ADMITTING STAFF AND PATIENTS

GENERAL DUTIES AND RESPONSIBILITIES

Directs and assigns appropriate room for patients with highly transmissible infectious diseases.

SPECIFIC DUTIES

- Assigns appropriate room for patients with infectious diseases.
- Implements precautionary measures for admitted patients with infectious implications.
- Informs the staff of the cases of with infection control implications.
- Observes standard precaution when admitting direct to room cases with infection control implications.

QUALIFICATIONS

- College graduate
- With good communication skills
- Willing to be trained on infection control
- Good moral character
- With decision making skills



POSITION	:	LAUNDRY REPRESENTATIVE
REPORTS TO	:	INFECTION CONTROL COORDINATOR AND ICT
SUPERVISES	:	LINEN STAFF

GENERAL DUTIES AND RESPONSIBILITIES

Controls proper handling, storage and processing of soiled linen.

SPECIFIC DUTIES

- Implements decontamination/ disinfection practices in delivery and transport of linen.
- Coordinates with the ICT on the proper disinfectants to be used.
- Implements policies on disinfection and sterilization.
- Ensures proper transport, handling, storage and processing and distribution of linen.

QUALIFICATIONS

- College graduate
- Willing to undergo training on infection control
- Good communication skills
- With good teaching skills
- With knowledge on disinfection and sterilization



Annex 3

REPORTING SYSTEM

The Notifiable Disease Report lists from the hospitals are consolidated every first day of every week. For early identification of the presence of outbreak, it should be reported to the regional Epidemiology Surveillance Unit (RESU) and then to the National Epidemiology Center (NEC), DOH, Manila.

The Notifiable Disease Report serves as a tool to determine the occurrence of diseases in the locality. Thus, getting the trend of these diseases on a weekly basis can indicate whether an upsurge of cases or an impending outbreak is present in a certain area in the municipality. This will guide Local Health Worker to conduct epidemiological investigation and thus identify the vulnerable population and pinpoint the real etiology of the outbreak, the sources and the mode of spread of the disease so that specific preventive and control measures can be instituted at an early stage.

REPORTING FLOW

Schedule	Person/s Responsible	Activities
First day of every week	HIC Nurse/Physician or Record Officer	<ul style="list-style-type: none"> Consolidates the Notifiable Disease If with outbreak, reports immediately to the Regional Epidemiology Surveillance Unit (RESU) and to National Epidemiology Center (NEC) Telefax No. 711-6760
First week of every month	do	<ul style="list-style-type: none"> Prepare on a 4 week basis the Nosocomial Infections
First week of 1 st month of every quarter	do	<ul style="list-style-type: none"> Submits quarterly report to DOH, National Center for Health Facility Development (NCHFD) Telefax No. 742-8091



Annex 4

WEEKLY NOTIFIABLE DISEASE REPORT

PHILIPPINE INTEGRATED DISEASE SURVEILLANCE AND RESPONSE (PIDSR)

Republic Act 3573 (Law of Reporting of communicable Diseases), requires all individuals and health facilities to report notifiable disease to local and national public health authorities.

Name of Disease Reporting Unit _____

Type of Facility: ☐ Government Hospital ☐ Private Hospital ☐ Rural Health Unit
☐ Clinic ☐ Government Laboratory ☐ Private Laboratory
☐ Seaport/Airport

Address: _____

This report is prepared by: _____ Date: _____
 (Signature over printed name)

This report was submitted to: _____ Date: _____
 (Name of RHU/CHO/PHO/CHD)

This report was approved by: _____ Date: _____
 (Name & Signature of Head of Office/Unit/Hospital/Clinic)

List of Notifiable Diseases/Syndromes
 (Indicate the number of case/s in the corresponding line for case/s of disease/
 syndrome seen and "0" if no cases seen.)

Category I (Immediately Notifiable)	Category II (Weekly Notifiable)
<input type="text"/> Acute Flaccid Paralysis	<input type="text"/> Acute Bloody Diarrhea
<input type="text"/> Adverse Event Following Immunization (AEFI)	<input type="text"/> Acute Encephalitis Syndrome
<input type="text"/> Anthrax	<input type="text"/> Acute Hemorrhagic Fever Syndrome
<input type="text"/> Human Avian Influenza	<input type="text"/> Acute Viral Hepatitis
<input type="text"/> Measles	<input type="text"/> Bacterial Meningitis
<input type="text"/> Meningococcal Disease	<input type="text"/> Cholera
<input type="text"/> Neonatal Tetanus	<input type="text"/> Dengue
	<input type="text"/> Diphtheria



Category I (Immediately Notifiable)	Category II (Weekly Notifiable)
<input type="checkbox"/> Paralytic Shellfish Poisoning <input type="checkbox"/> Rabies <input type="checkbox"/> Severe Acute Respiratory Syndrome (SARS) <input type="checkbox"/> Outbreaks <ul style="list-style-type: none"> • Clusters of diseases • Unusual diseases or threats 	<input type="checkbox"/> Influenza like illness <input type="checkbox"/> Lepidopteriosis <input type="checkbox"/> Malaria <input type="checkbox"/> Non-neonatal Tetanus <input type="checkbox"/> Pertussis <input type="checkbox"/> Typhoid and Paratyphoid fever

Category I : Notify simultaneously the PHO, CHD and NEC within **24 hours** of detection and send advance copy of the Case Investigation Form (CIF) as soon as possible.

Category II : Report all cases of notifiable diseases/syndromes every **FRIDAY** of the week to the next higher level using the Case Report Form (CRF).

Reminder : Submission of report is every **FRIDAY** of the week. The weekly report should include this page (Summary Page), Case Investigation Form (CIF) and the Case Report Form (CRF).

"Let's help prevent epidemics"



Annex 5

DEPARTMENT CIRCULAR NO. 176s 2001



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY
448 ng L. Con Luning Catand, 422 Avenue, 1st, Quezon City 1101
Tel. Nos. (02) 590-1644-1150, 1-800-745-1999, 240-1735, Email: DOH@DOH.gov.ph



July 27, 2001

DEPARTMENT CIRCULARNo. 176 s 2001

TO: All Regional Health Directors, Provincial Health Officers, Chiefs of Hospitals, City Health Officers, Municipal Health Officers, Laboratories and all others concerned.

SUBJECT: **2001 Revised List of Notifiable or Reportable Diseases**

Pursuant to Section 3 Act 3573 otherwise known as the Law of Reporting of Communicable Diseases, the list of notifiable diseases in the Philippines specified in Department Circular No. 325 – B s 1997 dated December 4, 1997 is hereby revised to include the following:

Notifiable Diseases	ICD No. (10th revision)
Anthrax	A22
Cholera	A00
Diphtheria	A36
Viral Encephalitis	A83-86
Viral Hepatitis	B15-17
Leprosy	A30
Leptospirosis	A27
Malaria	B50-54
Measles	B05
Viral Meningitis	A87
Neonatal Tetanus	A33
Non-neonatal Tetanus	A35
Meningococcal Infection	A39
Paralytic Shellfish Poisoning	T61.2
Rabies	A82
Typhoid and paratyphoid fever	A01
Whooping cough (Pertussis)	A37

These diseases have been selected due to their tendency to occur in epidemic proportion, are targeted for eradication or elimination, or subject to international health regulation.

Signed DC
Received in the Records
Section on 8/3/01




Because of the changing pattern of infectious disease threats and the possibility of new emerging and re-emerging diseases, unusual occurrences of the following syndromes should also be reported:

Acute Flaccid Paralysis (AFP)
Acute Hemorrhagic Fever Syndrome (e.g. Dengue Hemorrhagic Fever)
Acute Lower Respiratory Tract Infection and Pneumonia
Acute Watery Diarrhea
Acute Bloody diarrhea (e.g. Shigella)
Food Poisoning
Chemical Poisoning

For these diseases and syndromes, the established mechanism for notification and reporting of morbidity shall apply specifically with reference to the weekly notifiable reports as prescribed in the Field Health Service Information System (FHSIS). Outbreaks of these diseases/syndromes should be immediately reported to the Regional Epidemiology and Surveillance Units (RESUs) at the Center for Health Development or to the National Epidemiology Center (tel/fax no. 741-70-48; e-mail: nec_doh@yahoo.com)

For HIV/AIDS Reporting: Blood specimens that are reactive after screening tests for HIV should be submitted to the STD/AIDS Cooperative Central Laboratory (SACCL) at San Lazaro Hospital for confirmatory testing. The HIV/AIDS Reporting Form (Appendix B) should be accomplished for every client with reactive sample. For HIV positive cases that progress to AIDS or those who died, the physician should transmit the HIV/AIDS case reporting form directly to NEC within five working days following the event. Reports could also be sent by email: nhss@metro.net.ph or nec_doh@yahoo.com


MANUEL M. DAYRIT, MD, MSc
Secretary of Health



CASE DEFINITIONS OF NOTIFIABLE DISEASES

Anthrax (A22)

An illness with acute onset characterized by several clinical forms.

These are:

- localized form:
 - Cutaneous: skin lesion evolving over 1 to 6 days from papular through a vesicular stage, to a depressed black eschar invariably accompanied by edema that may be mild to extensive
- systemic forms:
 - Gastro-intestinal: abdominal distress characterized by nausea, vomiting, anorexia and followed by fever
 - Pulmonary (inhalation): brief prodrome resembling acute viral respiratory illness, followed by rapid onset of hypoxia, dyspnea and high temperature, with x-ray evidence of mediastinal widening.
 - Meningeal: acute onset of high fever possibly with convulsions, loss of consciousness, meningeal signs and symptoms; commonly noted in all systemic infections.

Cholera (A00)

Acute watery diarrhea and isolation of *Vibrio cholerae* from stool or rectal swab culture

Diphtheria (A36)

An illness of the upper respiratory tract characterized by laryngitis or pharyngitis or tonsillitis, and adherent membranes of tonsils, pharynx and/or nose.



Viral Encephalitis (A83-86)

Inflammation of the brain which manifests as mild diseases with headache and a general malaise and muscle ache similar to that associated with influenza. The more acute and serious symptoms may include fever, delirium, convulsions, and coma.

Leprosy (A30)

A person showing one or more of the following features, and who as yet has to complete a full course of treatment:

- Hypopigmented or reddish skin lesions with definite loss of sensation
- Involvement of the peripheral nerves as demonstrated by definite thickening with loss of sensation
- Skin smear positive for acid fast bacilli

Leptospirosis (A27)

Acute febrile illness with headache, myalgia (especially of calf muscles) and prostration associated with any of the following symptoms:

- conjunctival suffusion
- meningeal irritation
- anuria or oliguria and/or proteinuria
- jaundice
- hemorrhages (from the intestines; lung bleeding is notorious in some areas)
- cardiac arrhythmia or failure
- skin rash

and a history of exposure to infected animals or an environment contaminated with animal urine (e.g. washing in flood waters).

Malaria (B50-54)

Fever, chills, headache plus isolation of malarial parasites in the blood.



Measles (B05)

Suspect: Fever at least three days duration with maculopapular rash and any of the following: cough, coryza or conjunctivitis.

Confirmed: A suspect case positive for measles IgM antibody or suspect case with epidemiologic linkage to an IgM antibody positive case.

Viral Meningitis (A87)

A case with fever 38.5°C and one or more of the following:

- Neck stiffness
- Severe unexplained headache
- Neck pain and 2 or more of the following:
 - photophobia
 - vomiting
 - abdominal pain
 - pharyngitis with exudates

For children < 2 years of age a case is defined as

- Fever 38.5°C and one or more of the following:
 - Irritability
 - Bulging fontanel

Neonatal Tetanus (A33)

Occurrence of the following symptoms in a normal newborn within the 3rd to 28th day post partum:

- Inability to suck
- Generalized muscle spasm (stiffness)
- Convulsions and
- Risus sardonicus



Non-neonatal tetanus (A35)

Development of irritability, trismus or lockjaw, muscle spasms, or risus sardonicus secondary to either an open wound, dental caries, otitis media or any surgical procedure in a person more than 28 days old.

Meningococcal Infection (A39)

Sudden onset of fever and any of the following: neck stiffness, altered consciousness, other meningeal signs, petechial or purpurral rash, gram negative cocci on gram stain of CSF or skin scrapings and without apparent cause.

Paralytic Shellfish Poisoning (T61.2)

Previously well individual who develops two sensory and two motor signs and symptoms after taking shellfish (bivalve) meal or soup; shellfish in water source found positive for saxitoxin.

Rabies (A82)

- History of animal bite/scratch or human bite or eating brain of proven rabid animal
- Hydrophobia and
- Any two of the following: foaming of the mouth, convulsions, bladder paralysis, papillary dilatation, difficulty in swallowing

Typhoid and paratyphoid fever (A01)

Fever at least 5 days duration with any of the following:

- diarrhea or constipation
- abdominal discomfort
- malaise

with *Salmonella typhi* or *paratyphi* grown from blood or stool/rectal swab culture; (+) Typhi dot



Whooping cough (Pertussis) (A37)

Cough lasting at least two weeks with at least one of the following:

- paroxysms (i.e. fits) of coughing
- inspiratory "whooping"
- Post-tussive vomiting (vomiting immediately after coughing)
- without other apparent cause

SYNDROMES

Acute Flaccid Paralysis (AFP)

Sudden onset of flaccid ("floppy") paralysis in a child below 15 years old including those diagnosed to have Guillain Barre Syndrome for which no other cause could be identified.

Acute Hemorrhagic Fever Syndrome (e.g. Dengue Hemorrhagic Fever)

Acute onset of fever of less than 3 weeks duration in a severely ill patient and any 2 of the following:

- hemorrhagic or purpuric rash
- epistaxis
- hematemesis
- hemoptysis
- blood in stools
- other hemorrhagic symptom and no known predisposing host factors for hemorrhagic manifestation

Acute Lower Respiratory Tract Infections (ALRTI) and Pneumonia

Cough and/or dyspnea and other constitutional signs and symptoms with no apparent cause

Pneumonia

- Cough or difficulty of breathing and
- Breathing > 50/min for infant aged 2 months < 1 year



- Breathing > 40/min for child aged 1 to 5 years and
- No chest indrawing, stridor or danger signs

Severe Pneumonia

- Cough or difficulty of breathing + any general danger sign or chest indrawing or stridor in a calm child

General danger signs:

- For children aged 2 months to 5 years
- Unable to drink or breast feed, vomits everything, convulsions, lethargic or unconscious

Acute Watery Diarrhea

Acute watery diarrhea (passage of 3 or more loose watery stools in the past 24 hours) with or without dehydration,

Acute Bloody Diarrhea

Acute diarrhea (three or more bouts of loose stools) with visible blood in the stool.

Food Poisoning

Previously well individual who develops at least two of any gastrointestinal, neurologic, or generalized signs and symptoms with onset at least 30 minutes after taking the implicated meal (includes food poisoning such as staphylococci and botulism with isolation of causative organism with laboratory support).

Chemical Poisoning

Includes pesticide and other chemical poisonings that are diagnosed with laboratory support.



Annex 6

ADMINISTRATIVE ORDER NO. 2007-0036



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Department of Health
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October 1, 2007

ADMINISTRATIVE ORDER

No. 2007-0036

SUBJECT: Guidelines on the Philippine Integrated Disease Surveillance and Response (PIDSR) framework

I. BACKGROUND AND RATIONALE

The World Health Organization under the revised International Health Regulations (IHR) of 2005 requires all Member States to strengthen the core capacities for disease surveillance and response to avert occurrence and international spread of diseases and other public health threats. The new Regulations have a greatly expanded scope, which apply to diseases including those with new and unknown causes that present significant harm to humans irrespective of origin or source. Currently existing surveillance systems in the Philippines do not properly address such concerns.

The National Epidemiology Center (NEC) is primarily responsible for assessing the health status of Filipinos, detecting or confirming disease outbreaks and implementing outbreak control measures including but not limited to rapid containment. The NEC is the designated National Focal Point for IHR.

Four major disease surveillance systems exist in the country: 1) the Notifiable Disease Reporting System (NDRS) of the Field Health Service Information System (FHSIS); 2) the National Epidemic Sentinel Surveillance System (NESSS); 3) the Expanded Programme on Immunization diseases targeted for eradication or elimination Surveillance System (EPISurv); and 4) the Integrated HIV/AIDS Behavioral and Serologic Surveillance System (IHBS) including the AIDS Registry. Altogether they provide vital information that guide policy and implementation of priority health programs and projects.

These disease surveillance systems were established for specific purposes and each have their own individual data collection and reporting procedures, computer hardware and software requirements and, training and supervisory functions. For so many years now, numerous health programs and foreign-assisted projects also established parallel surveillance systems to complement existing surveillance systems. These may have resulted in inefficient surveillance systems characterized by redundancy and duplication of efforts,



extra and sometimes prohibitive costs, a demoralized health workforce, inaccurate and delayed reporting and ultimately unrealized health outcomes. Effective disease control relies on a functional disease surveillance system. Clarity of purpose, simple and practical use, effective feedback and efficient organizational and management arrangements define the functionality of surveillance systems.

A formal assessment of the existing surveillance system was done in 2006 and revealed the following:

- Lack of manual of procedures that will serve as a guide to field staff in properly carrying out surveillance and response tasks and responsibilities;
- Lack of capacity, especially at the local level, to perform the required epidemiological surveillance and response functions;
- Lack of training and supervision; and
- Inadequate funding support for equipment, travel, logistics and other supplies essential for the optimal operations of a disease surveillance system.

The inadequacy of the current disease surveillance systems in the Philippines and the need to comply with the 2005 IHR call for an urgent need to adopt newer approaches that will address those gaps without placing undue strain into the system.

The Philippine Integrated Disease Surveillance and Response (PIDSR) is hereby adopted to address these concerns and meet future challenges that were otherwise unforeseen. This Administrative Order provides the framework for PIDSR to guide its implementation at all levels of the health care delivery system as well as both the public and private sectors.

II. DECLARATION OF POLICIES

The PIDSR shall be guided by the following legal mandates and policies:

- A. *Republic Act 3573 (Law of Reporting of Communicable Diseases)* requires all individuals and health facilities to report notifiable diseases to local and national health authorities.
- B. *Resolution WHA48.13 (1995)* urges Member States to strengthen national and local programs of active surveillance for infectious diseases, ensuring that efforts were directed towards early detection of epidemics and prompt identification of new, emerging and re-emerging infectious diseases.
- C. *International Health Regulations of 2005, Article 5-1 Surveillance*, urges Member States to develop, strengthen and maintain, as soon as possible but no later than five years from the entry into force of these Regulations, the capacity to detect, assess, notify and report events in accordance with these Regulations.
- D. *Administrative Order No. 2005-0023 (Implementing Guidelines for Formula One for Health as Framework for Health Reforms)*, Section C2.c.iii, states that, "Disease surveillance shall be intensified to ensure that the targets for disease elimination, prevention and control are attained".



- E. *Department Personnel Order No. 205-1585* (Creation of a Management Committee on Prevention and Control of Emerging and Re-emerging Infectious Diseases or DOHMC-PCREID) creates the Epidemiology and Surveillance Sub-Committee (ESSC) in which one of its major functions is to "...formulate and recommend policies, standards, procedures, guidelines and systems on the early detection, contact tracing, surveillance, investigation and follow-up of emerging and re-emerging (EREID) suspects and the timely and accurate recording, reporting and collation of epidemiological data on EREID."

III. GOAL AND OBJECTIVES

A. Goal

A functional integrated disease surveillance and response system that would result in considerable reduction in morbidity, disability and mortality caused by communicable diseases and other conditions

B. General Objectives

1. To provide continuous, timely and accurate disease surveillance information that will guide response or interventions for all stakeholders, particularly local government units and national programs; and
2. To develop, improve and strengthen the capacity for an integrated surveillance and response at all levels of health system.

C. Specific Objectives

1. To list and prioritize notifiable diseases, syndromes or other conditions as specified in the IIR and according to consensus developed between local government units and national programs;
2. To design and establish an integrated disease surveillance system that enhances the use of standard case definitions for notification and case-based or event-based reporting of priority diseases, syndromes, conditions, or risks;
3. To establish or strengthen epidemiology and surveillance units (ESUs) at the regional and local levels that would serve as focal points for coordinating surveillance and response activities;
4. To strengthen surveillance data management (collection, collation, analysis, interpretation and dissemination);
5. To ensure use of information or knowledge for policy and decision-making at all levels;
6. To strengthen the capacity and networking of laboratories at the national and local levels;
7. To enforce the involvement of private health-care facilities in the surveillance system;
8. To strengthen community participation in disease detection, notification and response to epidemics;



9. To prepare national and local health staff to respond effectively to epidemics;
10. To establish a national coordinating body that would provide overall coordination of surveillance operations and the authority to shift priorities and resources according to changes in surveillance needs; and
11. To enhance the utilization of information and communication technology for prompt reporting and data management that would be appropriate at the national and local levels.

IV. SCOPE AND COVERAGE

This issuance shall apply to the entire health sector, to include public and private, national agencies and local government units, external development agencies, and the community involved in disease surveillance and response activities.

This issuance shall cover routine surveillance of priority diseases and events identified by the Department of Health.

V. DEFINITION OF TERMS

- A. **Active Surveillance** – refers to a system employing staff members to regularly contact health care providers or the population to seek information about health conditions. Active surveillance provides the most accurate and timely information, but it is also expensive.
- B. **Alert threshold** – refers to the level of disease that serves as an early warning for epidemics. An increase in the number of cases above the threshold level should trigger an epidemiologic investigation, assessment of epidemic preparedness and implementation of appropriate prevention and control measures.
- C. **Disease** – refers to a specific illness or medical condition, irrespective of origin or source that presents or could present significant harm to humans.
- D. **Epidemic** - refers to the occurrence in a community or region of cases of an illness, specific health-related behavior, or other health-related events clearly in excess of normal expectancy. The community or region and the period in which the cases occur are specified precisely. The number of cases indicating the presence of an epidemic varies according to the agent, size, and type of population exposed; previous experience or lack of exposure to the disease; and time and place of occurrence. (Adapted from Last JM, ed. *A Dictionary of Epidemiology*, 1997). A community may refer to specific groups of people (e.g., those attending a social function and got ill from food poisoning).

Note: *The terms epidemic and outbreak could be used interchangeably. For purposes of brevity and consistency, we used the term epidemic in this guideline.*

- E. **Epidemic threshold** - refers to the level of disease above which an urgent response is required. The threshold is specific to each disease and depends on the infectiousness, other determinants of transmission and local endemicity levels. For some diseases, such as poliomyelitis or SARS, one case is sufficient to initiate a response.



- F. **Epidemiology** - refers to the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems.
- G. **Epidemiology and Surveillance Unit (ESU)** - refers to a unit established in the Centers for Health Development (RESU), Provincial Health Offices (PESU), City Health Offices (CESU) and Municipal Health Units (MESU) or Inter-local Health Zones ((DESU) that provide services on public health surveillance and epidemiology
- H. **Event-based Surveillance** - refers to unstructured data gathered from sources of intelligence of any nature. These sources include scientific watch, direct notifications, media watch, international watch and intersectoral-events. It is a rapid reporting and response system that immediately alerts health authorities of public health events that require a timely response.
- I. **Expanded Program on Immunization Surveillance (EPISurv)** - refers to an intensive indicator-based, hospital-based surveillance of diseases targeted for eradication or elimination. This includes acute flaccid paralysis or suspected polio, measles and neonatal tetanus and adverse events following immunization. Periodic reviews of individual cases may be required to ascertain correct diagnosis.
- J. **Field Health Service Information System** - refers to the health information system that provides the Department of Health (DOH) with field-based surveillance of notifiable diseases and syndromes and categorical surveillance of program management indicators from priority public health programs.
- K. **HIV/AIDS Registry** - refers to the registry of all HIV-AIDS cases in the Philippines that are reported from both public and private hospitals, laboratories, and other agencies.
- L. **Integrated Disease Surveillance and Response** - refers to a process of coordinating, prioritizing, and streamlining of core surveillance activities (e.g., data collection, reporting, laboratory and epidemiological confirmation, analysis, feedback), support functions (e.g., training, monitoring, financial and logistics) and response (e.g., epidemic investigation) with the aim of making the system more efficient and effective in providing timely, accurate and relevant information for action.
- M. **International Health Regulations (IHR) of 2005** - refers to the international legal instrument that binds all WHO Member States to implement a set of international standards with the aim to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.
- N. **Laboratory-based surveillance system** - refers to a systematic referral of laboratory samples from defined conditions or random cases to detect occurrence of unusual or new pathogens.
- O. **National Epidemic Sentinel Surveillance System (NESSS)** - refers to the surveillance system of a pre-arranged sample of hospital-based reporting sources that agreed to report all cases of 15 diseases that have potential to cause outbreaks and which might indicate trends in the entire target population. Standard case definitions are used and some require strict confirmation in the laboratory before they are included as cases.



- P. **National IHR Focal Point**- refers to the national center, designated by each State Party, which shall be accessible at all times for communications with WHO IHR Contact Points under the 2005 IHR. The National Epidemiology Center (NEC) was designated as the National IHR Focal Point per Administrative Order No.2007- 0002 dated January 17, 2007..
- Q. **Notifiable Disease Reporting System (NDRS)** - refers to the reporting component of the Field Health Service Information System (FHSIS) that monitors 17 diseases and 7 syndromes. Data are generated from the barangay health stations, rural health units and municipal or city health centers on a periodic basis. Annual reports reflect annual incidence of notifiable diseases.
- R. **Notifiable Disease** - refers to a disease that, by legal requirements, must be reported to the public health or other authority in the pertinent jurisdiction when the diagnosis is made.
- S. **Outbreak** - see epidemic.
- T. **Passive surveillance** – refers to a system by which a health jurisdiction receives reports submitted from hospitals, clinics, public health units, or other sources. Passive surveillance is a relatively inexpensive strategy to cover large areas, and it provides critical information for monitoring a community's health. However, because passive surveillance depends on people in different institutions to provide data, data quality and timeliness are difficult to control.
- U. **Point of Entry** – refers to a passage for international entry or exit of travelers, baggage, cargo, containers, conveyances, goods and postal parcels as well as agencies and areas providing services to them on entry or exit.
- V. **Public health surveillance** - refers to the ongoing, systematic collection, analysis, interpretation and timely dissemination of health data for the planning, implementation and evaluation of public health program. The application of these data to disease prevention and health promotion program completes the surveillance cycle in public health.
- W. **Public Health Emergency of International Concern (PHEIC)** – refers to an extraordinary event which is determined, as provided in the 2005 IHR: 1) to constitute a public health risk to other states through the international spread of disease and 2) to potentially require a coordinated international response
- X. **Quarantine** – refers to the restriction of activities and/or separation from others of suspect persons who are not ill or of suspect baggage, containers, conveyances, or goods in such a manner as to prevent the possible spread of infection or contamination.
- Y. **Surveillance report** - refers to a regular publication with specific information on the disease under surveillance. It contains updates of standard tables and graphs as well as information on epidemics etc. In addition it may contain information on the performance of participants using agreed performance indicators.
- Z. **Syndromic Surveillance** – refers to a passive or active system that uses cases definitions of cases based on clinical features without accompanying clinical or laboratory diagnosis or, as it pertains to surveillance of bioterrorism, of syndromes attributable to use of potential agents by terrorists. Lacks specificity and often requires more investigations from higher levels.



- AA. **Zero case reporting** – refers to the reporting of ‘zero case’ when no cases have been detected by the reporting unit so as to distinguish it from missed or delayed reporting.

VI. GUIDING PRINCIPLES

- A. PIDSR shall be consistent with the technical leadership role of the DOH in health and shall contribute to the achievement of the National Health Objectives and the country's Millennium Development Goals.
- B. PIDSR shall respect and support priorities established under the *Fourmula One* framework for health reforms, particularly towards more responsive health systems.
- C. PIDSR shall be faithful to the spirit of decentralization and recognize the vital role of local government units on all matters related to health.
- D. PIDSR shall be adequately compatible with the 2005 IHR surveillance and response standards and be guided by the country's commitments and obligations.
- E. PIDSR shall build on the strength and learn from the weakness of what already exists.
- F. PIDSR shall comply with the overall guiding principles of usefulness, simplicity and flexibility of the system, orientation to a specific action, and integration.
- G. PIDSR shall recognize and adopt the principle of partnership and shared responsibility. A partnership is a voluntary agreement between two or more parties to work cooperatively toward a set of shared outcomes in disease surveillance. Partnership includes the public and private sectors, national agencies and local government units, external development agencies, and the community involved in disease surveillance and response activities. The principle of shared responsibility recognizes that disease surveillance and response is the responsibility of all sectors and governments at all levels.
- H. The privacy and confidentiality of patient's information should be maintained. Privacy is the right of patients to choose what information they will release about themselves and to whom. Confidentiality is the obligation of public health workers to keep information about individuals restricted only to those persons who absolutely need it for the health of the community. Patients have the right to know why they are providing information, to refuse to provide information, and to expect that information will be handled as confidential.
- I. Professionalism and the public trust should be maintained. To perform public health functions, including surveillance, it is essential that there is public support for professionalism among the ranks. Trust is an expression of confidence that public health workers will be fair, reliable, ethical, and competent.

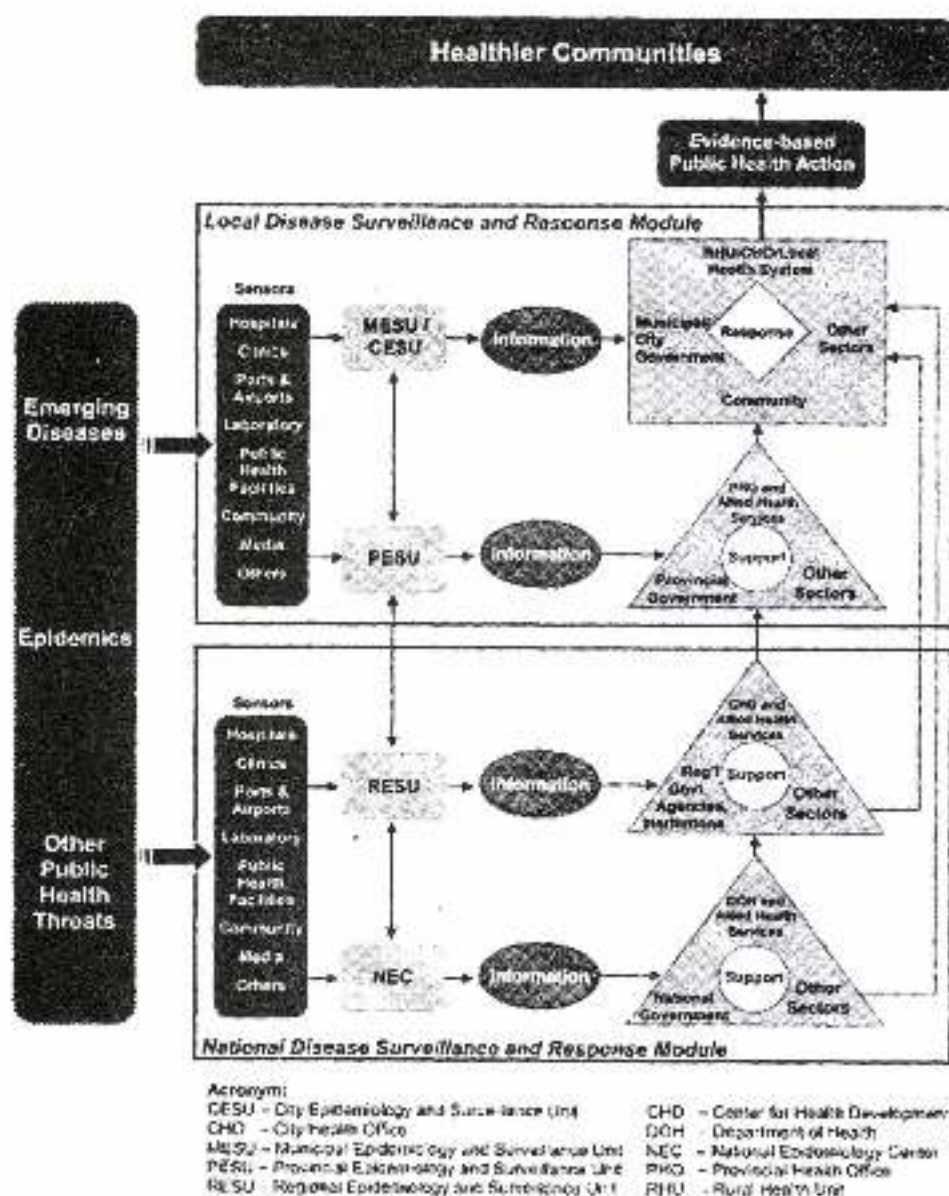
VII. FRAMEWORK

The PIDSR Framework embodies an integrated functional disease surveillance and response system institutionalized from the national level down to the community level. Each level of the health care delivery system interacts with each other while performing their basic



roles and responsibilities. Standard case definitions to detect priority diseases are to be used in all disease reporting units and a comprehensive flow of reporting is adopted. With the PIDSR, the local government units take an active role in disease detection and response in their respective localities while the regional and national levels will provide the necessary support. Policies, guidelines and trainings will also be provided by the national level. The interaction among all the levels of the health care delivery in the PIDSR system, the use of standard case definitions for priority diseases, and the adoption of a standard reporting flow will bring about harmonization and integration of disease surveillance and response in the country.

PIDSR Framework



VIII. IMPLEMENTING GUIDELINES

The PIDSR shall be promoted at all levels in order to create well-informed groups with increased sense of responsibility, urgency and ownership and to ensure maximum cooperation. This could be done through sensitization meetings, training workshops, advocacy campaigns using different media channels, including piggy-backing of integrated disease surveillance messages during intervention program activities. A technical assistance package that would strengthen the CHDs, PHOs, CHOs and MHOs perform their basic roles and responsibilities for surveillance and response shall be developed. The package shall be comprehensive to cover the requirements of a functional surveillance system and not just limited to skills development.

A. Core Surveillance Activities

1. Case Detection, Notification, and Reporting

- a. Standard case definitions shall be developed for each of the notifiable disease/syndrome.
- b. Reporting of notifiable diseases/syndromes or events shall fall into two categories. These are:

1) Immediately notifiable disease/syndrome or event

Diseases under this category shall be reported within 24 hours of detections to the PHO, CHD and NEC by the fastest means possible.

- a) AFP
- b) Adverse Events Following Immunization (AEFI)
- c) Anthrax
- d) Human Avian Influenza
- e) Measles
- f) Meningococcal Disease
- g) Neonatal Tetanus
- h) Paralytic Shellfish Poisoning
- i) Rabies
- j) SARS

2) Weekly notifiable disease/syndrome - All cases of notifiable diseases/syndromes seen within the week shall be reported to the next higher level.

- c. Zero case reporting of all notifiable diseases and syndromes shall be implemented in all levels. This means reporting of "zero case" when no cases have been detected by the reporting unit.
- d. PESUs and CESUs in chartered cities shall submit their surveillance data file weekly to the RESU through e-mail or by any other means. RESUs shall also submit their weekly surveillance data file to NEC through e-mail or by any other means.



- e. All government and private hospitals/clinics, MHOs and non-chartered CHOs shall designate a Disease Surveillance Coordinator (DSC).

2. Laboratory and Epidemiological Confirmation

- a. Specimens collected during epidemics for laboratory confirmation may be submitted to the appropriate national reference laboratories as stipulated in the DOH Department Order No. 393-F s. 2000

Other institutions like the UPPGH National Poison Control Center and BFAD may accept specific specimens for testing. Some Regional Public Health Laboratories and Regional Hospitals also have the capacity to do microbiological testing. Private tertiary hospitals may also offer laboratory support in cases of epidemics.

- b. Reference laboratories shall immediately inform NEC for any specimens received from the field for confirmation of suspected epidemics and vice versa. Reference laboratories shall process specimens and send timely results as required to each level.
- c. A standard protocol for specimen collection, preparation, storage, transport and interpretation of results shall be developed and available in all levels.
- d. Specimen collection kits for priority diseases (e.g., AFP, measles, and cholera) shall be available at the regional and provincial levels.
- e. A mechanism for building the capacity and networking of laboratories at the national and local levels and their involvement in disease surveillance shall be developed.
- f. Epidemiological confirmation involves intensive case-patient investigation in the field (e.g., household, hospital or workplace). The primary purpose is to examine the patient or patients to confirm that their signs and symptoms meet the case definition. Other epidemiological information is also obtained from the patient or a family member who can speak for the patient.

3. Data Analysis and Interpretation

- a. Data management shall be strengthened at all levels, with focus on the health facility and local levels. This includes providing training in all aspects of information management (including data quality assurance) to relevant staff as required.
- b. Computerized data management shall be strengthened at the central, regional and provincial levels. CHOs and MHOs, who have voluminous surveillance data and have the capacity to procure, operate and maintain computer equipment may opt to computerize data management.



4. Feedback

- a. Feedback to those who generated the information (e.g., local health-care providers) and those who transmitted the reports to the next higher level shall be strengthened.
- b. The MHOs and CHOs shall provide feedback to community members about reported cases and prevention activities.
- c. The PFSUs and RESUs shall alert nearby areas and provinces about epidemics and give health facilities regular, periodic feedback about routine control and prevention activities.
- d. The National Epidemiology Center shall develop and periodically distribute disease surveillance bulletins to all levels of the surveillance system. In addition, NEC shall maintain a website that provides information on disease trends, progress towards achievement of goals and reports on investigation and control of epidemics.

B. Epidemic Detection and Response

1. Detection - All suspected epidemics, including unofficial reports, shall be assessed by the National Epidemiology Center in coordination with the CHD, local government units, government agencies and other parties directly or indirectly involved in the investigation and control of epidemics.
2. Verification - Municipal and city health offices shall promptly verify reports of epidemics received from health facilities or through community rumors and notify the next higher level.
3. Declaration of an Epidemic
 - a. Declaration of an epidemic should be supported by sufficient scientific evidence. These include:
 - 1) Surveillance information
 - 2) Epidemiologic investigation (descriptive or analytic)
 - 3) Environmental investigation
 - 4) Laboratory investigation
 - b. The municipal/city health office can declare an epidemic if it has a functional surveillance system, otherwise the next higher level may provide technical assistance in the declaration of an epidemic.
 - c. The DOH Rules and Regulations Implementing the Local Government Code of 1991 (**DOH RRILGC of 1991**), Chapter 11, Section 44 c, specifies that the Department of Health has the final decision regarding the presence of epidemic, pestilence, or other widespread public health danger in a particular area or region. In compliance to this rule, the Secretary of Health shall have the sole authority to affirm or reverse any declaration of an epidemic.
 - d. The Secretary of Health shall have the sole authority to declare epidemics of national and/or international importance. These include the following:



- 1) Epidemic linked to nationally or internationally distributed product: Epidemic linked by investigation to a product that has national or international distribution, such as a manufactured food item, have the potential to affect individuals in municipalities and cities simultaneously.
- 2) Case(s) of exotic disease acquired locally: All cases of illness due to communicable diseases that are not endemic in the Philippines should be investigated rapidly to confirm whether the illness has been acquired locally or from overseas. Human avian influenza, SARS, Ebola, poliomyelitis are among the exotic diseases that are of national importance.
- 3) Diseases with high pathogenicity: Epidemics of highly-virulent organisms (e.g., Ebola) are likely to cause heightened public concern, and may require technical expertise and collaboration at the national level.
- 4) Diseases with significant risk of international spread:
- 5) Epidemics in tourist facilities, among foreign travelers or at national/international events:
- 6) Epidemics associated with health service failure: Epidemics linked to breakdown in standards of health care delivery, such as infection control failure, blood product contamination or systematic immunization failure will require a strategic national approach.

4. Containment

- a. Once the presence of an epidemic is verified, the MHO/CHO shall activate the epidemic response team. The team shall conduct a full epidemiologic investigation and implement appropriate control measures immediately.
- b. In instances where the MHO or CHO have no technical capacity to respond to an epidemic, the MHO or CHO shall immediately request for assistance either from the PHO, CHD or DOH central office.
- c. The Department of Health through the National Epidemiology Center in coordination with CHD-RESU shall provide immediate on-site technical assistance to the LGU in epidemic investigation in the following conditions:
 - 1) The epidemic is continuing (i.e., there is evidence of ongoing transmission).
 - 2) Similar epidemics have occurred before, or are expected in the future, and more information is needed to develop preventive measures.
 - 3) The epidemic is having, or likely to have, a very high impact on public health because of its size and/or the severity of illness.
 - 4) The epidemic has attracted public, media or political interest.
 - 5) The epidemic transmission route is new or unusual.
 - 6) The causative agent is unknown.
 - 7) Descriptive characteristics of the epidemic (time, place, person or organism subtype) suggest that a common source is highly likely.



- d. The National Epidemiology Center in coordination with the CHD, local government unit and other concerned agencies shall take the lead in the investigation of epidemics of national and international.

C. Support to Surveillance

1. Staffing

- a. City and Municipal Health offices shall designate one Medical or Nurse Disease Surveillance Officer and one Surveillance Assistant for surveillance activities.
- b. Provincial Health Offices shall establish their Provincial Epidemiology and Surveillance Units and provide for one full-time Provincial Medical or Nurse Disease Surveillance Officer, one full-time Surveillance Assistant, and one full-time Surveillance Clerk.

2. Training and Education

- a. The National Epidemiology Center shall develop PIDSR training modules. This modular training course, which will form part of the PIDSR Systems Development Technical Assistance Package, will have a specific module applicable to different types of surveillance staff at different levels.
 - b. The PIDSR training program shall be established and institutionalized at the regional and provincial levels. The training shall be offered on a regular basis to train new surveillance and response staff at the provincial and local levels.
 - c. The National Epidemiology Center shall develop and implement advanced courses, training programs or seminars on specific areas of public health surveillance.
 - d. Annual disease surveillance conferences shall be organized at the national and/or regional levels. This will be attended by ESU staff, DSCs, representatives from the public and private sectors.
 - e. The National Epidemiology Center shall continue to operate the Field Epidemiology Training Program (FETP). Physicians employed in CHDs, PHOs and CHOs who will be designated to head the RESU, PESU or CESU shall be given priority for this 2-year course on field epidemiology.
3. Supervision - Periodic technical supervision shall be conducted by the national and regional offices to track the progress in the implementation of the integrated disease surveillance and response system.
 4. Communication - Functional communication networks shall be established among all levels to strengthen the reporting and dissemination of information.
 5. Financing - It is highly recommended that PESUs, CESUs and RHUs shall be provided with a line item budget using appropriate local funds (e.g. calamity/disaster preparedness funds). The funds will be used to defray the operational costs of equipment, supplies, transportation, communications and logistics needed to support the ESU and response to epidemics.



D. Infrastructure

1. Epidemiology and Surveillance Units (ESU) shall be established/strengthened at the CHD, PHO, CHO and RHU levels.

IX. MONITORING AND EVALUATION

- A. A monitoring system shall be established to track the implementation of planned surveillance activities and of the overall performance of surveillance and response systems.

- B. The PIDSR system shall be evaluated every two years or as needed.

X. IMPLEMENTING MECHANISM

Roles and Responsibilities

A. DOH

1. National Epidemiology Center

- a. Assess all reported epidemics within 48 hours.
- b. Notify WHO when the assessment indicates that the event is a public health emergency of international concern (PHEIC).
- c. Determine rapidly the control measures required to prevent domestic and international spread of disease.
- d. Provide support through specialized staff and logistical assistance during epidemic investigation and response.
- e. Establish effective networking with other relevant government agencies at the national level and local level.
- f. Provide direct operational link with senior health and other officials at the national and local levels to approve rapidly and implement containment and control measures.
- g. Facilitate the dissemination of information and recommendations from DOH Central office and WHO regarding local and international public health events to the concerned agencies and institutions.
- h. Initiate the development and implementation of the integrated national epidemic preparedness and response plan.
- i. Facilitate the budget allocation for surveillance and response at the regional health offices.
- j. Oversee the design and implementation of PIDSR.



2. Bureau of Quarantine

- a. Develops and ensures compliance to protocols and field operation guidelines on entry/exit management of persons, conveyances and goods in coordination with airport and port authorities.
- b. Conducts surveillance in ports and airports of entry and sub-ports as well as the airports and ports of origin of international flights and vessels
- c. Monitors public health threats in other countries
- d. Provides effective networking and collaboration among the Bureau of Quarantine stakeholders
- e. Assist in the development and implementation of the integrated national epidemic preparedness and response plan.

3. National Center for Disease Prevention and Control

- a. Provides updates, technical advice and recommendations on the recognition, prevention and control of diseases
- b. Assist in the development and implementation of the integrated national epidemic preparedness and response plan.
- c. Organize the DOH Management Committee for the Prevention and Control of Emerging and Re-emerging Infectious Diseases

4. Health Emergency Management Staff

- a. Acts as the DOH coordinating unit and operations center for all health emergencies, disasters and incidents with potential of becoming an emergency
- b. Assist in the development and implementation of the integrated national epidemic preparedness and response plan.

5. Center for Health Development

- a. Provide on-site assistance (e.g., technical, logistics, and laboratory analysis of samples) as requested to supplement local epidemic investigations and control.
- b. Establish, operate and maintain a regional epidemic preparedness and response plan, including the creation of multidisciplinary/multisectoral teams to respond to events that may constitute a public health emergency of local and international concern;
- c. Assess reported epidemics immediately and report all essential information to DOH central office.
- d. Provide direct liaison with other regional government agencies



- e. Provide a direct operational link with senior health and other officials at the regional level.
- f. Facilitate submission of weekly notifiable disease surveillance reports from public and private hospitals.
- g. Provide technical and logistical assistance in the establishment of ESUs at the provincial/city/municipal health offices.
- h. Ensure the functionality of the regional disease surveillance and response system.
- i. The Hospital Licensing Team at the CHDs shall track and monitor the compliance of public and private hospitals in the implementation of PIDSR as part of the requirements for renewals of license to operate. The team will inform the CHDs/PHOs/LGUs of activities taken against non-complying hospital institutions. Likewise, CHOs/MHOs/PHOs shall report to the CHDs hospitals and related facilities that fail to comply with the PIDSR reporting requirements. The regional director shall issue a regional order to enforce compliance.
- j. Create Epidemic Management Committee (EMC) at the regional level.

B. LGUs

1. Provincial Health Office

- a. Set up and maintain a functional provincial disease surveillance system equipped with the necessary resources and adequate local financial support. Financial support may come from the disaster, calamity or other appropriate funding sources as determined by the provincial government officials.
- b. Collect, organize, analyze and interpret surveillance data in their respective areas.
- c. Report all available essential information (e.g., clinical description, laboratory results, numbers of human cases and deaths, sources and type of risk) immediately to the next higher level.
- d. Assess reported epidemics immediately and report all essential information to CHD and DOH central office.
- e. Provide on-site assistance (e.g., technical, logistics, and laboratory analysis of samples) as requested to supplement local epidemic investigations and control.
- f. Facilitate submission of weekly notifiable disease surveillance reports from public and private hospitals.
- g. Establish, operate and maintain a provincial epidemic preparedness and response plan, including the creation of multidisciplinary/multisectoral teams to respond to events that may constitute a public health emergency of local and international concern.
- h. Create Epidemic Management Committee (EMC) at the provincial level.



2. Municipal/City Health Office

- a. Set up and maintain a functional municipal/city/community disease surveillance system equipped with the necessary resources and adequate local financial support. Financial support may come from the disaster, calamity or other appropriate funding sources as determined by the municipal/city government officials.
- b. Collect, organize, analyze and interpret surveillance data in their respective areas.
- c. Report all available essential information (e.g., clinical description, laboratory results, numbers of human cases and deaths, sources and type of risk) immediately to the next higher level.
- d. Implement appropriate epidemic control measures immediately.
- e. Establish, update and maintain a municipal/city epidemic preparedness and response plan, including the creation of multidisciplinary/multisectoral teams to respond to events that may constitute a public health emergency.
- f. Facilitate submission of weekly notifiable disease surveillance reports from public and private hospitals.

C. Philippine Health Insurance Corporation (PHIC)

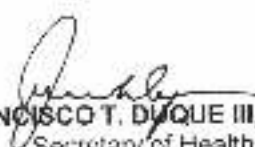
The Philippine Health Insurance Corporation shall support the implementation of PIDS in hospitals and private practitioners by using its accreditation authority and reimbursement of claims as a leverage to encourage compliance. A letter or memorandum from PHIC shall be issued to this effect.

XI. REPEALING CLAUSE

The provisions of previous Orders and other related issuances inconsistent or contrary with the provisions of this Administrative Order are hereby revised, modified, repealed or rescinded accordingly. All other provisions of existing issuances which are not affected by this Order shall remain valid and in effect.

XII. EFFECTIVITY

This order shall take effect immediately.


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



Annex 7

SURVEILLANCE

