



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

JUN 02 2020

ADMINISTRATIVE ORDER

No. ~~2019~~ 2020-0027

SUBJECT: Guidelines on the Implementation of the Food and Waterborne Diseases Prevention and Control Program

I. RATIONALE

It has been estimated that 1.8 million people worldwide die each year as a result of diarrheal diseases, most of which can be attributed to contaminated food or water. In the Philippines, contaminated food and water are the most common causes of diarrhea; which is one of the 10 leading causes of morbidity and mortality in the country. The incidence of Food and Waterborne Diseases (FWBD) increases along with poverty and peaks during rainy season and is usually high in areas with poor sanitation and hygienic practices.

According to the World Health Organization (WHO), the burden of diarrheal diseases alone is estimated to be 3.6% of the total Disability Adjusted Life Years (DALY) worldwide and is estimated to cause 1.5 million deaths per year. An estimated 1.1 billion people still lack access to improved drinking water sources and about 2.4 billion lack access to adequate sanitation worldwide. In the Philippines, around 90% of households have access to safe water. However, there is a lesser proportion of households with sanitary toilets. The prevalence of FWBD can be greatly reduced by interventions such as safe water, sanitation and hygiene (WASH). These interventions must be equally supported with continuous health education and information dissemination.

The Food and Waterborne Disease-Prevention and Control Program (FWBD-PCP) was established in 1997 through DOH AO No. 29-A. Way before this issuance, several policies and guidelines were already developed in support to the prevention and control of FWBDs in the country, particularly diarrhea. The DOH implemented the Control of Diarrheal Diseases (CDD) which was focused on the prevention, management and treatment of diarrhea among under five-year-old children. This was incorporated into the Integrated Management of Childhood Illnesses (IMCI) Program together with the Control of Acute Respiratory Illnesses (CARI).

Pursuant to the government's commitment in implementing FOURmula One Plus for Health and in achieving the Sustainable Development Goals (SDG), and recognizing the debilitating effects of FWBD, the DOH has reviewed and revised, A.O. 29-A s. 97 "Creation of the Food and Waterborne Prevention and Control Program".

II. OBJECTIVES

This Order aims to provide the revised guidelines in reducing mortality and morbidity due to FWBDs on the road to having a food and waterborne disease-free Philippines.

III. SCOPE AND COVERAGE

This Order shall apply to DOH Central Office, other relevant DOH Bureaus/Offices/Units and attached agencies, DOH Centers for Health Development (CHDs) and Ministry of Health-Bangsamoro Autonomous Region in Muslim Mindanao (MOH-BARMM), all public and private health care facilities, health care providers, LGUs, medical societies and organizations,

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CORAZON S. DELA CRUZ
KMITS - RECORDS SECTION
Department of Health

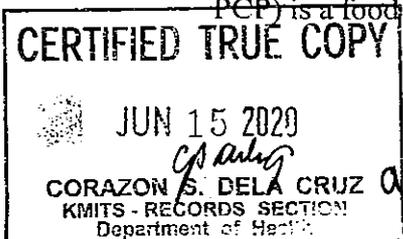
academe, and all other institutions relevant for the nationwide implementation of the FWBD-PC Program.

IV. DEFINITION OF TERMS

1. **Acute Diarrhea** – passage of three or more loose, watery or bloody stools from an immunocompetent person's normal baseline in a 24-hour period, with a duration of less than 14 days.
2. **Acute Gastroenteritis** – acute inflammation of the stomach and intestines associated with acute diarrhea accompanied by other clinical features suggesting enteric involvement and may be caused by chemical toxins, stress or infectious agents.
3. **Acute infectious diarrhea** – acute diarrhea that is usually accompanied by symptoms such as nausea, vomiting, abdominal pain and fever, and is caused by infectious agents such as bacteria, viruses, fungi or protozoa. (*Refer to D.C. No. 2019-0233*)
4. **Amoebiasis** – caused by the protozoan parasites with its transmission occurring via the fecal-oral route, either directly by person-to-person contact or indirectly by eating or drinking fecally-contaminated food or water.
5. **Cholera** – a rapidly dehydrating diarrheal disease caused by ingestion of bacterium *V. cholerae* present in fecally contaminated water or food. It is characterized by an explosive outpouring of fluid and electrolytes and if not treated appropriately can lead to death within hours.
6. **Diarrhea** – passage of the three or more loose or liquid stools per day accompanied by any of the following: nausea, vomiting, abdominal pain, fever. It is usually a symptom of gastrointestinal infection, which can be caused by a variety of bacterial viral and parasitic organisms.
7. **Food-Borne Helminths** – a group of parasitic infections caused by trematodes, cestodes, and nematodes acquired through ingestion of food contaminated with parasites including but not limited to *Heterophydes*, *Taenia*, *Capillaria* and *Paragonimus*.
8. **Food Poisoning** – occurrence of at least two (2) of any gastro-intestinal, neurologic or generalized signs and symptoms with onset at least 30 minutes after taking the contaminated food/water (*DOH DC No. 176 – 2001*).
9. **Functional Oral Rehydration Therapy (ORT) corner** – a designated space in the health facility equipped with essential supplies (e.g. Oresol, water dispenser, cups, mixer and water) and used for managing clients with diarrhea.
10. **Hepatitis A** – acute viral illness typically includes acute jaundice, dark urine, anorexia, malaise, extreme fatigue, and right upper quadrant tenderness caused by hepatitis A virus.
11. **Paralytic Shellfish Poisoning** – occurs after eating fish or shellfish containing saxitoxin made by dinoflagellates. Exposure to saxitoxin might cause numbness of the oral mucosa within 30 minutes after ingestion.
12. **Rotavirus** – a leading cause of severe diarrheal disease and dehydration in infants and young children throughout the world. Symptoms usually appear approximately 2 - 3 days after infection, and include projectile vomiting and very watery diarrhea, often with fever and abdominal pain.
13. **Typhoid** – typhoid and paratyphoid fever is systemic bacterial disease with insidious onset of sustained fever, severe headache, malaise, anorexia, relative bradycardia, splenomegaly, non-productive cough in the early stage of the illness, and constipation more often than diarrhea in adults.

V. GENERAL GUIDELINES

1. The vision of the Food and Waterborne Disease Prevention and Control Program (FWBD-PCP) is a food and waterborne disease free Philippines. Its mission is to reduce the burden



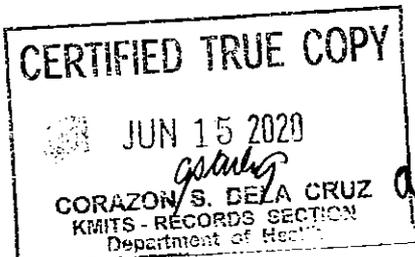
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of FWBDs and outbreaks through the effective implementation of its different program components namely: (Refer to Annex 3)

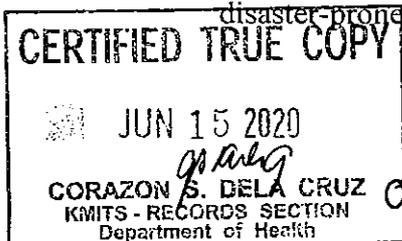
- a. Policy Development;
 - b. Health Promotion;
 - c. Laboratory Diagnosis;
 - d. Case Management;
 - e. Surveillance;
 - f. Logistics Management;
 - g. Research and Monitoring and Evaluation (M&E); and
 - h. Interagency Collaboration
2. The FWBD-PCP covers the following infections: cholera, typhoid, shigellosis and amoebiasis, hepatitis A, and infection caused by rotavirus and foodborne parasites (e.g. *Heterophyides*, *Taenia*, *Capillaria* and *Paragonimus*). It does not cover at present the diseases caused by chemicals.
 3. The FWBD-PCP shall be implemented by the Disease Prevention and Control Bureau (DPCB) Infectious Disease Prevention and Control Division (IDPCD) through the FWBD Program Manager who shall manage the FWBD-PCP in coordination with DPCB concerned divisions (e.g. Environmental Related Diseases Division, and Child Health Development Division), DOH Central Office Bureaus/Divisions (e.g. Epidemiology Bureau, Health Emergency Management Bureau), Centers for Health Development, MOH-BARMM, attached agencies (e.g. Food and Drug Administration), other government agencies (e.g. Department of Education, Department of Agriculture), private sector and academe, and developmental partners.
 4. Decision-making, policy formulation, and resource prioritization shall be based on evidence-generating systems such as the FWBD surveillance and response, research studies and other information management system. Clinical practice guidelines shall also be guided by quality data and scientific evidence.
 5. Necessary budget and logistics shall be allocated for the implementation of the national program at the DOH-Central Office, CHDs, MOH-BARMM, DOH Retained Hospitals and other attached agencies.
 6. The overall direction of the FWBD-PCP shall be aligned with the national and international commitments of the Philippines towards the prevention and control of FWBDs. The FWBD-PCP Strategic Plan shall be implemented, monitored, evaluated, updated and sustained on a regular basis by the FWBD-PCP in order to provide concrete actions and the strategic directions for its initiatives.
 7. The implementation of this Administrative Order shall be regularly monitored by DPCB IDPCD FWBD Program. The results of the regular monitoring shall be consolidated into an annual compliance report pursuant to this AO.

VI. SPECIFIC GUIDELINES

1. The FWBD-PCP shall facilitate the conduct of research to produce evidence that shall support program implementation and monitoring in coordination with different stakeholders. It shall prepare an annual research agenda linked with the priorities in the strategic plan to help address challenges in FWBD program implementation.
2. The Strategic Plan for FWBD 2019-2023 shall provide the directions to guide the implementation of FWBD initiatives within the health sector. The CHDs and MOH-BARMM shall prepare their respective annual Work and Financial Plans (WFPs) consistent with the Strategic Plan (Refer to Annex 1 and 2).



3. The FWBD Program different components shall involve two or more agencies working together to achieve the desired change in reducing morbidity and mortality from FWBDs. These components are the following: *(Refer to Annex 3)*
 - a. Policy Development
 - b. Health Promotion
 - c. Laboratory Diagnosis
 - d. Case Management
 - e. Surveillance
 - f. Logistics Management
 - g. Research and M&E
 - h. Interagency Collaboration
4. The FWBD-PCP shall facilitate the development and implementation of a communication and advocacy plan on FWBD in coordination with the Health Promotion and Communication Service (HPCS), Regional Health Education and Promotion Officers (HEPOs) and the Development Management Officers (DMOs). This includes the conduct of strategic, regular and well-timed activities throughout the year.
5. The DPCB IDPCD - FWBD shall facilitate the development and updating of FWBD-PCP tools and documents in coordination with the CHDs, MOH-BARMM and other key stakeholders including:
 - a. Capacity building plan;
 - b. Clinical Practice Guidelines;
 - c. Monitoring and Evaluation System; and
 - d. Manual of Operations.
6. The DOH FWBD-PCP shall conduct an annual review of accomplishments, implementation challenges and recommendations with the relevant bureaus and offices including all CHDs, MOH-BARMM and other partners to assess the continuing relevance of this Order as a whole or its parts. Proposed amendments and supplementary policies shall be discussed during this review for updates. The budget for the annual review shall be sourced from the GAA of DOH indicated in Section VIII (FUNDING) of this Order.
7. The CHDs and MOH-BARMM shall allocate budget for the implementation of FWBD initiatives. CHDs and MOH-BARMM shall also encourage LGUs to allocate budget to address FWBDs in their 3-Year Local Investment Plan for Health (LIPH). DOH and LGU counterparts on FWBD shall be integrated in the Annual Terms of Partnership between DOH and the LGU.
8. FWBD focal persons shall be designated in all DOH CHDs and MOH-BARMM provinces, municipalities/cities as well as partner agencies.
9. A functional ORT corner with competent and knowledgeable health care provider shall be included as part of FWBD services in all RHUs/Health Centers and government hospitals to administer hydration to diarrhea cases. *(Refer to Annex 4; D.M. 2019-0172)*
10. FWBD-PCP interventions and services shall prioritize those from the vulnerable and marginalized sectors of the society. Special attention must also be directed to those living in the geographically isolated and disadvantaged areas (GIDAs), flood-prone and other disaster-prone areas where contamination of water and food is most likely to occur.



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11. FWBD-PCP shall employ measures to evaluate the effectiveness of the risk management program on a continuous basis based on the strategic plan.

VII. ROLES AND RESPONSIBILITIES

1. Infectious Disease Prevention and Control Division (IDPCD) – FWBD – DPCB

- a. The overall management and coordination of the FWBD-PCP is lodged in the IDPCD-DPCB. It shall take the lead in setting the overall policy direction and focus of the Program.
- b. Ensure the provision/delivery of quality diagnosis, management and treatment services of FWBDs;
- c. Disseminate national policies, standards and guidelines governing the management and implementation of the FWBD-PCP;
- d. Facilitate conduct of FWBD-PCP trainings to Centers for Health Development;
- e. Maintain and regularly update a database of FWBD focal persons from DOH CHDs, MOH-BARMM, provinces, municipalities/cities as well as partner agencies;
- f. Undertake monitoring and evaluation of the status and performance of the FWBD-PCP;
- g. Coordinate with other DOH offices in promoting WASH practices and key messages on prevention and control of FWBDs; and
- h. Coordinate with related offices/agencies on any outbreak due to FWBD such as Epidemiology Bureau (EB) for surveillance and monitoring, Health Emergency Management Bureau (HEMB) for logistics augmentation, Environment-Related Disease Division for immediate action on water and sanitation, and Department of Agriculture (DA) for diseases that may be attributed to animal, plant and aquatic resources.

2. Environmental Related Disease Division (ERDD)

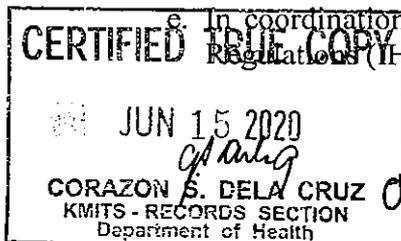
- a. Provide technical assistance to the regions and LGUs to comply with the provisions and requirements of the Sanitation Code of the Philippines;
- b. Formulate policies, guidelines and standards in promoting increased access to safe water, sanitation and hygiene services;
- c. Design strategic approaches to achieve zero open defecation areas nationwide; and
- d. Coordinate with the Department of Environment and Natural Resources (DENR) for interventions that shall support the prevention and control of FWBDs.

3. Family Health Office (Women and Men's Health Development Division and Children's Health Development Division)

- a. Provide technical assistance to the DOH CHDs, MOH-BARMM, Provincial DOH Offices (PDOs), and LGUs to comply with the relevant child health policies and guidelines in support of the FWBD-PCP; and
- b. Integrate guidelines on hand-washing, sanitation and hygiene practices in maternal and newborn care, infant and young child feeding, early child development, oral health, nutrition, integrated management of childhood illness, and management of acute malnutrition.

4. Epidemiology Bureau (EB)

- a. Maintain and strengthen FWBD surveillance nationwide;
- b. Inform/communicate with the FWBD-PCP and other offices concerned of any impending or notable FWBD outbreaks;
- c. Generate timely FWBD surveillance reports and disseminate to concerned DOH offices;
- d. Provide assistance to RESUs and LESUs if needed in the investigation of cases of FWBDs;
- e. In coordination with the FWBD-PCP, notify the WHO through the International Health Regulations (IHR) National Focal Point when the assessment indicates a food or waterborne



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disease event is notifiable pursuant to paragraph 1 of Article 6 and Annex 2 and to inform WHO as required pursuant to Article 7 and paragraph 2 of Article 9 of IHR (Annex 3.8A).

5. Health Emergency Management Bureau (HEMB)

- a. Coordinate the mobilization of WASH resources to ensure adequate and safe water through water quality surveillance, disinfection/treatment in coordination with DPCB-ERDD; and
- b. Support in the augmentation of logistics to FWBD to respond to emergencies, disaster and outbreaks.

6. Health Promotion and Communication Services (HPCS)

- a. Formulate and design a health promotion and communication plan to address FWBDs; and
- b. Develop key messages for various groups of audiences relative to the prevention and control of FWBDs.

7. Research Institute for Tropical Medicine (RITM), National Reference Laboratories (Parasitology, Bacterial Enteric Diseases and Rotaviruses and Other Enteric Viruses) and Surveillance and Response Unit

- a. Perform confirmatory laboratory testing for human samples referred for the FWBD pathogen surveillance and outbreak investigation (e.g. stool, sputum, blood, urine);
- b. Provide technical support for collection, transport and storage of specimen for the disease reporting unit and training on FWBD pathogens and quality assurance to the regional laboratories;
- c. Provide line-list of laboratory results to EB and RESU, and individual laboratory results to the RESU, in the form of transmittals (for distribution to the Disease Reporting Units); and
- d. Perform further studies on new technologies to determine other etiologies of FWBD.

8. Food and Drug Administration (FDA)

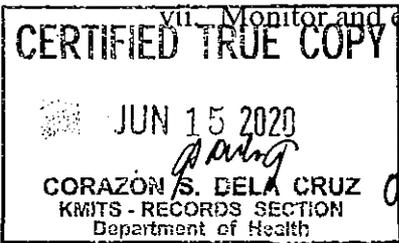
- a. Perform microbiologic tests on processed food samples submitted to the laboratory and provide EB with a report of FWBD etiologic agents on food samples tested;
- b. Undertake surveillance of microbiologic agents of food and waterborne diseases which are transmissible to humans on pre-packaged food in the market and issue Public Advisory / Warning to prevent consumption of contaminated food; and
- c. Alert the DOH offices in cases of unusual increases in the number of reported organisms known to cause FWBD in humans.

9. DOH – Centers for Health and Development (CHDs)

a. Infectious Disease Prevention and Control Cluster

- i. Disseminate national policies, standards and guidelines governing the management and implementation of the FWBD-PCP;
- ii. Facilitate the conduct FWBD-PCP trainings to LGUs;
- iii. Develop research proposals addressing FWBD concerns in coordination with FWBD PCP and Health Policy Development and Planning Bureau (HPDPB) for submission and approval to Philippine Council for Health Research and Development (PCHRD);
- iv. Develop regional plans on FWBD and ensure inclusion of budgetary requirements for FWBD in their respective WFPs;
- v. Augment logistics support on FWBD-PCP to LGU;
- vi. Coordinate with the regional Environmental Health unit, RESU, DMU, LGU and other partners on the implementation and management of the FWBD-PCP particularly during disasters and outbreaks; and

vii. Monitor and evaluate the implementation of the program to LGU.



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b. Family Health Cluster

- i. Disseminate national policies, standards and guidelines on child health and nutrition in support the FWBD-PCP;
- ii. Support the Infectious Disease Cluster in the development of integrated local plans on child health and nutrition to implement and cascade FWBD-PCP to LGUs;
- iii. Provide complementary child health and nutrition capacity development activities and technical assistance on MNCHN that shall support effective implementation of FWBD-PCP to LGUs;
- iv. Coordinate with the Regional Environmental and Occupational Health on the implementation of the FWBD-PCP; and
- v. Monitor and evaluate the MNCHN-related indicators and variables related to the implementation of the FWBD-PCP to LGU.

c. Regional Epidemiology and Surveillance Unit (RESU)

- i. Regions shall ensure completeness and timeliness of data base reports from the LGUs and hospitals and conduct weekly analysis of FWBD data and submit weekly report to EB on notifiable diseases;
- ii. Provide technical assistance to LESUs in the conduct of outbreak investigation and immediate reporting through ESR if there is an outbreak or clustering of cases;
- iii. Coordinate and facilitate submission of samples; and
- iv. Notify EB through the International Health Regulations (IHR) National Focal Point when the assessment indicates a food or waterborne disease event is notifiable pursuant to paragraph 1 of Article 6 and Annex 2 and to inform WHO as required pursuant to Article 7 and paragraph 2 of Article 9 of IHR (Annex 3.8A).

d. Environmental and Occupational Health Office

- i. Provide technical assistance and training to LGUs to increase households (HHs) with access to safe water and with sanitary toilet, and achievement of zero open defecation and augment logistics support to LGUs;
- ii. Assist in the investigation of FWBD Outbreaks; and
- iii. Monitor the LGU's implementation of WASH on the prevention and control of FWBD.

e. Health Promotion and Communication Services

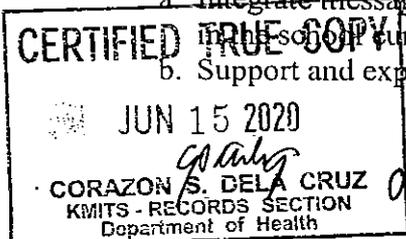
- i. Implement health communication plan;
- ii. Localize key messages for various groups of audiences relative to the prevention and control of FWBDs; and
- iii. Participate in the conduct of FWBD training.

10. Department of the Interior and Local Government (DILG)

- a. Support the DOH and DA in the collection and documentation of food-borne illness data, monitoring and research;
- b. Provide budget allocation for capacity building of LGU health workers;
- c. Endorse LGU health workers to participate in training programs, standards development and other food safety activities to be undertaken by the DA, DOH and other concerned national agencies; and
- d. Recommend to LCEs to adopt and support FWBD-PCP initiatives.

11. Department of Education (DepEd)

- a. Integrate messages on proper water, food and sanitary practices including personal hygiene in the school curriculum; and
- b. Support and expand the implementation of WASH in schools and school feeding programs.



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12. Department of Agriculture (DA)

- a. Alert the DPCB FWBD and EB in cases of unusual increase in the number of reported organisms known to cause foodborne disease in humans.
- b. Develop and transfer technologies to LGUs to improve and sustain the development of the plant, livestock and aquaculture industry which ensure food security and competitiveness of the local produce in the global market;
- c. Inform and share with DOH of new technologies related to FWBD;
- d. Plan, coordinate and implement research and development programs in support to food safety; and
- e. Coordinate with FDA regarding all laboratory confirmations involving foodborne disease with outbreak potential.

13. Department of Social Welfare and Development (DSWD)

- a. Ensure proper water, food and sanitary practices including personal hygiene at the DSWD Residential, Centers, Community Kitchen and in Evacuation Centers;
- b. Support and expand implementation of hand-washing practices during feeding programs;
- c. Promote the FWBD Advocacy or Information, Education and Communication (IEC) materials in partnership with the DOH.

14. Department of Environment and Natural Resources (DENR)

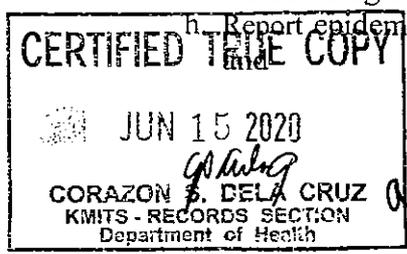
- a. Control the construction and maintenance of waterworks, sewerage, and sanitation systems and other public utilities;
- b. Prohibit dumping of waste products detrimental to the plants and animals or inhabitants therein and in exposed and unsanitary condition on the ground or in bodies of water;
- c. Raise awareness on the importance of maintaining reliable and effective treatment of wastewater and recycled water for the benefit of communities; and
- d. Endeavour to achieve social justice by ensuring the integrity of our ecosystems on which local communities depend for food and livelihood.

15. Local Government Units (LGUs)

The LGUs are primarily responsible in the delivery of quality FWBD diagnosis, management and treatment and conduct of preventive and control interventions at the local level. Specifically, the LGUs are expected to:

- a. Ensure adoption of DOH-FWBD policies through ordinances;
- b. Advocate for LCEs' support and encourage LGUs to provide funds/budget for FWBD-PCP through inclusion in the Local Investment Plan for Health;
- c. Facilitate the provision of funds for logistics, capacity building (training and transportation of LGU health workers), and WASH campaign;
- d. Ensure household access to safe drinking water and sanitation facilities and establish water filtration system during emergencies and disasters;
- e. Maintain and sustain local epidemiology and surveillance units and assist in the investigation and outbreak response;
- f. Notify RESU and FWBD Regional Coordinator when the assessment indicates a food and waterborne disease event is notifiable pursuant to paragraph 1 of Article 6 and Annex 2 of IHR and to inform WHO as required pursuant to Article 7 and paragraph 2 of Article 9 of IHR (Annex 3.8A);
- g. Fill up laboratory request forms and submit appropriately labeled specimens from patients and samples of suspected food/water vehicles to the appropriate DOH or DA laboratory for microbiological tests;

h. Report epidemiologic data on the occurrence of food and waterborne infections to RESU;



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- i. Monitor implementation of FWBD with functional ORT corner, availability of ORS and competent health workers in RHUs and other health facilities.

16. Hospitals

- a. Attend to cases of diarrhea, its comorbidity illness, and its complications using appropriate CPGs;
- b. Re-establish oral rehydration solution stations or corners in outpatient and emergency departments; (household chlorination; infection control policy disposal of the dead e.g. Cholera);
- c. Notify RESU when the assessment indicates a food and waterborne disease event is notifiable pursuant to paragraph 1 of Article 6 and Annex 2 of IHR and to inform WHO as required pursuant to Article 7 and paragraph 2 of Article 9 of IHR (Annex 3.8A);
- d. Encode and collate epidemiologic data on the occurrence of Salmonellosis and other food and waterborne infections and submit monthly reports to RESU;
- e. Perform new technologies, e.g. Rapid Diagnostic Test (RDT) to determine other etiologies of FWBD; and
- f. Conduct of death review/verbal autopsy for FWBD cases.

17. Laboratory

a. Regional Laboratories

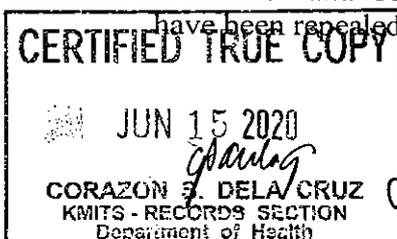
- i. Perform laboratory testing of samples (bacterial, viral and parasitic) from FWBD cases referred by the disease reporting units, as well as from cluster/outbreak investigations;
 - ii. Participate in monitoring and evaluation visits by the FWBD Monitoring team;
 - iii. Participate in the laboratory quality assurance program;
 - iv. Provide laboratory results to the National Reference Laboratories and RESU, and coordinate with the NRLs for technical concerns (specimen collection, transport, storage, testing and troubleshooting);
 - v. Perform direct fecal smear, modified acid fast staining, formalin ether concentration technique, kato-katz and RDT for detection of FWB parasites; and
 - vi. Send isolates for confirmatory testing.
- b. **Tertiary Laboratories** – Perform direct fecal smear, bacteriological culture, modified acid fast staining, formalin ether concentration technique, kato-katz and RDT for detection of FWB parasites.
- c. **Secondary Laboratories** – Perform direct fecal smear, kato-katz and modified acid fast staining for detection of FWB parasites.
- d. **Primary Laboratories** – Perform direct fecal smear, kato-katz and modified acid fast staining for detection of FWB parasites.
- e. **Rural Health Units** – Perform direct fecal smear and kato-katz for detection of FWB parasites.

VIII. FUNDING

The funding requirements for the full implementation of the FWBD-PCP shall be sourced from the Public Health Management budget line item as well as budgets of CHDs and MOH-BARMM and other sources including LGU budgets and development partners for technical assistance and research purposes.

IX. REPEALING CLAUSE

Administrative Order No. 29-A s.1997, "*Creation of the Food and Waterborne Diseases Prevention and Control Program*" and other issuances which are inconsistent to this Order have been repealed by this policy.



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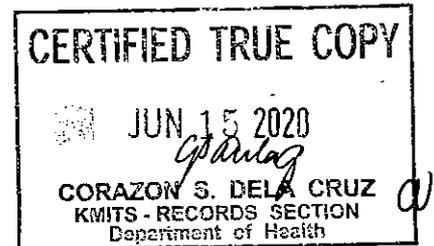
X. SEPARABILITY CLAUSE

If any provision of this Order is declared unauthorized or rendered invalid by any court of law or competent authority, those provisions not affected thereby shall remain valid and effective.

XI. EFFECTIVITY

This order shall take effect immediately after its publication in the Official Gazette or in a newspaper of general circulation. Copies of this Order shall be filed with the U.P. Law Center pursuant to Book VII, Chapter 2, Sec. 3 of E.O. 292.


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



ANNEX 1.
ADOPTION OF THE NATIONAL FWBD PROGRAM 2019-2023 STRATEGIC PLAN



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

May 31, 2019

DEPARTMENT CIRCULAR
No. 2019- 0221

FOR : ALL UNDERSECRETARIES, ASSISTANT SECRETARIES, DIRECTORS OF BUREAUS, CENTERS FOR HEALTH DEVELOPMENT AND SERVICES, EXECUTIVE DIRECTORS OF SPECIALTY HOSPITALS, CHIEFS OF MEDICAL CENTERS, HOSPITALS AND SANITARIA, PROVINCIAL HOSPITALS, MEDICAL CENTERS AND OTHERS CONCERNED

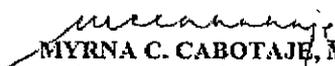
SUBJECT : Adoption of the National Food and Waterborne Disease Prevention and Control Program 2019-2023 Strategic Plan

To strengthen implementation of the National Food and Waterborne Disease (FWBD) Prevention and Control Program, the developed 2019-2023 Strategic Plan shall be used by program managers and coordinators, health workers in public and private health facilities, training officers and medical practitioners in the prevention and control of FWBDs. Likewise, this will guide the partner organization in assisting the program strategies and activities.

The FWBD 2019-2023 Strategic Plan will be posted at the DOH website www.doh.gov.ph and adopted by concerned agencies.

Dissemination of the information and guidance to all concerned requested.

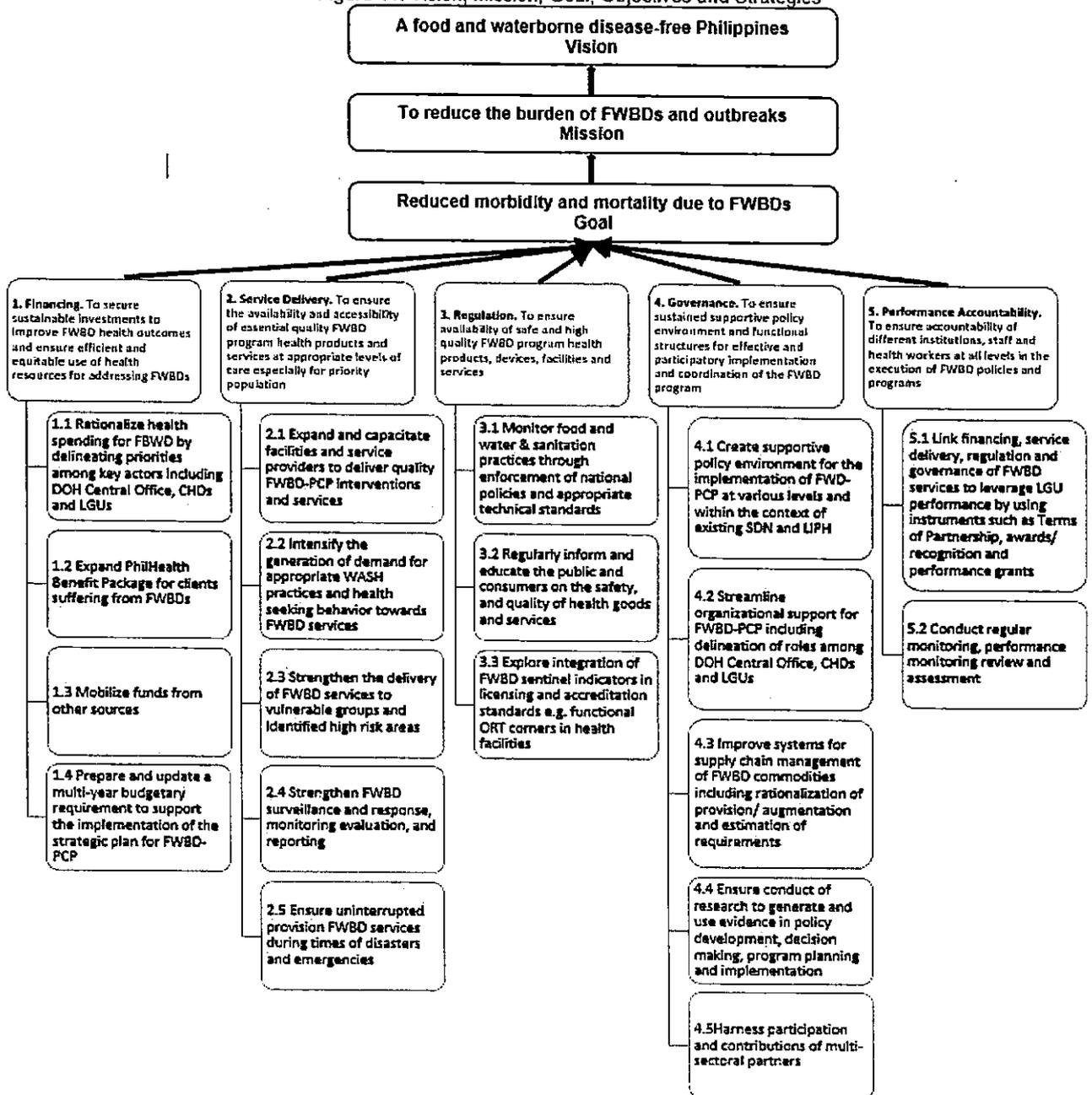
By Authority of the Secretary of Health:


MYRNA C. CABOTAJE, MD, MPH, CESO III
Undersecretary of Health
Public Health Services Team

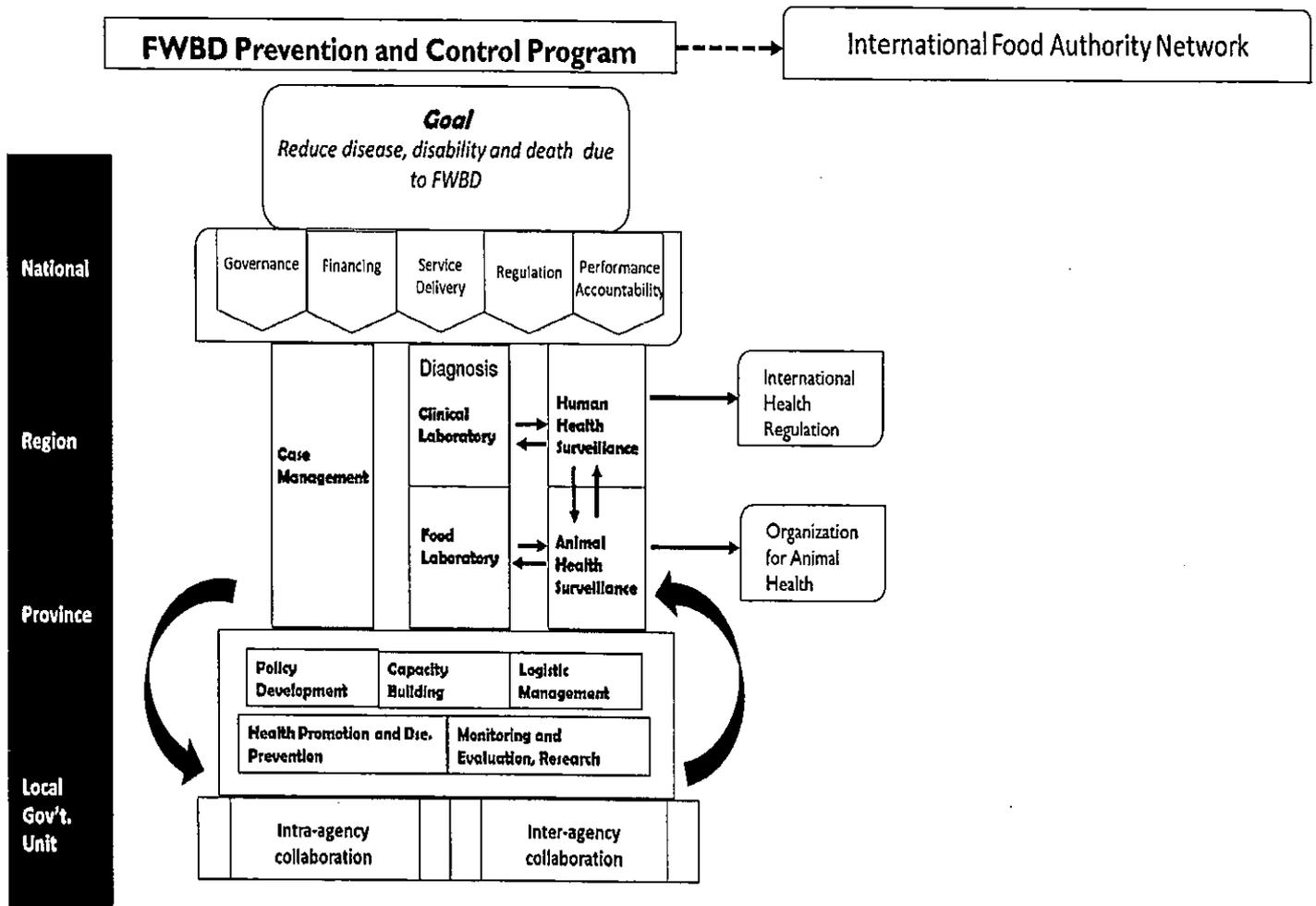
ANNEX 2. FWBD PROGRAM VISION, MISSION, GOAL, OBJECTIVES AND STRATEGIES

Vision, Mission, Goal, Objectives and Strategies

Figure 11. Vision, Mission, Goal, Objectives and Strategies



**ANNEX 3.
FWBD PROGRAM IMPLEMENTATION FRAMEWORK AND PROGRAM
COMPONENTS**



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ANNEX 4.
FWBD PROGRAM ORAL REHYDRATION THERAPY (ORT) CORNER



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

April 15, 2018

DEPARTMENT MEMORANDUM
No. 2019 - 0172

FOR: CENTERS FOR HEALTH DEVELOPMENT DIRECTORS,
CHIEF OF HOSPITALS / MEDICAL CENTERS /
SANITARIA, COORDINATORS OF FOOD AND
WATERBORNE DISEASE PREVENTION AND CONTROL
PROGRAM

SUBJECT: Supplemental Guidelines for the Implementation of the Food and
Waterborne Disease (FWBD) Program Oral Rehydration
Therapy (ORT) Corner utilizing the Clinical Practice Guidelines
on Acute Infectious Diarrhea

I. RATIONALE

The Food and Waterborne Disease (FWBD) Program is bringing back the Oral Rehydration Therapy (ORT) Corner at the Rural Health Units (RHUs) and other point-of-care facilities for early management and treatment of diarrhea utilizing the FWBD Clinical Practice Guidelines (CPG) on the hydration of patients with signs of diarrhea on an outpatient basis. The restoration of ORT Corner intends to strengthen the health service delivery for prompt response to diarrhea cases.

II. OBJECTIVES

This Department Memorandum is issued to provide supplemental guidelines on the implementation of Oral Rehydration Therapy (ORT) Corners based on the FWBD – CPG.

III. SCOPE

This issuance shall be applied to DOH Central Office, other relevant DOH Bureaus/Offices/Units and attached agencies, DOH CHDs and ARMM, health care facilities, health care providers, medical societies and organizations, and all other institutions relevant for the nationwide implementation of the FWBD Program.

IV. GENERAL GUIDELINES

1. The FWBD -CPG shall be used as the primary guide for the hydration management of diarrhea to be utilized by all health facilities.
2. Health facilities shall have a designated area or space, commodities and supplies for the pre-implementation and implementation of ORT corners.
 - a. The ORT corner or a hydration area shall be placed primarily in public health facilities, Outpatient Departments, Emergency rooms, Rural Health Units (RHUs), school clinics and other facilities with health providers that manage mild to moderate diarrhea.

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- b. A standardized capacity building program on the implementation of FWBD CPG and the restoration of an ORT corner shall be provided to all health workers by the National FWBD Program through the Centers for Health Development (CHDs). This shall be cascaded to the LGUs.
- c. CHDs shall provide capacity building, advocacy and health promotion while Local Government Units shall allocate funds for the maintenance of the ORT corners to include supply of ORS as a part of their regular service delivery.
- d. All diarrhea cases (Moderate to severe) that cannot be managed and treated initially in the health facility shall be referred immediately to the nearest hospital for further management. Other illnesses not related to diarrhea shall be treated accordingly (e.g. cough, skin disease etc.)
- e. Monitoring of ORT corner implementation shall be conducted at least once every quarter utilizing FWBD Monitoring and Evaluation developed tool.

V. SPECIFIC GUIDELINES

1. DEHYDRATION ASSESSMENT

Clinical Parameters Indicative of Dehydration with Acute Infectious Diarrhea

1.1. In Children

1. Clinical findings indicative of dehydration in children include abnormal vital signs (tachycardia, tachypnea), depressed level of consciousness, depressed fontanels, sunken eyes, decreased or absent tears, poor skin turgor, prolonged capillary refill time, abnormal respiratory pattern, and decreased urine output. The parameters to assess the severity of dehydration in children are shown in Annex 1. (*Annex 1. Clinical manifestations of dehydration in children according to severity*).

These parameters are unreliable for patients with severe malnutrition. Use other parameters to distinguish malnutrition from dehydration.

1.2. In Adult

1. Clinical findings indicative of dehydration in adults include fatigue, thirst, sunken eyes, orthostatic hypotension, tachypnea, tachycardia, lethargy, dry oral mucosa, muscle weakness, poor skin turgor, prolonged capillary refill time, and cold, clammy skin.
2. Laboratory parameters indicative of dehydration in adults include Increased urine specific gravity (≥ 1.010), increased urine osmolality (> 800 mosm/kg), increased serum osmolality (≥ 295 mosm/kg), increased BUN/creatinine ratio (> 20), and metabolic acidosis (pH < 7.35 , $\text{HCO}_3^- < 22$ mmol/L).

The clinical and laboratory parameters to assess the severity of dehydration in adults are shown in Annexes 2 and 3. (*Annex 2. Clinical manifestations of dehydration in adults according to severity; Annex 3. Other parameters used in assessing dehydration in adults*).

3. Laboratory parameter values (*see Annex 3*) are appropriate for assessing severity of dehydration if the patient has no fever.
4. Skin turgor is best assessed at the anterior forearm, anterior thigh, anterior chest, subclavicular area, or sternum.
5. Capillary refill time should be assessed with the examiner's middle finger at the same level as the patient's heart.

2. DEHYDRATION MANAGEMENT

2.1. In Children

1. For breastfed infants, breastfeeding shall be continued in addition to hydration therapy.

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2. Carbonated, sweetened, caffeinated and sports drinks are not recommended for fluid replacement.
3. Check the child from time to time during rehydration to ensure that ORS is being taken satisfactorily and that signs of dehydration are not worsening. Evaluate the child's hydration status at least hourly.
4. The recommended management according to level of dehydration is shown in Annex 4. (*Annex 4. Recommended management for children with acute infectious diarrhea according to level of dehydration*). The algorithm for fluid resuscitation is shown in Annex 2A and Annex 2B.

2.2. In Adult

1. The recommended management for dehydration in adults is summarized in Annex 5. (*Annex 5. Recommended management for adults according to degree of dehydration*).
2. Sports drinks and soda are NOT recommended to replace losses.
3. For calculations of maintenance fluid rate, it is suggested to use the actual or estimated body weight. However, the ideal body weight should be used for overweight or obese patients.
4. Elderly patients and those at risk of fluid overload (patients with heart failure or kidney disease) should be referred to a specialist for individualized fluid management.
5. Recommendations for type of fluid:
 - 5.1. PLRS, a chloride-restrictive IVF, is the fluid of choice for hydration and fluid resuscitation of patients with diarrhea. If PLRS is not available, plain normal saline solution may still be used.
 - 5.2. During initial resuscitation, hourly monitoring of vital signs, mental status, peripheral perfusion, and urine output must be done. The subsequent frequency of monitoring should be based on the clinician's judgment.
 - 5.3. The routine use of albumin, hydroxyethyl starch (HES), dextran, or gelatin for fluid resuscitation of dehydrated patients is not recommended. (*Refer to Annex 6. Algorithm for initial assessment of dehydration in adult patients.*)

NOTE: Patients with signs/mild dehydration shall be initially assessed and managed initially with ORS if tolerated. If after assessment, patient's condition has improved, he is advised to go home with proper instructions

However, if patient condition does not improve, and does not respond to ORS, or condition worsens; the patient should be referred to the nearest hospital for further management.

3. CRITERIA FOR ADMISSION

3.1. In Children

- 3.1.1. Children with acute infectious diarrhea who have any of the following signs and symptoms should be admitted:
 - *Based on clinical history:* unable to tolerate fluids, suspected electrolyte abnormalities, or conditions for safe follow-up and home management are not met
 - *Based on physical findings:* altered consciousness, abdominal distention, respiratory distress, or hypothermia (temperature <36°C)
- 3.1.2. Children with acute infectious diarrhea who have any of the following co-existing medical conditions should be admitted:

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- Co-existing infections such as pneumonia, meningitis/encephalitis, or sepsis
- Moderate to severe malnutrition
- Suspected surgical condition

3.2. In Adult

- 3.2.1.** Presence of any of the following clinical history and physical findings warrant admission
- Poor tolerance to oral rehydration
 - Moderate to severe dehydration
 - Acute kidney injury
 - Electrolyte abnormalities
 - Unstable comorbid conditions (e.g. uncontrolled diabetes, congestive heart failure, unstable coronary artery disease, chronic kidney disease, chronic liver disease, immunocompromised conditions)
 - Frail or elderly (≥ 60 years old) patients
 - Poor nutritional status
 - Patients with unique social circumstances (living alone, residence far from a hospital)

VI. ORT CORNER OPERATIONAL GUIDELINES

A. Functions of ORT Corner

1. Assessment & classification of children with diarrhea;
2. Oral rehydration therapy with ORS;
3. Administration of first dose of Zinc tablets (20mg or 10mg);
4. Administration of Vitamin A (200,000/100,000IU);
5. Counseling on continued diarrhea treatment of the child at home.

B. Components of an ORT Corner

1. Space Location

Health facility shall have designated area or space within main entry points (e.g., OPD, ER, Ward) where patients with diarrhea disease are assessed, classified, treated and counseled.

2. ORT Corner Equipment, Commodities and Supplies

(Refer to Annex 7 ORT Corner Equipment, Commodities and Supplies).

3. Information, Education and Communication Materials

- 3.1. Flip chart on "Pagatae"
- 3.2. Poster on "Pagatae"
- 3.3. ORT Corner Operational Guidelines
- 3.4. Clinical Practice Guidelines on Acute Infectious Diarrhea Pocket Guide Booklet

4. Human Resource

1. Ensure availability of ORT Corner commodities, supplies and data tools;
2. Collect, analyze and submit timely diarrhea disease data & facility reports;
3. Promote disease surveillance;
4. Maintain all the ORT corner equipment;
5. Ensure correct sick child management;
6. Counsel mother on when to return (Danger signs);
7. Correct sick child management (Assess, Classify & Treat);
8. Counsel on Home treatment:
 - 8.1. Give extra fluids-ORS & recommended home fluids;

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- 8.2. Give extra feeds during & after diarrhea, and extra exclusive breast feeding if age < 6 months.
- 8.3. Give Zinc tablets as per the HCWs instructions
- 8.4. When to return if no improvement (Danger Signs)

5. Monitoring & Evaluation Tools Checklist at Facility (Annex 8 & 9)

- 1. The ORT Register
- 2. ORT data summary sheet
- 3. Supervision checklist
- 4. Graphical display of monthly cases of diarrhea and classifications
- 5. ORT Corner guidelines & M&E document
- 6. Sick Child recording forms
- 7. Referral & counter referral forms

VI. ROLES AND RESPONSIBILITIES

1. Disease Prevention and Control Bureau (DPCB)

The DOH-DPCB through the Food and Waterborne Disease (FWBD) Program shall oversee the implementation of the policy and guidelines. They shall undertake the following tasks:

- 2.1. Oversee the distribution of ORT Corner supplies through the CHDs;
- 2.2. Coordinate with EB for efficient data gathering and recording. Data analysis shall be jointly done with EB; and
- 2.3. Monitor and evaluate the implementation together with the region, provincial/city/municipal health offices and other concerned technical partners. Provide recommendations for immediate actions.

2. Environmental Related Disease Division (ERDD)

Environmental Health shall focus on the prevention of diarrhea and containment of possible cholera outbreak through provision of safe water, safe food, hygiene promotion messages and environmental sanitation activities.

2.1. Prevention

- 2.1.1. Provide technical assistance to the regions and LGUs to comply with the provisions and requirements of the Sanitation Code in the Philippines;
- 2.1.2. Formulate policies, guidelines and standards in promoting increased access to safe water and sanitation services;

2.2. Containment

- 2.2.1. Lead the case investigation and assessment together with the other members of the investigating team when clustering is observed.
- 2.2.2. Submit an assessment/investigation report including recommendations to the local and regional health offices.
- 2.2.3. Implement control measures together with local officials and environmental health staff.

3. Epidemiology Bureau (EB)

- 3.1. Use the data of the line list to enhance PIDS especially on the diarrhea case definitions; and
- 3.2. Ensure the reporting of diarrhea cases and use of ORT from the implementers to the region and national offices through the RESU.

4. Health Promotion and Communication Services

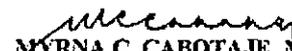
- 4.1. Develop Information, Education and Communication (IEC) materials on food and waterborne diseases appropriate to the situation.
- 4.2. Advocate to seek early consultation at health facilities and include messages to promote on the use of ORT corner.

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- 4.3. Advocate for safe food preparation/handling, transport, storage and consumption.
5. **Centers for Health Development (CHDs)**
 - 5.1. Disseminate the policy and guidelines of ORT corner implementation at the health facilities and evacuation centers;
 - 5.2. Orient the health workers on the use of ORT corner in partnership with the FWBD program and EB;
 - 5.3. Provide the needed supplies to the concerned health workers / implementers;
 - 5.4. Ensure timely submission of the FWBD form listing on diarrhea cholera cases through the RESU to EB;
 - 5.5. Integrate the monitoring of ORT corner implementation in their supervisory monitoring visits;
 - 5.6. Coordinate with the Provincial/City/Municipal Health Office to:
 - 5.6.1. Conduct orientation/training of concerned staff on the use of ORT corner;
 - 5.6.2. Advocate with municipalities/cities to adopt and support the use of ORT corner;
 - 5.6.3. Support the quality assurance system of ORT corner; and
 - 5.6.4. Provide timely report to the region using the PIDS reporting system.
 - 5.6.5. Coordinate with the Rural Health Units to:
 - a. Implement the use of ORT corner for screening and early diagnosis of cholera cases;
 - b. Ensure proper storage of ORT corner commodities to ensure longer shelf life; and
 - c. Ensure timely submission of diarrhea cases using PIDS reporting system including ORT corner data.

For your guidance and strict compliance.

By the Authority of Secretary of Health:


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