Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

November 26, 2020

DEPARTMENT MEMORANDUM
No. 2020 - 0512

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

SUBJECT: **Revised Omnibus Interim Guidelines on Prevention, Detection, Isolation, Treatment, and Reintegration Strategies for COVID-19**

I. BACKGROUND

The Department of Health (DOH) continuously recalibrates its strategies targeted to address the overall objective of the COVID-19 response. Among its top priority is to increase the capacity of the health system to identify those infected and determine the appropriate level of care and facilities that can cater to them. DOH has employed strategies to strengthen contact tracing, isolation, and quarantine, as well as scaling up testing capacity of the country and monitoring innovations and technologies which can be potentially useful in detecting the virus.

On 31 August 2020, the National Task Force Against COVID-19 entrusted the DOH to develop algorithms on quarantine/isolation, testing, and discharge for priority subgroups, as well as to strengthen current algorithms for contact tracing, quarantine/isolation, and discharge of close contacts to include particular settings, such as communities and workplaces.

Furthermore, given the number of testing devices and kits being introduced now in the market, DOH remains vigilant in recommending the appropriate diagnostic tests for COVID-19 intended for public use. Knowledge of diagnostic tests for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is still evolving, and a clear understanding of the nature of the tests and interpretation of their findings is important.

This policy provides interim guidelines on surveillance, screening, contact tracing, quarantine or isolation, and testing as part of the COVID-19 response, reflecting revisions recommended by the Inter-Agency Task Force for the Management of Emerging Infectious Diseases and implementing agencies. These guidelines are subject to change as new evidence comes in.

II. GENERAL GUIDELINES

A. Implementation of the Prevention, Detection, Isolation, Treatment, and Reintegration Strategies shall be the cornerstone of response to prevent further transmission, and shall be a shared responsibility of the national government, local government units, private sector, and the public.

1. The DOH shall provide guidelines and oversight for all surveillance, contact tracing, quarantine or isolation, and response management activities.
2. The external agencies engaged in COVID-19 response shall comply with their specific roles and corresponding operational guidelines issued by the National Task Force for COVID-19 response.

B. Minimum public health standards, which include physical distancing, hand hygiene, cough etiquette, and wearing of masks among others, shall be strictly implemented across all settings, regardless of severity of risk.

C. Contact tracing shall be initiated after case investigation of every reported probable and confirmed COVID-19 case. Close contacts shall refer to persons who has experienced any one of the following exposures during the 2 days before and the 14 days after the onset of symptoms of a probable or confirmed case (WHO Public Health Surveillance for COVID-19, 7 Aug 2020):

1. Face-to face contact with a probable or confirmed case within 1 meter and for at least 15 minutes;
2. Direct physical contact with a probable or confirmed case;
3. Direct care for a patient with probable or confirmed COVID-19 disease without using recommended personal protective equipment OR;
4. Other situations as indicated by local risk assessments.

D. Contact tracing shall also commence for contacts of suspect cases upon detection, while waiting for specimen collection for SARS-CoV-2 diagnostic testing for the suspect case, or while waiting for rRT-PCR results. Contacts of suspect cases shall also be listed, traced, and assessed based on the same criteria used to identify close contacts. Second- and third-generation close contacts may also be traced as part of active contact tracing.

E. Proper clinical assessment shall be the basis for quarantine or isolation, and testing algorithms anchored on two main factors: symptoms and exposure, and shall reflect the most cost-effective intervention following the pretest probability framework: quarantine/isolate only, quarantine/isolate and test, or test only. Clinical assessments shall be conducted by licensed or deputized health workers, such as physicians, nurses, or midwives in the appropriate Personal Protective Equipment (PPE), using the standardized clinical and exposure assessment form ***(See Annex A)***.

1. Clinical Assessment
   a. Individuals shall be screened for symptoms indicative of COVID-19, as specified in the latest Philippine Society for Microbiology and Infectious Diseases Interim Guidance on the Clinical Management of Adult Patients with Suspected or Confirmed COVID-19 Infection, including the date of onset of illness, if

applicable (See Annex B).

b. Health care workers shall also screen individuals for existing comorbid illnesses (e.g. hypertension, chronic kidney disease, etc.), or other risk factors (e.g. elderly, high risk pregnancy, etc.).

2. Exposure Assessment
   a. All individuals must declare possible exposure to COVID-19 within 14 days prior to entry. Possible exposures include travel from other countries or areas with sustained community transmission as recommended by the Interagency Task Force for Emerging Infectious Disease (IATF-EID).

F. The difference between isolation and quarantine shall also be emphasized. Isolation refers to the separation of sick people with a contagious disease from people who are not sick. Therefore, isolation intends to treat and monitor suspect, probable, and confirmed cases. On the other hand, quarantine refers to the separation and movement restrictions of people who were exposed to a contagious disease to see if they become sick. Hence, quarantine intends to keep individuals under observation to see if they will develop COVID-19 signs or symptoms or if they will test positive for COVID-19 ***(See Annex B)***.

1. All close contacts of probable and confirmed cases, and travelers shall be placed under quarantine. In the event that they develop symptoms or test positive for COVID-19, they shall be isolated and shall be admitted and treated in the appropriate facility.

2. All suspect, probable, and confirmed cases shall be isolated in the proper facility depending on the severity of symptoms. Asymptomatic confirmed and mild cases shall be admitted and isolated in Temporary Treatment and Monitoring Facilities (TTMFs). Moderate cases shall be isolated and managed in Level 1 or Level 2 hospitals. Severe and critical cases shall be isolated and managed in Level 2 or Level 3 hospitals. Step-down care and proper inter-health facility referral system shall be applied to all cases whenever applicable.

G. Second-generation and third-generation close contacts, and general contacts shall be advised to self monitor, strictly adhere to the minimum health standards, and report for appearance of signs or symptoms.

H. Contacts of suspect cases shall be notified and advised to self-monitor, and adhere to stringent minimum public health standards. Should the suspect case turn out to be probable or confirmed, contacts will be asked to undergo quarantine or isolation whichever is appropriate ***(See Annex C)***.

I. COVID-19 Expanded Testing is defined as testing all individuals who are at-risk of contracting COVID-19 infection. This includes testing the following groups: (1) suspect cases or (2) individuals with relevant history of travel and exposure (or contact), whether symptomatic or asymptomatic, and (3) health care workers with possible exposure, whether symptomatic or asymptomatic. Sub-groups of at-risk individuals arranged in order of greatest to lowest need for rRT-PCR testing are identified ***(See Annex D)***. Due to global shortage of testing kits and other supplies, and limitation in local capacity for testing, there is a need to rationalize available tests and prioritize subgroups A and B.

Indiscriminate rRT-PCR testing beyond close contacts of a confirmed COVID-19 case is not recommended.

J. Reasons for testing the identified priority groups are also emphasized - testing for diagnosis, screening, or surveillance.

1. ***Diagnostic testing / Testing for diagnosis*** looks for presence of COVID-19 at the individual level and is performed when there is a particular reason to suspect that an individual may be infected (i.e. manifestation of symptoms or known history of exposure). Diagnostic testing intends to diagnose an infection in patients suspected of COVID-19 by their healthcare provider, such as in symptomatic individuals, individuals who have had recent exposure, and individuals who are in a high-risk group such as healthcare providers with known exposure. In these guidelines, this shall be applied to close contacts and suspect cases identified after symptoms-based screening.

2. ***Screening testing / Testing for screening*** intends to identify infected individuals prior to development of symptoms or those infected individuals without signs or symptoms who may be contagious, so that measures can be taken to prevent them from infecting others. This includes broad screening of asymptomatic individuals without known exposure and then deciding on the next courses of action based on individual test results. In these guidelines, this shall be applied to travelers from high prevalence areas.

3. ***Surveillance testing / Testing for surveillance*** is primarily used to obtain information at a population level, rather than an individual level. Surveillance testing may be random sampling of a certain percentage of a specific population, to (1) monitor for increasing or decreasing prevalence, and (2) determine the effects of community interventions such as social distancing at the population level. In these guidelines, these shall be applied to frontliners and essential workers.

K. In determining the right test for the right reason under any circumstance, the following shall be considered:

1. Availability of test;
2. Best time to use the test;
3. Turn-around-time of test results; and
4. Test specificity and sensitivity which shall be independently validated.

L. Use and limitations on the reliability and validity of the current available test kits shall be recognized. Interpretation of results of any tests for COVID-19 shall be done by a licensed physician and **shall always be correlated with the clinical picture** of the patient.

1. The currently recommended test to confirm COVID-19 infection is the Real-time reverse transcription polymerase chain reaction(rRT-PCR) assay, which detects the viral RNA ***(See Annex E)***. rRT-PCR testing shall prioritize diagnostic testing of exposed symptomatic individuals and close contacts, as well as screening testing of travelers, in accordance to the subgroups in **Annex D**

2. The use of the rapid antigen test (AgT) as a substitute for rRT-PCR shall be allowed for diagnostic testing of suspect, including symptomatic and asymptomatic close contacts who fit the suspect case definition, and probable cases (a) in the community or hospital setting when rRT-PCR capacity is insufficient, (b) in the hospital setting where the turnaround time is critical to guide patient cohort management, or (c) in the community during outbreaks for quicker case finding, provided that in any setting, only FDA-certified antigen tests with sensitivity and specificity in conformity with HTAC specifications ***(See Annex F)*** are used. For symptomatic close contacts, a positive AgT result shall be treated as the final diagnostic test result. Symptomatic close contacts who tested negative for AgT, as well as asymptomatic close contacts regardless of AgT result, shall undergo confirmatory rRT-PCR test ***(See Annex F)***.

3. The use of rapid antigen test (AgT) shall be allowed for diagnostic testing of close contacts in communities and close or semi-closed institutions with confirmed outbreaks and in remote settings where RT-PCR is not immediately available, in compliance with DM 2020-0468 *Supplemental Guidance on the Use of Rapid Antigen Test Kits*.

4. Pooled testing may be used for screening and surveillance testing of asymptomatic populations from low prevalence areas ***(See Annex F)***. Pooled test results shall not be used in lieu of any other diagnostic testing requirements. DOH shall issue supplementary guidelines on the use of pooled RT-PCR testing.

M. Discharge criteria for suspect, probable, and confirmed COVID-19 cases shall no longer entail repeat testing. Repeat testing should not be a prerequisite for the issuance of a clearance or certification to be issued by medical doctors.

1. Patients with mild symptoms who have completed at least 10 days of isolation from the onset of illness either at home or a temporary treatment and monitoring facility inclusive of 3 days of being clinically recovered and asymptomatic can be discharged and reintegrated to the community without the need for further testing, provided that a licensed medical doctor clears the patient. Confirmed cases with mild symptoms can be tagged as recovered once discharge criteria are met.

2. Patients with moderate, severe or critical symptoms who have completed at least 21 days of isolation in a hospital from the onset of illness, inclusive of 3 days of being clinically recovered and asymptomatic can be discharged and reintegrated to the community without the need for further testing, provided that a licensed medical doctor clears the patient. Confirmed cases with moderate, severe or critical symptoms can be tagged as recovered once discharge criteria are met.

3. Asymptomatic immunocompetent individuals who test PCR positive (+) and remained asymptomatic for at least 10 days from date of specimen collection can discontinue isolation after 10 days and be tagged as a recovered confirmed case without need for further testing, provided a licensed medical doctor certifies or clears the patient.

4. Close contacts who remain asymptomatic for at least 14 days from date of exposure can discontinue their quarantine without the need of any test.

5. Inbound international travelers who test PCR negative (-) and are asymptomatic can discontinue quarantine, provided certification from a licensed or deputized health worker that the traveler is not a COVID-19 case.

N. Surveillance, contact tracing, quarantine, isolation, and testing activities shall endeavor to meet the following targets:

1. Surveillance staff of 1:100,000 population ratio;
2. >80% of investigations done within 48 hours of getting rRT-PCR test results in areas with new cases as sources of infection;
3. Contact tracing staff of 1:800 population ratio;
4. 70% of close contacts are traced within 24 hours of getting rRT-PCR test results; and 100% are traced within 48 hours of getting rRT-PCR test results;
5. 100% of asymptomatic confirmed cases and symptomatic are isolated in an isolation facility within 48 hours; and
6. 100% of those requiring quarantine or isolation who opt to use their homes are in households that meet the criteria for home quarantine or isolation.

O. Reporting of the full line list of all rRT-PCR specimen tests, regardless of results, from the start of the operations of DOH licensed COVID-19 laboratories shall use the COVID-19 Repository Document System (CDRS). Line list of antigen tests results shall be reported by the local government units through their municipal or city epidemiology and surveillance units to DOH using CDRS as well.

P. The COVID-19 Case Investigation Form (CIF) ***(See Annex G)*** and any information technology system registered to DOH and/or validated by the Department of Information and Communications Technology shall be used for case investigation and testing.

Q. All hospitals, isolation facilities, and testing facilities shall utilize the appropriate PhilHealth benefit package and/or any benefit package provided by Health Maintenance Organizations or Private Health Insurance for COVID-19 to reimburse the costs of admissions, and testing of suspect and probable cases, close contacts, workers, returning residents, and returning Filipinos. Foreign travelers with essential businesses (diplomats, other foreigners with international engagements) shall be required to avail private health insurance prior to travel to the country, which shall shoulder the cost of quarantine, admissions, and testing.

R. Local government units (LGUs) shall set their respective requirements for interzonal travel, which may include testing, quarantine, registration, confirmed bookings prior to travel, and/or coordination with a travel agency, provided strict alignment with these guidelines, especially on the use of testing technologies.

S. Other government agencies shall issue supplementary guidance for their respective sectors, provided strict alignment with these guidelines.

III. SPECIFIC GUIDELINES

A. Surveillance General Process

1. Disease surveillance and response systems of the Department of Health (DOH) along with its local counterparts shall be the first line of defense to epidemics and health events that pose risk to public and security.

2. Disease surveillance shall be done by the DOH and its local counterparts following the provisions specified in the 2020 Revised Implementing Rules and Regulations (IRR) of Republic Act No. 11332, or the Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act. This includes:

    a. Regular updating of Priority Diseases/ Syndromes/ Conditions Targeted for Surveillance by the Epidemiology Bureau (EB) following the specified inclusion and exclusion criteria in the IRR;

    b. Declaration of Public Health Emergency by the Secretary of Health, the President, or by Provincial, City, or Municipal Health Offices provided that the declaration is supported by sufficient scientific evidence based on disease surveillance data, epidemiologic investigation, environmental investigation, and laboratory investigation;

    c. Ensuring that the DOH and its local counterparts maintain functional disease and response systems;

    d. Establishment of Epidemiology and Surveillance Units in every province, city, and municipality nationwide that will conduct disease surveillance and epidemiologic response activities including contact tracing, recommended needed response, and facilitation of capacity building in applied field epidemiology, disease surveillance and response as organized and provided by EB;

    e. Disease surveillance by the Bureau of Quarantine in ports and airports of entry and sub-ports as well as the airports and ports of origin of international flights and vessels; and

    f. Facilitation of CHDs/ Regional Offices and Regional Epidemiology Unit (RESU) of submission of weekly notifiable disease surveillance reports from public and private hospitals.

B. Contact Tracing General Processes

1. Contact identification

    a. All Disease Reporting Units (DRUs), including health facilities, local government units (LGUs), and laboratories, shall complete the Case Identification Forms (CIFs) of all suspect, probable, and confirmed cases they

encounter, and simultaneously submit such information to DOH information systems and the respective LGU.

b. Patients who self-report symptoms personally or through DOH information systems, and patients reported by occupational safety and health (OSH) officers shall be included in LGUs' list of contacts and cases that shall be for case investigation.

c. All Local Epidemiology and Surveillance Units (LESUs) shall initiate case investigation for daily new contacts from submissions of DRUs and extracts from DOH information systems.

2. Case investigation or contact listing

a. All LESUs shall develop a contact tracing ecosystem that are composed of community support teams such as Barangay Health Emergency Response Teams (BHERTs), interviewers, encoders, analysts, and technical support staff.

b. All LESUs shall assign a contact tracer for each suspect, probable, and confirmed case manually or through DOH information systems.

c. Laboratory confirmation shall not delay the initiation of contact tracing.

d. Case and contact interviews shall be conducted in safe and conducive environments to establish trust and rapport.

e. Cognitive interviewing techniques shall be used to elicit the following information, as applicable:
   i. All people with direct physical contact;
   ii. All people who lived with the case in the same household;
   iii. All places, establishments, and workplaces visited;
   iv. All healthcare facilities visited; and
   v. Anyone else who might be exposed.

f. Other methods, including records and CCTV review, shall be conducted to obtain the following information mentioned above. All disease reporting units and other entities, such as workplaces, flight, sea vessel and land transport services, hotels, malls, etc, shall ensure that LESUs are provided access to pertinent records and help facilitate the interview of the confirmed COVID-19 cases, and their relatives, caregivers, and/or guardians.

g. Patients shall provide information to communicate with the contacts such as contact number and address.

h. Each contact tracer shall identify all close contacts and exposure histories of the case and input the information in CIF forms, which shall be submitted by contact tracer or LESU to DOH information systems.

i. All identified close contacts that belong to a different LGU shall be forwarded by the originating LESU to the LESU of the next LGU for appropriate action, either manually or through DOH information systems.

3. Case Management

   a. All contact tracers shall ensure that all close contacts identified shall be:
      i. Informed of the protocols for communicating with, managing, and secure reporting of identified close contacts;
      ii. Informed of protocols for daily symptom monitoring;
      iii. Referred by the BHERTs to appropriate quarantine, isolation, or tertiary care facilities as applicable based on risk screening;
      iv. Requested to personally notify their close contacts for preemptive quarantine and isolation even prior to communication by designated contact tracer;
      v. Referred for testing following protocols and prioritization for testing described below, and follow up and update information systems with test results as necessary;
      vi. Monitored by the BHERTs for at least 14 days, depending on severity, for progression of symptoms or case status and subsequent updating of health status in DOH information systems.

   b. Contact tracers shall be deputized to provide test results to confirmed cases using information available from DOH information systems, while waiting for official laboratory results from laboratories, provided processes for such are followed as developed by the LGU.

   c. Contact tracers or the LESU shall notify establishments or workplaces that suspect, probable, and confirmed cases have visited, based on guidelines developed by the LGU.

   d. Contact Tracing Teams shall be composed of physicians, nurses, midwives, sanitary inspectors, population officers, staff from local disaster risk reduction and management offices, Bureau of Fire Protection, local police officers, members of the Armed Forces of the Philippines (AFP) and volunteers for contact tracing, navigation, and monitoring of cases. In areas with limited numbers of healthcare workers, allied healthcare workers shall serve as lead of CTTs and other key community members shall be included, such as parent leaders of the Pantawid Pamilyang Pilipino Program and members of civil society organizations.

   e. Close contacts shall be managed accordingly based on the latest Interim Management Guidelines for COVID-19 of the Philippine Society for Microbiology and Infectious Diseases, Inc.

C. Setting-Specific Pathways for Contact Tracing, Quarantine or Isolation, and Diagnostic Testing ***(See Annex H)***

1. Asymptomatic Close Contacts of Probable and Confirmed Cases in the Community - When an asymptomatic close contact is identified and traced, they shall undergo immediate quarantine and be monitored whether or not symptoms will manifest during the 14-day period.

   a. If symptoms did not manifest, they shall be discharged after the 14-day quarantine starting from date of their last exposure to the probable or confirmed case.

b. If symptoms develop, they shall be admitted to a TTMF and be tested using rRT-PCR, or if not available, antigen test. If results are NEGATIVE, they shall be discharged after the completion of 10-day isolation inclusive of at least three (3) days of being asymptomatic. If results are POSITIVE, they shall be isolated, managed and discharged following **Section II.F and M**.

2. Symptomatic Close Contacts of Probable and Confirmed Cases in the Community - When a symptomatic close contact who fit the suspect case definition is identified and traced, they shall be referred to an appropriate health facility for isolation, testing, and clinical management following **Section II.F, L, and M**.

3. Asymptomatic Close Contacts of Probable and Confirmed Cases in the Workplace - Listed close contacts in the workplace shall undergo immediate quarantine. The Occupational Safety and Health (OSH) Officer shall also inform concerned LESUs. LESUs shall generate the list of close contacts outside the workplace and shall be referred to LGU Contact Tracing Teams. While in quarantine, close contacts shall be monitored whether or not symptoms will manifest during the 14-day quarantine. The algorithm for monitoring the progression of symptoms of close contacts in the community shall be followed ***(See Section III.C.1.a & b)***. Clearance for returning to work shall be symptoms-based and upon the assessment of the OSH Officer.

4. Suspects (Symptomatic Close Contacts) in the Workplace - When a suspect, or symptomatic close contact who fit the suspect case definition, has been identified at work, the OSH Officer of the workplace shall determine and trace all close contacts of the case. The OSH Officer shall also inform concerned LESU. LESUs shall generate the list of close contacts outside the workplace and shall be referred to LGU Contact Tracing Teams. Suspects shall be referred to an appropriate health facility for isolation, testing, and clinical management. The same algorithm for symptomatic close contacts in the community shall apply ***(See Section C.2.a & b)***. Clearance for returning to work shall be symptoms-based and upon the assessment of the OSH Officer.

5. Self-reporting Close Contacts - When a patient knows s/he is a close contact, is asymptomatic and wants to self-report, they shall contact their respective BHERTs for assessment and proper referral to the appropriate facility. They shall be monitored whether or not symptoms will manifest during the 14-day quarantine. The algorithm for monitoring the progression of symptoms of close contacts in the community shall be followed ***(See Section III.C.1.a & b)***.

6. Self-reporting Suspects (Symptomatic Close Contacts) - When a close contact is symptomatic, they shall contact their respective BHERTs for assessment, proper referral to a TTMF, and testing. If the patient fits the suspect case definition, the algorithm for symptomatic close contacts in the community shall apply ***(See Section C.2.a & b)***.

7. Contacts of Suspect Cases in the Workplace or Community - Contacts of suspect cases shall be notified and advised to self-monitor, and adhere to stringent minimum public health standards. Should the suspect case turn out to be probable or confirmed, contacts will be asked to undergo quarantine or isolation whichever is

appropriate. They shall follow the algorithm for close contacts of probable or confirmed cases, depending on their symptoms and setting.

D. Pathways for Screening, Quarantine or Isolation, and Testing for Screening of Travelers *(See Annex I)*

All travelers, particularly inbound international travelers and interzonal domestic travelers shall be required to undergo clinical and exposure assessment ***(See Section E)***.

1. All symptomatic travelers identified at points of entry or exit shall be admitted to the appropriate facility and tested using rRT-PCR. Contact tracing shall be initiated. ***(See Section II.D, F, L, and M)***
2. All travelers identified as close contacts of confirmed or probable cases shall follow the pathways for close contacts ***(See Section III.C)***.
3. Asymptomatic international travelers shall be tested using RT-PCR and placed under quarantine while waiting for results. If negative, they shall be discharged, provided strict adherence to minimum public health standards. Exemptions for testing and quarantine protocols for international travelers staying in the country for less than 72 hours, and exemptions for quarantine protocols for international travelers staying for less than 14 days shall be provided, subject to the guidelines and/or approval of respective agencies and authorities.
4. Asymptomatic interzonal domestic travelers with no established exposure/contact to a probable or confirmed case shall be allowed to travel, provided strict adherence to minimum public health standards and symptoms monitoring. Additional measures and requirements, including but not limited to negative test results using rRT-PCR, pooled testing, or rapid antigen testing, and facility- or home-based quarantine, shall be in compliance with respective local government unit guidelines.

E. Pathways for Screening, Return-To-Work, and Surveillance Testing of Workers *(See Annex J)*

1. Proper clinical assessment shall be the primary basis for return-to-work decisions of all workers. If asymptomatic, they shall be allowed to return to work without the need for diagnostic testing, provided that they strictly adhere to minimum public health standards. If symptomatic, they shall follow the pathway for symptomatic close contacts in the workplace ***(See Section III.C.4a & b)***
2. Surveillance Testing using pooled testing of healthcare workers, frontliners indirectly involved in COVID-19 Response, frontliners in tourist areas, and economy workers may be conducted in areas with ≤10% prevalence of COVID-19. Pooled testing shall only be applied to asymptomatic workers ***(See Annex E.B)***. Asymptomatic workers who underwent surveillance testing may be allowed to return to work, provided that they strictly adhere to the minimum public health standards.
    a. If a pooled test result is negative, then all specimens can be presumed negative with the single test. However, if a pooled test result is positive, then all the specimens in the pool have to be retested individually and all individuals included in the pool have to be immediately quarantined.
    b. If the individual tests negative, they can discontinue quarantine.
    c. If the individual tests positive, they shall be contact traced and continue quarantine ***(See Section II. C, F and M)***.

F. Treatment of COVID-19 Cases

1. For patients with mild COVID-19 disease, supportive care is recommended. These include antipyretics for fever, oral fluids for hydration, isolation in temporary treatment and monitoring facilities or, if applicable, at home. Routine empiric antibiotics and routine anti-influenza drugs are not recommended for mild COVID-19 disease.
2. Patients with moderate, severe and critical symptoms shall be admitted to the hospital and shall be managed accordingly, following the latest Interim Management Guidelines for COVID-19 of the Philippine Society for Microbiology and Infectious Diseases, Inc.

IV. REPEALING CLAUSE

Provisions of DOH DM 2020-0439 or "Omnibus Interim Guidelines on Prevention, Detection, Isolation, Treatment, and Reintegration Strategies for COVID-19", DM 2020-0189 or "Updated Guidelines on Contact Tracing of Close Contacts of Confirmed Coronavirus Disease (COVID-19) Cases", DOH DM No. 2020-0258 or "Updated Interim Guidelines on Expanded Testing for COVID-19" and its amendment, DM No. 2020-0200 or "Omnibus Interim Guidelines for the Quarantine and Testing Procedures for All Arriving Overseas Filipinos (OFs) and Foreign Nationals During COVID-19 Pandemic," DM No. 2020-0220 or "Interim Guidelines on the Return-to-Work," DM 2020-0178 or "Interim Guidelines on Health Care Provider Networks during the COVID-19 Pandemic" and other issuances inconsistent with or contrary to this Order are hereby repealed, amended, or modified accordingly. All other provisions of existing issuances which are not affected by this DM shall remain valid and in effect.

For strict compliance.

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

ANNEX A. Standardized Clinical and Exposure Assessment Form

A. Clinical Information		
Symptoms	**Date of Onset**	**Comorbidities**
❑ Fever _____ °C		❑ None
❑ Cough		❑ Hypertension
❑ General weakness		❑ Diabetes
❑ Fatigue		❑ Heart Disease
❑ Headache		❑ Lung Disease
❑ Myalgia		❑ Gastrointestinal
❑ Sore throat		❑ Genito-urinary
❑ Coryza		❑ Neurological Disease
❑ Dyspnea		❑ Cancer
❑ Anorexia		❑ Others:
❑ Nausea		
❑ Vomiting		
❑ Diarrhea		
❑ Altered Mental Status		
❑ Anosmia (loss of smell)		
❑ Ageusia (loss of taste)		
❑ Others:_____		
Other Risk Factors		
❑ Elderly	Age: _____	
❑ Pregnant	High risk?	❑ Yes ❑ No

B. Relevant Exposure	
1. Have you been in close contact (<1 meter, >15 minutes, and without a face mask/respirator) with a probable or confirmed COVID-19 case, including family and household members, and coworkers?	❑ Yes ❑ No
For international travelers 2. Which country did you come from? _____ 3. Did you visit other countries, including layovers, in the last 14 days? a. If yes, which country or countries and how long? _____ _____ _____	❑ Yes ❑ No ❑ Yes ❑ No
For interzonal travelers 4. Are you from or visited a higher community quarantine classification compared to your locality of destination within the last 14 days?	❑ Yes ❑ No
5. Did you visit a crowded place without wearing a mask? a. Where? _____	❑ Yes ❑ No

ANNEX B. Additional Guidance on Isolation and Quarantine

A. Difference between Isolation and Quarantine

<table>
<tr><th></th><th>EXPOSED</th><th>SUSPECT, PROBABLE, OR CONFIRMED</th></tr>
<tr><td>WITH SYMPTOMS</td><td colspan="2">ISOLATION
Needs medical attention/symptom management and monitoring by a medical personnel</td></tr>
<tr><td>NO SYMPTOMS</td><td>QUARANTINE
Needs monitoring to (1) take action as needed for possible onset of symptoms, (2) ensure restricted movement by a non-medical personnel of the BHERT or the OSH, and (3) provide clearance for travel of returning and tourist bubbles</td><td>ISOLATION
Needs medical attention and monitoring by a medical personnel</td></tr>
</table>

a. Isolation separates sick people with a contagious disease from people who are not sick.
b. Quarantine separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick.

B. Implications of Differentiating Isolation and Quarantine

Clear delineation of purpose and identification of isolation and quarantine facilities	**Isolation Facilities (generally TTMFs)** • Intended to treat and monitor suspect, probable, and confirmed cases • e.g. Community Isolation Units, Mega TTMFs **Quarantine Facilities** (generally hotels, repurposed schools and buildings) • Intended to house individuals under OBSERVATION to see if they will develop COVID-19 signs or symptoms or if they will test positive for COVID-19 (e.g. close contacts, returning Filipinos and residents, tourist bubbles)
Standards	Isolation facilities -- considered a medical facility with HCW complement; will be subjected under the CHD Certification process Quarantine facilities -- may opt to not have a medical personnel
PHIC Reimbursement	Isolation facilities shall be covered by the CIU Package

ANNEX C. Pathways for Other Types of Contacts

Type of Contact	Intervention	Symptom Development
Second-generation and Third- generation Close Contacts	• Advise to self-monitor and strictly adhere to minimum public health standards • If first-degree *exposure* becomes a probable or confirmed case, immediately quarantine in a facility	If symptoms manifest, immediately do self-isolation and contact BHERT for assessment and possible referral for facility isolation.
General contacts	Advise to self-monitor and and strictly adhere to minimum public health standards	
Close Contacts of Suspect Cases	• Advise to self-monitor and strictly adhere to minimum public health standards • If exposure becomes a probable or confirmed case, immediately quarantine in a facility	

ANNEX D. Sub-group of at-risk individuals arranged in order of greatest to lowest need for testing using rRT-PCR

A. Sub-group A: Individuals with severe/critical symptoms and relevant history of travel and/or contact;
B. Sub-group B: Individuals with mild symptoms and relevant history of travel and/or contact, and considered vulnerable. Vulnerable populations include those elderly and with preexisting medical conditions that predispose them to severe presentation and complications of COVID-19;
C. Sub-group C: Individuals with mild symptoms, and relevant history of travel and/or contact;
D. Sub-group D: Individuals with no symptoms but with relevant history of travel and/or contact or high risk of exposure. These include:
    1. Subgroup D1: Contact-traced individuals
    2. Sub-group D2: Healthcare workers, who shall be prioritized for testing to ensure the stability of our healthcare system.

       Healthcare workers with high COVID-19 exposure and who live or work in our outside Special Concern Areas, as well as healthcare workers who do not have high COVID-19 exposure but live or work in Special Concern Areas, may be tested as determined by the Infection Prevention and Control Committee of the facility. In this regard, healthcare workers who are directly working or have direct involvement in COVID-19 care (e.g., nurses, doctors, or any staff working at COVID-19 facilities, hospital wards, emergency rooms, isolation facilities, or quarantine facilities, and laboratory technicians and pathologists at COVID-19 testing facilities) are may be considered to have high COVID-19 exposure.

    3. Sub-group D3: Returning Overseas Filipino Workers, who shall immediately be tested at the port of entry;
    4. Sub-group D4: Filipino citizens in a specific locality within the Philippines who have expressed intention to return to their place of residence/home origin (Locally Stranded Individuals) may be tested subject to the existing protocols of the IATF.
E. Sub-group E: Frontliners indirectly involved in health care provision in the response against COVID-19 may be tested as follows:
    1. Sub-group E1: Those with high or direct exposure to COVID-19 regardless of location may be tested up to once a week. These include the following:
        a. Personnel manning the Temporary Treatment and Quarantine Facilities (LGU- and Nationally-managed);
        b. Personnel serving at the COVID-19 swabbing center;
        c. Contact tracing personnel; and
        d. Any personnel conducting swabbing for COVID-19 testing.
    2. Sub-group E2: Those who do not have high or direct exposure to COVID-19 but who live or work in Special Concern Areas may be tested up to every two to four weeks. These include the following:
        a. Personnel manning Quarantine Control Points, including those from Armed Forces of the Philippines, Bureau of Fire Protection, and others;
        b. National/Regional/Local Risk Reduction and Management Teams;
        c. Officials from any local government/city/municipality health office (CEDSU, CESU, etc.)
        d. Barangay Health Emergency Response Teams and barangay officials providing barangay border control and performing COVID-19-related tasks;

e. Personnel of Bureau of Corrections and Bureau of Jail Penology and Management;
f. Personnel manning the One-Stop-Shop in the Management of the Returning Overseas Filipinos;
g. Border control or patrol officers, such as immigration officers and the Philippine Coast Guard; and
h. Social workers providing amelioration and relief assistance to communities and performing COVID-19-related tasks.

F. Sub-group F: Other vulnerable patients and those living in confined spaces. These include, but are not limited to:
1. Pregnant patients who shall be tested during the peripartum period;
2. Dialysis patients;
3. Patients who are immunocompromised, such as those who have HIV/AIDS, inherited diseases that affect the immune system;
4. Patients undergoing chemotherapy or radiotherapy;
5. Patients who will undergo elective surgical procedures with high risk for transmission;
6. Any person who have had organ transplants, or have had bone marrow or stem cell transplant in the past 6 months;
7. Any person who is about to be admitted in enclosed institutions such as jails, penitentiaries, and mental institutions.

Individuals falling under (i) to (vi) above shall be tested at the discretion of the attending physician, following the existing guidelines of their respective professional or medical societies. Meanwhile, testing of individuals classified as (vii) above is mandatory prior to admission into the facility.

G. Sub-group G: Residents, occupants or workers in a localized area with an active COVID-19 cluster, as identified and declared by the local chief executive in accordance with existing DOH Guidelines and consistent with the National Task Force Memorandum Circular No. 02 s.2020 or the Operational Guidelines on the Application of the Zoning Containment Strategy in the Localization of the National Action Plan Against COVID-19 Response. The local chief executive shall conduct the necessary testing in order to protect the broader community and critical economic activities and to avoid a declaration of a wider community quarantine.

H. Sub-group H: Frontliners in Tourist Zones:
1. Sub-group H1: All workers and employees in the hospitality and tourism sectors in El Nido, Boracay, Coron, Panglao, Siargao and other tourist zones, as identified and declared by the Department of Tourism. These workers and employees may be tested once every four (4) weeks.
2. Sub-group H2: All travelers, whether of domestic or foreign origin, may be tested at least once, at their own expense, prior to entry into any designated tourist zone, as identified and declared by the Department of Tourism.

I. Sub-group I: All workers and employees of manufacturing companies and public service providers registered in economic zones located in Special Concern Areas may be tested regularly.

In order to re-open the economy safely, the covered economic zone employees may be tested every quarter.

The Department of Trade and Industry (DTI), in coordination with the Philippine Economic Zone Authority (PEZA) and the freeport and special economic zone administrators, may include other priority sectors or economic zones within their mandate through an appropriate issuance, in consultation with the Department of Health.

Likewise, the above government agencies may deprioritize or remove sectors from this list at their discretion.

J. Sub-group J: Economy Workers
   1. Sub-group J1: Frontline and Economic Priority Workers, defined as those (1) who work in high priority sectors, both public and private, (2) have high interaction with and exposure to the public, and (3) who live or work in Special Concern Areas, may be tested every three months. These workers include, but are not limited to:
      a. Transport and Logistics
         (1) Drivers of Taxis, Ride Hailing Services (two and four wheels), Buses, Public Transport Vehicles
         (2) Conductors
         (3) Pilots, Flight Attendants, Flight Engineers
         (4) Rail operators, mechanics, servicemen
         (5) Delivery staff
         (6) Water transport workers – ferries, inter island shipping, ports
      b. Food Retail
         (1) Waiters, Waitresses, Bar Attendants, Baristas
         (2) Chefs and Cooks
         (3) Restaurant Managers and Supervisors
      c. Education – once face to face classes resume
         (1) Teachers at all levels of education
         (2) Other school frontliners such as guidance counselors, librarians, cashiers
      d. Financial Services
         (1) Bank Tellers
      e. Non-Food Retail
         (1) Cashiers
         (2) Stock clerks
         (3) Retail salespersons
      f. Services
         (1) Hairdressers, Barbers, Manicurist, Pedicurist, Massage Therapists
         (2) Embalmers, Morticians, Undertakers, Funeral Directors
         (3) Parking Lot Attendants
         (4) Security Guards
         (5) Messengers
         (6) Ushers, Lobby Attendants, Receptionist
         (7) Clergy
         (8) Market Vendors
      g. Construction
         (1) Carpenters
         (2) Stonemasons
         (3) Electricians
         (4) Painters
         (5) Construction workers, including Foremen, Supervisors
         (6) Civil Engineers, Structural Engineers, Construction Managers
         (7) Crane and Tower operators
         (8) Elevator installers and repairers
      h. Water Supply, Sewerage, Waste Management,
         (1) Plumbers
         (2) Recycling and Reclamation workers/Garbage Collectors
         (3) Water/Wastewater engineers

(4) Janitors and cleaners

i. Public Sector
   (1) Judges,
   (2) Courtroom clerks, staff and security
   (3) All national and local government employees rendering frontline services in Special Concern Areas

j. Mass Media
   (1) Field reporters, photographers, and cameramen

   The DTI and the Department of Labor and Employment, may designate other frontline and economic priority workers within their mandate through an appropriate issuance, in consultation with the Department of Health. Likewise, the relevant government agencies may deprioritize or remove jobs from this list at their discretion.

   In order to re-open the economy safely, frontline and economic priority workers may be tested once every quarter.

ii. Sub-group J2: All other employees not covered above are not required to undergo testing but are encouraged to be tested every quarter. Private sector employers are highly encouraged to send their employees for regular testing at the employers' expense in order to avoid lockdowns that may do more damage to their companies.

ANNEX E. Summary of the Nature, Use, and Interpretation of test kits available in the Philippine Market

Objective	Right Test	Sample tested	Methodology	Who to test	Best Time to Test	Peak Sensi-tivity	What it means?	Test site	Release Period
Determine CURRENT infection	rRT-PCR	Swab. use full PPE to collect	Looks for the genetic material and amplifies it	Confirmatory test for Suspect, probable cases, and close contacts	At symptom onset or 5 to 7 days after exposure	80%	**Positive** - confirmed case, isolate and triage according to clinical status **Negative** - absence of SaRS-CoV-2, but does not rule out COVID-19	BSL-2 Lab	rRT-PCR - 24-72 hours GeneXpert – 24 hours
	Antigen	Swab, use full PPE to collect	Looks for a protein (antigen) of the virus; some kits are point-of-care, some need specific reader;	For diagnosis of suspect and probable cases, in areas with outbreak where rRT-PCR capacity is limited	1-5 days after onset of symptoms	65%	**Negative** - should be confirmed with rRT-PCR **Positive** - confirmed COVID-19 case, isolate	Lab/ Properly equipped health facility setting	1 hour
Determine PAST infection Determine prevalence of infection among a group of people	Antibody Test	Blood, use appropriate PPE (mask, gown, gloves at the minimum) and observe universal precautions for handling blood	Looks for the antibody made against the virus	Determination of Antibodies	14 days or later after illness onset	95-99% (ELISA or CLIA/ECLIA)	**Positive** serology test results mean a past or recent infection **Negative** serology test results can mean: - no past infection; had infection but immune response not strong enough to make antibodies; incubating or active infection; past infection with waning of titers	Health facility setting	15 min (RATs) 24 hours (ELISA or CLIA/ECLIA)
Clearance for work	14-day symptom test	None	Screens asymptomatic individuals for symptoms within 14 days of exposure	Determines COVID-19 infection	Within 14 days of exposure	92.8% sensitivity 98.3% specificity	**Positive for symptoms:** isolate and do rRT-PCR for confirmation **Negative symptoms:** clear for work upon completion of 14-day quarantine	Health facility Workplace clinic	

Annex F. Additional Guidance on Testing

All testing activities shall use only COVID-19 test kits authorized by the Food and Drug Administration (FDA), validated by the Research Institute for Tropical Medicine and other DOH-designated institutions, and have met the minimum criteria for sensitivity and specificity recommended by the Health Technology Assessment Council. The DOH shall regularly publish the list of test kits that have been validated by the RITM and other DOH-designated institutions, as well as the validation results as published in the Foundation for Innovative New Diagnostics.

Healthcare workers and laboratory personnel shall strictly follow infection prevention and control protocols, and proper biosafety precautions at all times. when handling potentially infectious biological samples (e.g., nasopharyngeal/oropharyngeal swabs, lower respiratory tract specimens, or blood samples) during specimen collection, transport, and processing. Samples should be processed within the amount of time specified by the manufacturer. Full personal protective equipment (PPE) shall be used when collecting nasopharyngeal/oropharyngeal swabs, preferably in a negative pressure or well-ventilated single room with only the patient and the swabber present. Blood samples may be collected with appropriate attire using universal precautions and proper handling of sharps. Disposal of test kits, PPE, and other materials used in testing, shall adhere to the 4th Edition of Health Care Waste Management Manual.

A. Real-time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) Assay

1. rRT PCR is a widely used molecular biology technique to detect and amplify the genetic material of the virus. A positive rRT-PCR result when properly collected and processed means that an individual has the SARS-CoV-2 virus and is considered a confirmed case of COVID-19 infection. A negative result suggests the absence of SARS-CoV-2 virus, but it does not completely rule out infection.

2. To date, the most reliable test for diagnosis of COVID-19 has been the rRT-PCR test performed using nasopharyngeal swabs or lower respiratory tract specimens. Oropharyngeal swabs can be used but are less accurate than nasopharyngeal swabs. It is recommended that both a nasopharyngeal swab and oropharyngeal swab are collected and processed together. If it is not possible, a nasopharyngeal swab is preferred over an oropharyngeal swab. Saliva has been studied as an alternative specimen but is still currently being validated by the Research Institute of Tropical Medicine.

3. It is best to conduct rRT-PCR at or shortly after the onset of illness for symptomatic patients; or at least five (5) to seven (7) days after exposure for presumed asymptomatic close contacts or pre-symptomatic close contacts.

4. All symptomatic individuals suspected of having COVID-19 should ideally undergo SARS-CoV-2 rRT-PCR assay testing to diagnose acute COVID-19 infection. Subgroups A-C, based on Department Memorandum 2020-0258 and its amendment, shall be prioritized for rRT-PCR testing.

5. rRT-PCR assays are also available in cartridge-based test kits, such as the GeneXpert.

    a. Subgroups A, B, C, and F shall be prioritized for testing in regions with access to

laboratories using GeneXpert procedure only.

b. Patients with emergency situations or life-threatening conditions shall be prioritized for testing using GeneXpert cartridges to facilitate immediate diagnosis of COVID-19 disease and necessary treatment, in regions with access to both rRT-PCR and GeneXpert techniques.

6. Nasopharyngeal and/or oropharyngeal specimens can be used for swab-based SARS-CoV-2 testing. Specimen collection shall follow the guidelines provided under Department Circular 2020-0204 or the "Advisory on Specimen Collection of Nasopharyngeal and Oropharyngeal Swabs in Swabbing Centers."

7. Specimens from sputum, endotracheal aspirates, and bronchoalveolar lavage among hospitalized patients may also be used for rRT-PCR assay following standard collection techniques and biosafety precautions.

8. The qualitative reporting of results of SARS-COV-2 rRT-PCR as positive or negative is sufficient for the diagnosis. However, it may also be supplemented by a cycle threshold (Ct) report, a semi-quantitative value, correlated with timing of symptom onset to guide infection control, public health, and occupational health decisions (i.e., duration of isolation, clearance for work, clearance for medical or surgical procedures). Since Ct value may be kit and machine dependent, indicating the brand of the kit and machine used should be reported as well.

9. Repeat rRT-PCR testing for confirmed COVID-19 cases to document recovery is **no longer required** for patients with asymptomatic, mild or moderate cases.

   a. Asymptomatic patients who remain without symptoms can be discharged from quarantine after 14 days from the original positive rRT-PCR test without the need for repeat testing.

   b. Patients with mild to moderate COVID-19 disease can be released from isolation after 10 days from the onset of symptoms, with at least three days without symptoms, whichever is longer, upon clearance of a physician.

   c. Hospitalized COVID-19 cases with severe or critical disease and those with immunocompromising conditions may need to be isolated for longer periods of time, and may need repeat testing at the discretion of the attending physician.

B. Pooled Testing

1. In line with the recent HTAC recommendations, pooled testing may be used for screening and surveillance testing of asymptomatic populations from low prevalence areas. These guidelines may be updated as new evidence comes in, through issuance of supplementary guidelines.

2. Pooled testing shall **not** be done for any individual that fall under the following cohorts:
   a. Symptomatic individuals;
   b. Recovered patients, regardless if symptomatic or asymptomatic; and

c. Close contacts of positive individuals.

3. Pooled testing can be done among asymptomatic persons belonging to the targeted populations below:
   a. Communities with prevalence rate of 10% or less;
   b. Surveillance of health care workers and all workers in the health facility;
   c. Workplace surveillance testing;
   d. Border testing at ports of entry for inbound foreign travelers and returning residents;
   e. Overseas deployment of overseas Filipino workers (OFWs), and returning OFWs;
   f. Frontline government workers; and
   g. Locally stranded individuals

4. A pool sample of five (5) is recommended to be used, until an accurate prevalence of cases with the presence of SARS-CoV-2 is identified in the population.

C. Antigen Testing

1. An antigen test detects the presence of viral proteins or antigens, which is expressed only when the virus is replicating. These tests are best used to identify acute or early infection.

2. Antigen tests are most useful during the acute phase of the disease when the viral load is high, which is within 5 days after onset of symptoms. A positive result suggests presence of virus whereas a negative result suggests absence of the virus.

3. Only properly validated, FDA-authorized COVID-19 antigen tests should be used. Only kits with a minimum of 80% sensitivity and 97% specificity are recommended for use.

4. Use and interpretation of antigen tests should only be at the direction of a qualified licensed healthcare professional and should always be correlated with the overall clinical and epidemiological context (i.e. history of exposure.)

5. The processing of the specimen should be done by a properly trained healthcare worker using conditions and equipment that minimize aerosolization of the sample and minimizing spillage or splashing of the sample.

6. Results should be read after the recommended time has elapsed using direct visualization or the dedicated electronic reader in accordance with the recommendations of the manufacturer.

7. Antigen tests can be used for diagnostic testing of close contacts, suspect, and probable cases in the event of a confirmed outbreak in (2.1) communities or (2.2) closed/semi-closed institutions or (2.3) remote settings or referred to as GIDA barangays; provided that RT-PCR is not immediately available in their respective provinces.

8. Health care providers shall fill out the CIF prior to testing, and shall report the results of antigen testing using the COVIDKaya.

D. Antibody Testing

1. An antibody test detects the presence or absence of antibodies against the virus present in patient serum. This is not a confirmatory or diagnostic test but can determine whether a person was recently infected with SARS-CoV-2 and has now developed the antibodies against the virus. It is best used 14 days or later after the onset of illness.

2. Only antibody-based test kits approved by the FDA and locally-validated by the RITM or other institutions designated by DOH, or those validated by World Health Organization-Foundation for Innovative New Diagnostics (WHO-FIND) with acceptable performance of >90% sensitivity and >95% specificity may be used.

3. Rapid antibody tests (RATs) using lateral flow technology shall not be used as a standalone test for the diagnosis of COVID-19.

4. RATs are **not** recommended for use in seroprevalence surveys, return-to-work decisions, entry-to-country/ province policies or for similar use due to uncertainties over accuracy, correlation to immunity, and the long-term persistence of antibodies.

5. RATs using lateral flow technology are **not** recommended for disease surveillance activities (i.e. contact tracing or as part of acute outbreak investigations) to guide public health decisions.

6. A validated rapid antibody test kit may be used on patients who have symptoms for at least 15 days that are highly suggestive of COVID-19 but whose rRT-PCR tests have turned out to be negative.

7. Only licensed medical doctors may request, administer, and interpret results of RATs. Other health professionals may also administer RATs with the supervision of licensed medical doctors.

8. Results of the testing are only applicable to the health status of the patient at the time of the test and do not correlate to future risk of infection.

9. Laboratory-based immunoassays such as chemiluminescence assay (CLIA/ECLIA) and enzyme-linked immunosorbent assay (ELISA) are the preferred tests for antibody determination over RATs. These are best done on the third week onwards from the onset of symptoms.

ANNEX G. Updated Case Investigation Form

Philippine Integrated Disease Surveillance and Response

Case Investigation Form
Coronavirus Disease (COVID-19)
Version 7

General Instructions

1] The Case Investigation Form is meant to be administered as an interview by a health care worker or any personnel of the Disease Reporting Unit. This is not a Self-Administered Questionnaire.

2] Please be advised that Disease Reporting Units are only allowed to obtain 1 copy of accomplished CIF from a patient.

3] Please fill out all blanks and put a check mark ✓ on the appropriate box. Never leave an item blank, just write N/A or not applicable. Items with * are required fields.

4] All dates must be in **MM/DD/YYYY** format.

Disease Reporting Unit*	DRU Region and Province	PhilHealth No.*
Name of Interviewer	**Contact Number of Interviewer**	**Date of Interview (MM/DD/YYYY)***
Name of Informant (If patient unavailable)	**Relationship**	**Contact Number of Informant**

Type of Client	☐ COVID-19 Case (Suspect, Probable, or Confirmed)	☐ Close Contact
	☐ For RT-PCR Testing (Not a Case of Close Contact)	☐ Others, please specify

1. Testing Category/Subgroup (Check all that apply) *Refer to Appendix 1*

☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ I ☐ J

Part 1. Patient Information

2. Patient Profile

Last Name*	First Name (and Suffix)*	Middle Name*
Birthday (MM/DD/YYYY)*	Age*	Sex* ☐ Male ☐ Female
Civil Status	Nationality	Occupation

3. Current Address in the Philippines and Contact Information* (Give address of institution if you live in closed settings, see Part 2 #9)

House No./Lot/Bldg.	Street/Purok/Sitio	Barangay	Municipality/City
Province	Home Phone No. (& Area Code)	Cellphone No.	Email Address

4. Current Workplace Address and Contact Information

Lot/Bldg.	Street	Barangay	Municipality/City
Province	Name of Workplace	Phone No./Cellphone No.	Email Address

5. Consultation and Admission Information

Did you have previous COVID-19 related consultation?	☐ Yes, Date of First Consult(MM/DD/YYYY)* _____ ☐ No
Name of facility where first consult was done	
Was the case admitted in a health facility?	☐ Yes, Date of Admission (MM/DD/YYYY)* Indicate earliest date if admitted in multiple health facilities _____ ☐ No
Name of Facility where patient was first admitted	
Region and Province of Facility	

6. Disposition at Time of Report* (Provide name of hospital/isolation/quarantine facility)

☐ Admitted in hospital _____ Date and Time admitted in hospital _____
☐ Admitted in isolation/quarantine facility _____ Date and Time isolated/quarantined in Facility _____
☐ In home isolation/quarantine Date and Time isolated/quarantined at home _____
☐ Discharged to home If Discharged: Date of Discharge (MM/DD/YYYY)* _____ ☐ Others: _____

7. Health Status at Consult*

☐ Asymptomatic ☐ Mild ☐ Moderate ☐ Severe ☐ Critical

8. Case Classification* (*Refer to Appendix 2*)

☐ Suspect ☐ Probable ☐ Confirmed ☐ Non-COVID-19 Case

PART 2: Case Investigation Details

9. Special Population

Health Care Worker*	☐ Yes, Name & location of health facility _____	☐ No
Returning Overseas Filipino*	☐ Yes, Country of origin _____	☐ No
Foreign National Traveler*	☐ Yes, Country of origin _____	☐ No
Locally Stranded Individual/APOR/Traveler*	☐ Yes, City, Mun. & Prov of origin _____	☐ No
Lives in Closed Settings*	☐ Yes, specify Type of Institution (e.g. prisons, residential facilities, retirement communities, care homes, camps etc.) _____ and specify Name of Institution _____	☐ No

10. Permanent Address and Contact Information (if different from current address)

House No./Lot/Bldg.	Street /Purok/Sitio	Barangay	Municipality/City
Province	**Home Phone No. (& Area Code)**	**Cellphone No.**	**Email Address**

11. Address Outside the Philippines and Contact Information (for Overseas Filipino Workers and Individuals with Residence outside PH)

House No./Lot/Bldg.	Street	Municipality/City	Province
Country	**Place of Work**	**Employer's Name**	**Employer's/Office Contact No.**

12. Clinical Information

Date of Onset of Illness (MM/DD/YYYY)* _____

Signs and Symptoms (Check all that apply if present)

- ☐ Asymptomatic
- ☐ Fever _____ °C
- ☐ Cough
- ☐ General weakness
- ☐ Fatigue
- ☐ Headache
- ☐ Myalgia
- ☐ Sore throat
- ☐ Coryza
- ☐ Dyspnea
- ☐ Anorexia
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Altered Mental Status
- ☐ Anosmia (loss of smell)
- ☐ Ageusia (loss of taste)
- ☐ Others _____

Comorbidities (Check all that apply if present)

- ☐ None
- ☐ Hypertension
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Gastrointestinal
- ☐ Genito-urinary
- ☐ Neurological Disease
- ☐ Cancer
- ☐ Others _____

Are you pregnant? ☐ Yes, LMP _____ ☐ No

High-risk pregnancy? ☐ Yes ☐ No

Were you diagnosed to have Severe Acute Respiratory Illness? (Refer to *Appendix 2*) ☐ Yes ☐ No

Chest imaging findings suggestive of COVID-19

Imaging Done (Check all that apply)	Results	
☐ Chest radiography	☐ Normal ☐ Pending	☐ Hazy opacities, often rounded in morphology, with peripheral and lower lung distribution ☐ Other findings, specify _____
☐ Chest CT	☐ Normal ☐ Pending	☐ Multiple bilateral ground glass opacities, often rounded in morphology, with peripheral and lower lung distribution ☐ Other findings, specify _____
☐ Lung ultrasound	☐ Normal ☐ Pending	☐ Thickened pleural lines, B lines (multifocal, discrete, or confluent), consolidative patterns with or without air bronchograms. ☐ Other findings, specify _____

☐ None

13. Laboratory Information

Test Done* (Check all that apply)	Date Collected*	Laboratory	Results*	Date Released
☐ RT-PCR (OPS)			☐ Pending ☐ Negative ☐ Positive ☐ Equivocal	
☐ RT-PCR (NPS)			☐ Pending ☐ Negative ☐ Positive ☐ Equivocal	
☐ RT-PCR (OPS and NPS)			☐ Pending ☐ Negative ☐ Positive ☐ Equivocal	
☐ RT-PCR (specimen type _____)			☐ Pending ☐ Negative ☐ Positive ☐ Equivocal	
☐ Antigen Test			☐ Pending ☐ Negative ☐ Positive ☐ Equivocal	
☐ Antibody Test			☐ IgM (+) IgG (-) ☐ IgM (+) IgG (+) ☐ IgG (+) IgM (-) ☐ IgM (-) IgG (-)	
☐ Others _____			Specify Results:	

Have you ever tested positive using RT-PCR before? ☐ Yes, Date of Specimen Collection (MM/DD/YYYY)* _____ ☐ No

If Yes, Laboratory _____ **Number of previous RT-PCR swabs done** _____

14. Outcome/Condition at Time of Report*

☐ Active (Currently admitted or in isolation/quarantine) ☐ Recovered, Date of Recovery (MM/DD/YYYY)* _____

☐ Died, Date of Death (MM/DD/YYYY)* _____

Cause of Death* **Immediate Cause** _____

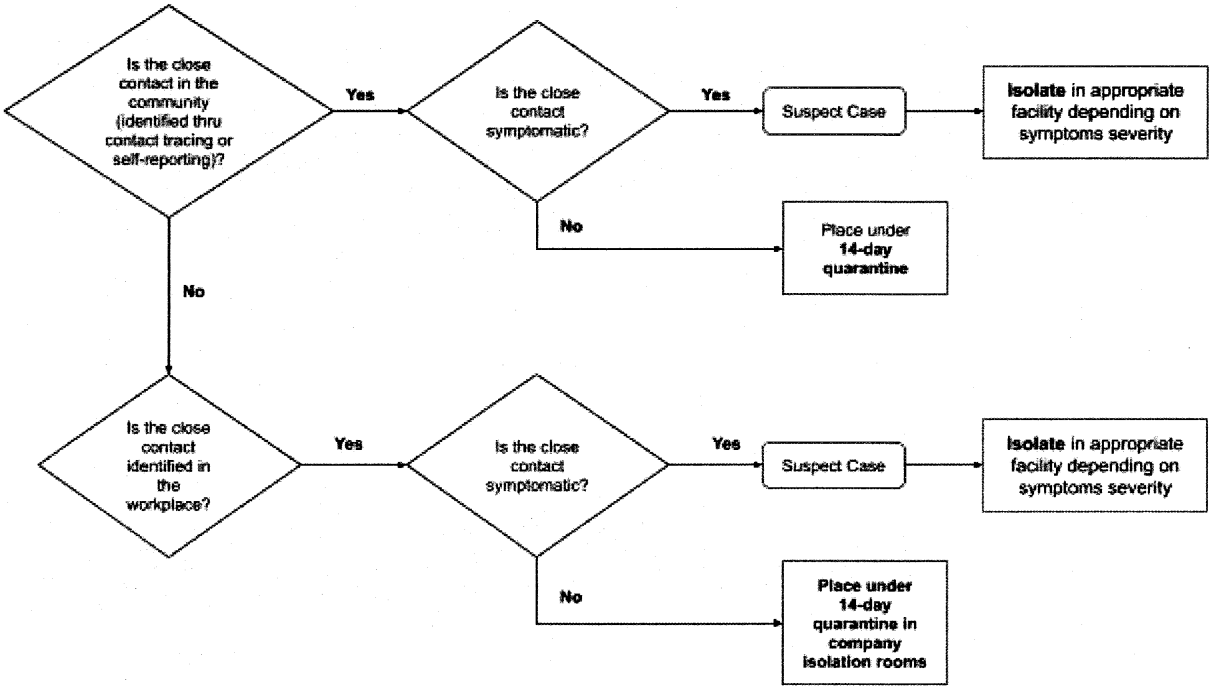
Antecedent Cause _____ **Underlying Cause** _____

Part 3: Contact Tracing					
15. Exposure History					
History of exposure to known probable and/or confirmed COVID-19 case 14 days before the onset of signs and symptoms?* OR If Asymptomatic, 14 days before swabbing or specimen collection?**			☐ Yes, Date of LAST Contact (MM/DD/YYYY)*_____ ☐ No ☐ Unknown		
Have you been in a place with a known COVID-19 community transmission 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection?**			☐ Yes ☐ No ☐ Unknown exposure		
If Yes, specify place (Check all that apply, provide details such as name of establishment, transport service, venue, location etc. and date of visit in MM/DD/YYYY)					
Place Visited	Details	Date of Visit	Place Visited	Details	Date of Visit
☐ Health Facility			☐ Transportation		
☐ Closed Settings (e.g. Jail)			☐ Workplace		
☐ Market			☐ Local Travel		
☐ Home			☐ Social Gathering		
☐ International Travel			☐ Others		
☐ School					
16. Travel History					
History of travel/visit/work in other countries with a known COVID-19 transmission 14 days before the onset of signs and symptoms			☐ Yes, Country of exit _____ ☐ No		
Airline/Sea vessel	Flight/Vessel Number		Date of Departure (MM/DD/YYYY)	Date of Arrival in PH (MM/DD/YYYY)	
History of travel/visit/work in other local place with a known COVID-19 transmission 14 days before the onset of signs and symptoms			☐ Yes, Place of origin _____ ☐ No		
Airline/Sea vessel/Bus line/Train	Flight/Vessel Number/ Bus No.		Date of Departure (MM/DD/YYYY)	Date of Arrival in the Current City/Mun (MM/DD/YYYY)	
List the names of persons who were with you two days prior to onset of illness until this date and their contact numbers. *If asymptomatic, list the names of persons who were with you on the day you submitted specimen for testing until this date and their contact numbers. (Use additional space below if needed)			Name	Contact No.	

For Additional Close Contact (Include ALL Household Contacts)

Name	Contact Number	Exposure Setting (ex. Household, Work)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

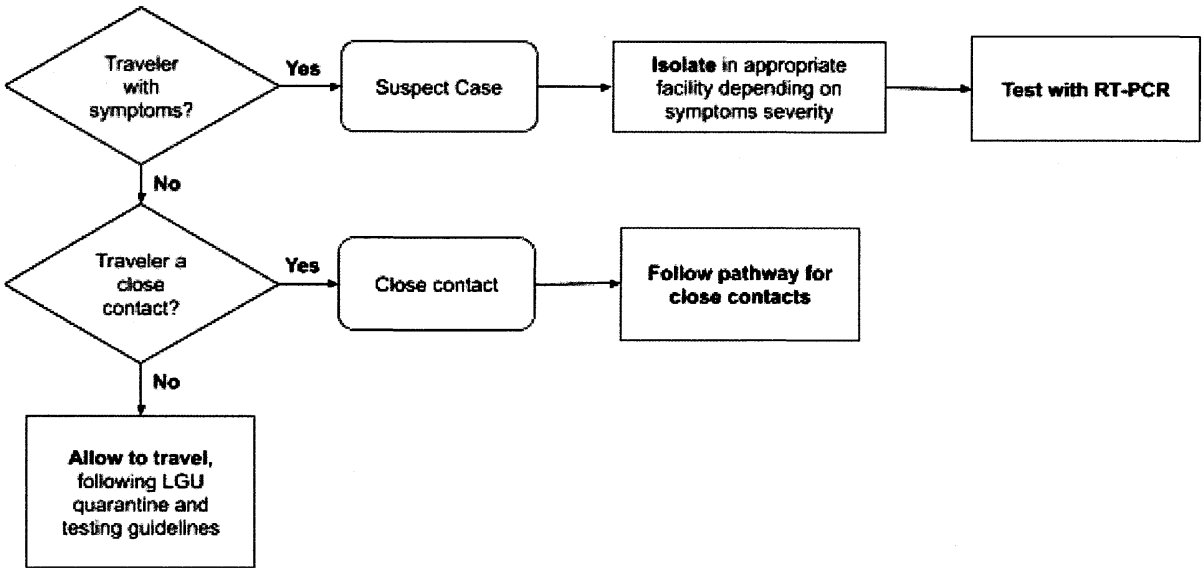
ANNEX H. Setting-Specific Pathways for Contact Tracing



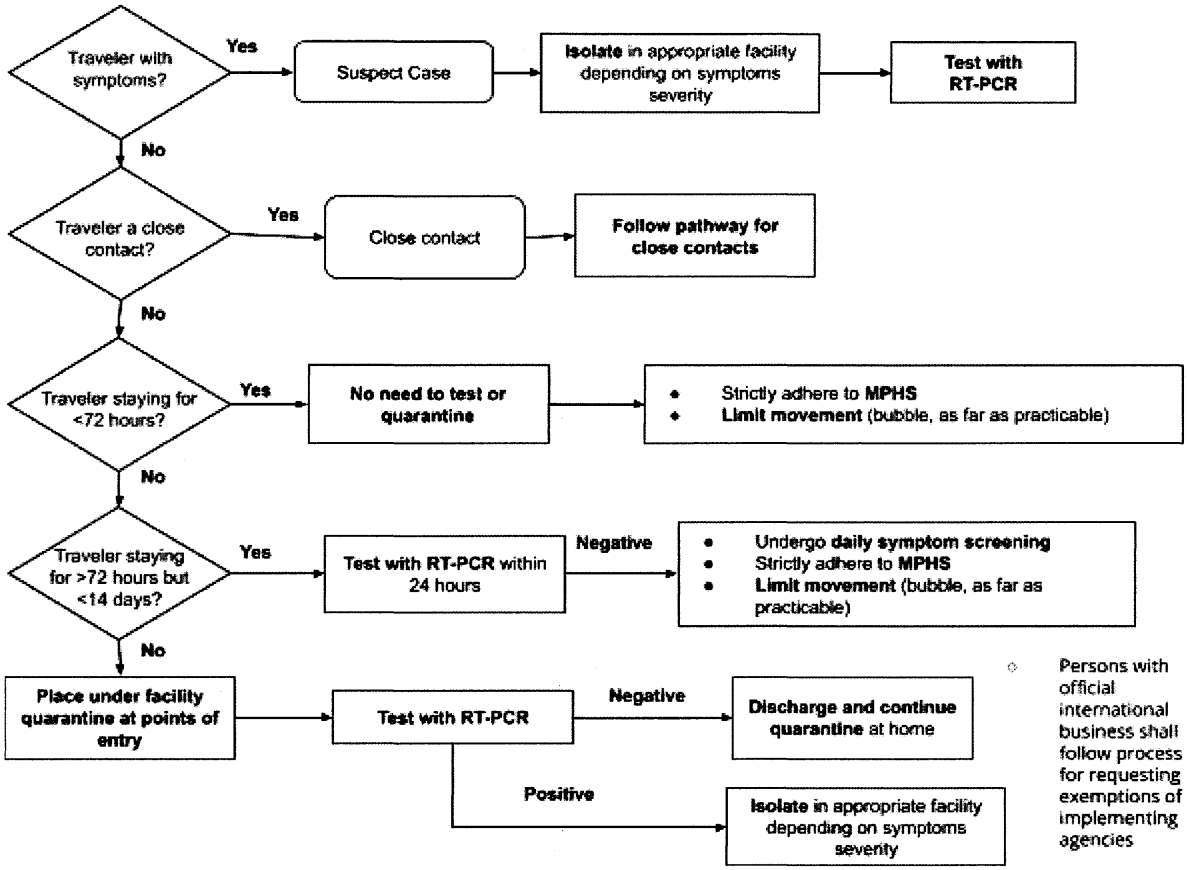
*If rRT-PCR capacity is limited, antigen tests can be used among symptomatics.

ANNEX I. Pathways for Travelers

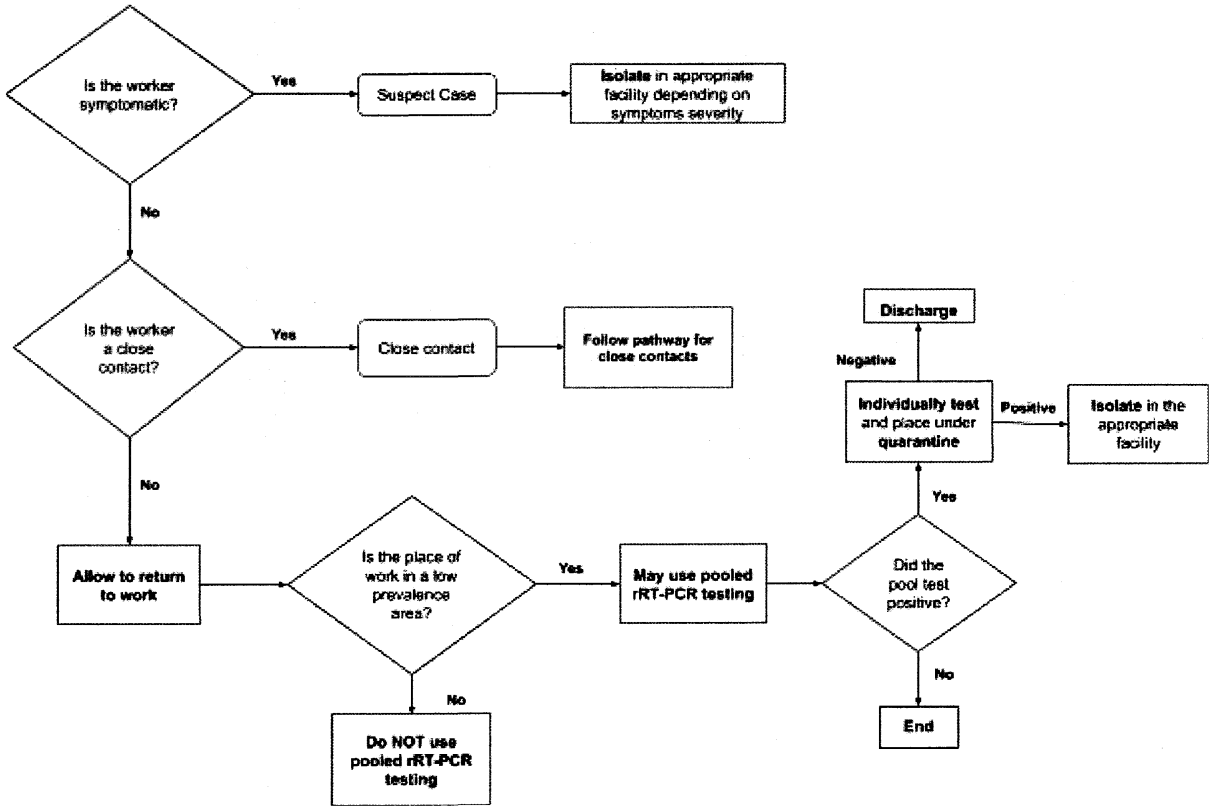
A. Interzonal Domestic Travelers (At places of origin)



B. Inbound International Travelers



ANNEX J. Pathways for Screening, Return to Work, and Surveillance Testing of Workers



ANNEX K. Definition of Terms

A. Case - a person with a particular problem requiring or receiving medical or welfare attention. A case is often used to label individuals further as suspect, probable, or confirmed *(AO 2020-0013)*

B. Case definition - a set of standard criteria for classifying whether a person has a particular disease, syndrome, or other health condition *(AO 2020-0013)*

1. **Mild/Moderate/Severe/Critical**
   a. **Mild** - patients with mild symptoms and stable vital signs. Unless the patient belongs to high-risk subgroups or has comorbidities, they are often not admitted to a treatment facility
   b. **Moderate** - patients with difficulty breathing, altered mental status, considered high-risk or in need of hospital care.
   c. **Severe COVID-19 disease** - confirmed cases classified as either severe pneumonia based on PhilHealth Circular 2020-009; or suspect, probable or confirmed case of COVID-19, exhibiting severe (dyspnea, hypoxia, or >50% lung involvement on imaging) signs or symptoms *(DM 2020-0138: Adoption of PSMID Clinical Practice Guidelines on COVID-10) (MC 2020-0027)*
   d. **Critical cases** - or suspect, probable or confirmed case of COVID-19 with impending or ongoing respiratory failure, in need of mechanical ventilation, or with evidence of end-organ damage
2. **Suspect/Probable/Confirmed** (WHO Public health surveillance for COVID-19, 7 Aug 2020)
   a. Suspect Case
      i. A person who meets the clinical AND epidemiologic criteria:
         (a) Clinical criteria:
            (i) Acute onset of fever AND cough **OR**
            (ii) Acute onset of any three or more of the following signs or symptoms: fever, cough, general weakness, fatigue, headache, myalgia, sore throat, coryza, dyspnea, anorexia/nausea/vomiting, diarrhea, altered mental status
         (b) Epidemiologic criteria
            (i) Residing or working in an area with high risk of transmission of the virus: for example, closed residential settings and humanitarian settings, such as camp and camp-like settings for displaced persons, any time within the 14 days prior to symptom onset **OR**
            (ii) Residing in or travel to an area with community transmission anytime within the 14 days prior to symptom onset; **OR**
            (iii) Working in health settings, including within health facilities and within households, anytime within the 14 days prior to symptom onset
      ii. Patient with severe acute respiratory illness (SARI: acute respiratory infection with history of fever or measured fever ≥38C, and cough with onset within the last 10 days and who require hospitalization)
   b. **Probable COVID-19 case**
      i. A patient who meets clinical criteria above AND is a contact of a probable or confirmed case, or epidemiologically linked to a cluster of cases which has had at least one confirmed case identified within that cluster

ii. A suspected case (detailed above) with chest imaging showing findings suggestive of COVID-19 disease*

*Typical chest imaging findings suggestive of COVID-19 include the following:

- Chest radiography: hazy opacities, often rounded in morphology with peripheral and lower lung distribution
- Chest CT: multiple bilateral ground glass opacities, often rounded in morphology, with peripheral and lower lung distribution
- lung ultrasound: thickened pleural lines, B lines (multifocal, discrete, or confluent), consolidative patterns with or without air bronchogram

iii. A person with recent onset of anosmia (loss of smell) or ageusia (loss of taste) in the absence of any other identified cause

iv. Death, not otherwise explained, in an adult with respiratory distress preceding death AND who was a contact of a probable or confirmed case or epidemiologically linked to a cluster which has had at least one confirmed case identified within that cluster.

c. Confirmed COVID-19 case

i. A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms

3. **Active/Recovered**

a. **Active Case** - refers to an individual that is:

i. rRT-PCR positive AND

ii. Has not yet clinically recovered or asymptomatic AND

iii. Has not yet completed the 14 days isolation period after onset or clinical recovery

b. **Recovered patient**

i. For Symptomatic

Confirmed COVID-19 patients with mild or moderate symptoms who have clinically recovered OR are no longer symptomatic at least three days prior to discharge AND have completed at least 10 days of isolation can be discharged and tagged as recovered without the need for further testing, provided that a licensed medical doctor clears the patient.

Confirmed COVID-19 patients in severe or critical conditions who clinically improved or are no longer symptomatic; AND have completed at least 21 days of isolation from the onset of illness, can be discharged from isolation and re-integrated to the community without the need for further testing, provided that a licensed medical doctor clears the patient.

ii. For Asymptomatic

Patients can be released from quarantine after 14 days as long as the patient remains asymptomatic for the entire duration of the quarantine, even without testing or test results. There is no need to repeat rRT-PCR testing prior to discharge and tagging as recovered.

4. **Case investigation** -profiling of suspect, probable, and confirmed COVID-19 case, which include but is not limited to review of medical, surveillance and laboratory records, case interview, and review of other records and documentation *(AO 2020-0013)*

5. **Case investigation form (CIF)** – The standardized form developed by the Department of Health for COVID-19 to collect surveillance-related information from COVID-19 cases; to establish epidemiological link or track the sources of infection and contain further spread and learn about the epidemiology of the disease

C. **Cluster** - an unusual aggregation, real or perceived, of health events that are grouped together as to time and space and that is reported to a public health department. For the purposes of this document, it is further defined as two or more confirmed cases from the same area over a period of 14 days. The following criteria shall be followed:

i. **Geographical boundary (purok, barangay, zone)** - 2 confirmed cases from 2 different households.

ii. **Residential building** - 2 confirmed cases from 2 different housing units.

iii. **Workplace** - 2 confirmed cases regardless if same or different office space.

iv. **Health care facilities and other closed settings (jail, detention centers, long-term care facility, etc.)** - 2 confirmed cases regardless if from the same location in said closed setting.

D. **Close Contact** - a person who has experienced any one of the following exposures during the 2 days before and the 14 days after the onset of symptoms of a probable or confirmed case: (WHO Public health surveillance for COVID-19, 7 Aug 2020)

1. Face-to face contact with a probably or confirmed case within 1 meter and for at least 15 minutes
2. Direct physical contact with a probable or confirmed case
3. Direct care for a patient with probable or confirmed COVID-19 disease without using recommended personal protective equipment OR
4. Other situations as indicated by local risk assessments

Close contacts can be classified further into first-, second-, and third-generation close contacts:

1. First-generation close contacts - close contacts of a probable, or confirmed case
2. Second-generation close contacts - close contact of a first generation close contact.
3. Third-generation close contacts - close contact of a second generation close contact.

E. **Contact Tracing** - the identification, listing, assessment, and monitoring of persons who may have come into close contact with a confirmed COVID-19 case. Contact tracing is an important component in containing outbreaks of infectious diseases. (DM 2020-0189)

F. **COVID-19** - the Coronavirus Disease 2019 which is caused by the virus known as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (DC 2020-0286)

G. **COVID-19 related Data** - all types of information related to COVID-19 disease surveillance and response, including personal health information of COVID-19 cases and identified close contacts (MC2020-0021), A COVID-19 death is defined by the WHO for surveillance purposes as a death resulting from a clinically compatible illness in a probable or confirmed COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID-19 disease (e.g. trauma)

H. **Death**

1. **Death due to COVID-19 disease** - A COVID-19 death is defined for surveillance purposes as a death resulting from a clinically compatible illness in a probable or confirmed COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID-19 disease (e.g. trauma). There should be no period of complete recovery between the illness and death.
2. **Deaths not due to COVID-19 disease** - deaths of persons with COVID-19 bue died due to other conditions not directly due to COVID-19, such as motor vehicular accidents, are not deaths due to COVID-19 and should not be certified as such. (DC 2020-0202)

I. **Disease** - an illness due to a specific toxic substance, occupational exposure or infectious agent, which affects a susceptible individual, either directly or indirectly as from an infected animal or person, or indirectly through an intermediate host, vector, or the environment (IRR RA 11332)

J. **Disinfection** - the process of reducing the number of viable microorganisms on a surface to a less harmful level. It involves use of chemicals including but not limited to a bleach solution, and is more effective if done after cleaning (which is the physical removal of contaminants such as dirt, and organic material such as blood and secretions from surfaces, using cleaning agents such as soap and water, among others, as a first step in preparation for disinfection and sterilization) (MC No. 2020-0020).

K. **Essential goods and services** - covers health and social services to secure the safety and wellbeing of persons, such as but not limited to, food, water, medicine, medical devices, public utilities, energy and others as may be determined by the IATF (MC 2020-0025)

L. **Epidemiologic investigation** - an inquiry to the incidence, prevalence, extent, source, mode of transmission, causation of, and other information pertinent to a disease occurrence; (IRR RA 11332)

1. **Attack rate** - also known as 'incidence proportion', is the proportion of an initially disease-free population that develops disease, during a specific period of time. The attack rate is calculated as the number of people who contract the disease divided by the number of people at risk for the disease/population.
2. **Case fatality rate** - An estimate of the risk of mortality/deaths of the disease. Calculated as total number of deaths among cases divided number of total cases, multiplied by 100 in a given time period
3. **Doubling time** - measures speed of outbreak. The amount of time it takes for a value to double itself at a consistent rate of growth. In COVID-19, it is a model which allows health authorities to quantitatively forecast the time evolution of infections and fatalities during the pandemic wave
4. **Positivity rate** - Refers to the percentage of patients who have positive tests. This is an indicator used to track the spread of disease or calculate the contagiousness of a disease. It can be calculated by dividing the number of total cases who tested positive by the total number of individuals tested, multiplied by 100.
5. **Recovery rate** - Refers to the percentage of patients who recovered from COVID-19 based on the recovery classification. It can be calculated by dividing the number of recovered patients from the total cumulative number of COVID-19 cases in a specific period of time, multiplied by 100.

M. **General Contact** - individuals who may have been exposed to a confirmed case (such as those who were in the same event, social gathering, or venue as the confirmed case) but did not fulfill the case definition for a close contact (e.g. were beyond one meter distance from the confirmed case or did not have prolonged interaction or direct contact with the confirmed case).

N. **Health event of public health concern** - either a public health emergency or a public health threat due to biological, chemical, radio-, nuclear and environmental agents (IRR RA 11332)

O. **Health and emergency frontline services** - services provided by public health workers (all employees of the Department of Health (DOH), DOH Hospitals, Hospitals of LGUs, and Provincial, City, and Rural Health Units, and Drug Abuse Treatment and Rehabilitation Centers including those managed by other government agencies (e.g. police and military hospitals/clinics, university medical facilities), uniformed medical personnel, private health workers, such as but not limited to medical professionals, hospital and health facility administrative and maintenance staff, and aides from private

health facilities, as well as their service providers, health workers and volunteers of the Philippine Red Cross and the World Health Organization, and employees of Health Maintenance Organizations (HMOs), the Philippine Health Insurance Corporation (PHIC), health insurance providers, disaster risk reduction management officers, and public safety officers (MC 2020-0025)

P. Healthcare Providers -refer to any of the following:

1. **Health Worker** - Refers to medical, allied medical, and other necessary personnel regardless of the nature of employment assigned in hospitals, and health facilities who are directly catering to or exposed to persons who are classified as either suspect, probable or confirmed COVID-19 cases. (MC2020-0030) These health workers are:
   a. Employee occupying regular, contractual, or casual position, on full time or part-time basis, in a public or private health facility;
   b. Worker engaged through contract of service (COS) or job order (JO), ' duly accredited volunteer workers including but not limited to swabbers, encoders/barcoders, contact tracers, ambulance. drivers and barangay health workers, regardless of the nature of engagement, provided they are assigned in health facilities; OR
   c. Medical or allied medical personnel under the Armed Forces of the Philippines, Department of National Defense; and Philippine National Police, Bureau of Fire Protection and Bureau of Jail Management and Penology under the Department of the Interior and Local Government; Bureau of Corrections under the Department of Justice; Philippine Coast Guard urider the Department of Transportation; and the National Mapping and Resource Information Authority under the Department of Environment and Natural Resources, Philippine 'National Red Cross and other government agencies providing medical services for COVID-19 response. *(DOH-DOLE-DBM JAO No. 2020-001, 4 June 2020)*
2. **Healthcare professiona**l - doctor of medicine, nurse, midwife, dentist, or other skilled allied professional or practitioner duly licensed to practice in the Philippines; (MC2020-0021)
   a. **Physician** - all individuals authorized by law to practice medicine pursuant to Republic Act No. 2382, or the "Medical Act of 1959,"as amended; (MC 2020-0016) (MC 2020-0024)
      i. **Deputized Physicians -** medical students who have completed the first four years of the medical course, graduates of medicine, and registered nurses who have been given limited and special authorization by the Secretary of Health to render services as deputized physicians for the purposes of this Order, where the services of duly registered physicians are not available. (MC No. 2020-0020)
3. **Health facility** - public or private facility or institution devoted primarily to the provision of services for health promotion, prevention, diagnosis, treatment, rehabilitation and palliation of individuals suffering from illness, disease, injury, disability, or deformity, or in need of medical and nursing care. (MC2020-0021)

Q. Influenza-like Illness (ILI) - a condition with sudden onset (within 3 days of presentation and fever should be measured at the time of presentation) of fever => 38C and cough or sore throat in the absence of other diagnoses (AO 2020-0013)

R. Inbound international travel - the movement from any country to the Philippines.

S. Interzonal domestic travel - the movement of people between provinces, highly urbanized cities, and independent component cities under different community

quarantine classification. For this purpose, the National Capital Region shall be considered as one area.

T. **Laboratory** - a health facility where COVID-19 testing (SARS- CoV-2 detection) is done on specimens from the human body to obtain information about the health status of a patient for the prevention, diagnosis and treatment of disease. (AO 2020-0014) (AO 2020-0013)

U. **Local COVID-19 Task Force (LCTF)** - all units organized under a local government unit for the purpose of monitoring, reporting and preventing COVID-19 in their community (MC No. 2020-0020)

V. **Mental Health and Psychosocial Support (MHPSS)** -used to describe a range of activities that aims to protect/promote psychosocial well-being of individuals and communities in their affected environment and/or prevent or treat mental disorder (MC No. 2020-0020)

W. **Minimum Health System Capacity Standards** -refers to the minimum expected COVID-19 response both from public and private sectors. (Reference policy AO2020-0016)

X. **Minimum public health standards** – Refers to guidelines set by the DOH as well as sector-relevant guidelines issued by national government agencies as authorized by the IATF, to aid all sectors in all settings to implement non-pharmaceutical interventions (NPI), which individuals and communities can carry out in order to reduce transmission rates, and the duration of infectiousness of individuals in the population to mitigate COVID-19. (Reference policy AO2020-0015)

1. **Modification Potential** -refers to the degree which mitigation strategies and other public health measures can reduce the risk for COVID-19 transmission in different settings (DM 2020-0217)

Y. **Protective personal equipment (PPE)** -refers to protective garments or equipment worn by individuals to increase personal safety from infectious agents (DM 2020-0217) (AO 2020-0015)

1. **Full PPE** -refers to a set of PPE appropriate to healthcare personnel, settings and activities to be carried out (DM 2020-0067)
2. **Medical-grade Protective Apparel** -refers to the specialized personal protective equipment worn by healthcare workers and other frontliners involved in the disease outbreak response, for the purpose of protection against infectious materials. These include surgical facemasks, N95 respirators, face shield or goggles, coveralls, isolation gowns, surgical gloves, protective oversleeves, head cap, and shoe cover among others (DM 2020-0217) (AO 2020-0015)
3. **Rational Use of PPE at the community level (MC 2020-0020)**

Target population	**Activity**	**Type of PPE**
Patients with respiratory symptoms	Any	Maintain distance of at least 1 meter Provide medical mask if tolerated, except when sleeping
Maintenance/Support Personnel	Entering patient's room, but not providing direct care or assistance	Surgical mask Rubber boots
Health Care Worker or	Providing direct care, or	Surgical mask

Caregiver	when handling stool, urine, or waste from a COVID-19 patient	n-95 mask (if with aerosolizing procedure such as oxygen support or nebulization) Gown Gloves Eye protection Face shield (if with risk of splash) Apron (if with risk of splash Rubber boots

4. **Respirator** -type of mask used to prevent inhalation of hazardous or infectious materials conforming to US National Institute for Occupational Safety and Health (NIOSH) N95 standards or equivalent (DM 2020-0067)

Z. Quarantine and Isolation

1. **Quarantine** -the restriction of movement, or separation from the rest of the population, of healthy persons who may have been exposed to the virus, with the objective of monitoring their symptoms and ensuring early detection of cases (MC No. 2020-0020)
   a. **Self-Quarantine** - strict quarantine of a contact of COVID-19 in a separate room or area in the household, for the whole duration of fourteen (14) days. (MC No. 2020-0020)
   b. **Home Quarantine** - an intervention where a person is prohibited from leaving his/her room until allowed by the local health official or his/her designated physician to do so, following the guidelines set forth in DOH Department Memorandum No. 2020-0090 as well as the requirements set forth in MC No. 2020-0020, which are as follows:

Infrastructure	Accomodations	Resource for Patient Care and Support
• Line for communication with family and health workers • Electricity • Potable water • Cooking source • Solid waste and sewage disposal	• Ability to provide a separate bedroom for the patient, or separate bed with enough distance (>3 feet or 1 meter) so long as there are no vulnerable persons in the household • Accessible bathroom in the residence; if multiple bathrooms are available, one bathroom designated for use by the patient	• Primary caregiver who will remain in the residence and who is not at high risk for complications, and is educated on proper precautions • Medications for pre-existing conditions, as needed; family planning supplies as desired • Digital thermometer,

		preferably one per patient, disinfected before and after use • Meal preparation • Masks, tissues, and other hygiene products • Laundry • Household cleaning products

c. **Community Quarantine** – Refers to restriction of movement within, into, or out of the area of quarantine of individuals, large groups of people, or communities, designed to reduce the likelihood of transmission of COVID-19 among persons in and to persons outside of affected areas. (IATF omnibus guidelines)
   i. **General Community Quarantine (GCQ)** -refers to the **implementation** of temporary measures limiting movement and transportation, regulation of operating industries, and presence of uniformed personnel to enforce community quarantine protocols (MC 2020-0025)
   ii. **Enhanced Community Quarantine (ECQ)** -refers to the implementation of temporary measures imposing stringent limitations on movement and transportation of people, strict regulation of operating industries, provision of food and essential services, and heightened presence of uniformed personnel to enforce community quarantine protocols (MC 2020-0025) (DC 2020-0286)
   iii. **Lockdown** – A condition imposed by governmental authorities (as during the outbreak of an epidemic disease) in which people are required to stay in their homes and refrain from or limit activities outside the home involving public contact; thus, limiting exposure to potentially infected individuals and reducing transmission rates.

2. **Isolation** -the separation of ill or infected persons from others to prevent the spread of infection or contamination (MC No. 2020-0020)
   a. **Self-Isolation** - strict isolation of a suspect, probable or a confirmed case of COVID-19 with mild symptoms in a separate room or area in the household for the whole duration that he/she is symptomatic (MC No. 2020-0020)
   b. **Temporary Treatment and Monitoring Facility (TTMF)** -(also known as Mega LIGTAS COVID Center) -larger scale versions of the LIGTAS COVID Center, managed by the national government, operating at the provincial/regional level to supplement LIGTAS COVID Centers and properly refer patients to appropriate facilities in accordance with separate guidelines for the purpose to be issued by the DOH. (MC No. 2020-0020)
   c. **Community Isolation Unit (CIU)** -a DOH certified publicly or privately owned non-hospital facilities set-up in coordination with or by the national government or local government units to serve as quarantine facilities for COVID-19 cases, based on DOH guidelines. Examples of CIUs include LIGTAS COVID Centers and Mega LIGTAS COVID Centers (MC No. 2020-0020)
   d. **Local Isolation and General Treatment Areas for COVID-19 cases (LIGTAS COVID) center** -a community-managed facility within a barangay, municipality, city or province, where contact, suspect, probably, and confirmed cases of COVID-19 with mild symptoms, whose home environment cannot support

physical distancing (e.g. crowded living conditions) can be temporarily housed for quarantine or isolation, which is linked to a healthcare institution (HCI) for referral purposes. A LIGTAS COVID Center is one type of Community Isolation Unit (CIU). (MC No. 2020-0020)

AA. Regional/Provincial/Hospital/Municipal Epidemiology and Surveillance Unit (RESU/PESU/HESU/CESU/MESU) -refers to information service nodes for field epidemiology data coming from local health units (MC No. 2020-0020)

BB. Returning Filipinos (RFs) - refer to Filipino citizens who are returning to the Philippines from abroad. There are two (2) categories of RFOs:

1) **Overseas Filipino Workers (OFWs)** - are overseas Filipinos whose primary reason for being outside the country or for leaving the country is due to a contract of employment in a foreign nation or a vessel flying another nation's flag
2) **Non-Overseas Filipino Workers (Non-OFWs)** - are overseas Filipinos whose primary reason for being outside the country is not due to a contract of employment in a foreign nation or a vessel flying another nation's flag *(Operational Guidelines on the Management of ROFs, 23 June 2020)*

CC. Returning Residents (RRs) - Refer to foreign nationals or Filipino citizens (e.g. construction and domestic workers, tourists, students, among others) in a specific locality within the Philippines who have expressed intention to return to their place of residence/home origin *(NTF Against COVID-19 Order No. 2020-02, 13 May 2020)*

DD. Severe Acute Respiratory Infection (SARI) -an acute respiratory illness with onset during the previous 7 days requiring overnight hospitalization. A SARI case should meet the ILI case definition AND any one of the following: a). shortness of breath or difficulty breathing, b). severe pneumonia of unknown etiology, acute respiratory distress, or severe respiratory disease possibly due to novel respiratory pathogens (such as COVID-19) (AO 2020-0013)

EE. Categories for Transmission Pattern (WHO Public health surveillance for COVID-19, 7 Aug 2020)

1. No cases -Countries/territories/areas with no cases
2. Sporadic cases -Countries/territories/areas with one or more cases, imported or locally detected
3. Clusters of cases -Countries/territories/areas experiencing cases, clustered in time, geographic location and/or by common exposures
4. Community transmission -Countries/territories/areas experiencing larger outbreaks of local transmission defined through an assortment of factors including, but not limited to:
   a. large numbers of cases not linkable to transmission chains
   b. large numbers of cases from sentinel lab surveillance or increasing positive tests through sentinel samples (routine systematic testing of respiratory samples from established laboratories)
   c. multiple unrelated clusters in several areas of the country/territory/area

FF. Time-based Tagging - cases who are asymptomatic or had mild diseases whose onset of illness or specimen collection date was 14 days prior may be tagged as recovered. This is implemented at 15-day increments.

GG. Telemedicine -the practice of medicine by means of electronic and telecommunications technologies such as phone call, chat or short messaging service (SMS), audio- and video-conferencing to deliver healthcare at a distance between a patient at an originating site, and a physician at a distant site (MC 2020-0016) (MC 2020-0024) (MC 2020-0034)

HH. Vulnerable groups - socially disadvantaged groups that are most susceptible to suffer directly from disasters and health events. These include senior citizens, immunocompromised individuals, women, children, persons deprived of liberty (PDL), persons with disabilities (PWDs), and members of indigenous peoples (IPs), internally displaced persons (IDPs), indigenous cultural communities (ICCs), among others (DM 2020-0217) (AO 2020-0015)

1. **Comorbidity -** presence of one or more additional conditions co-occurring with (that is, concomitant or concurrent with) a primary condition that may increase an individual's risk for complications or mortality if afflicted by COVID-19. This includes immunocompromised individuals (such as but not limited to those with cancer, HIV/AIDS and other autoimmune disorders) and individuals with chronic conditions (such as but not limited to hypertension, diabetes mellitus, and chronic kidney disease) *(DM 2020-0217) (AO 2020-0015)*
2. **Most-at-Risk Population (MARP)** for COVID-19 - population groups who have a higher risk of developing severe COVID-19 infection, such as individuals aged 60 and above, pregnant, and those with underlying conditions or comorbidity at risk of COVID-19 exacerbation (DM 2020-0217) (AO 2020-0015)