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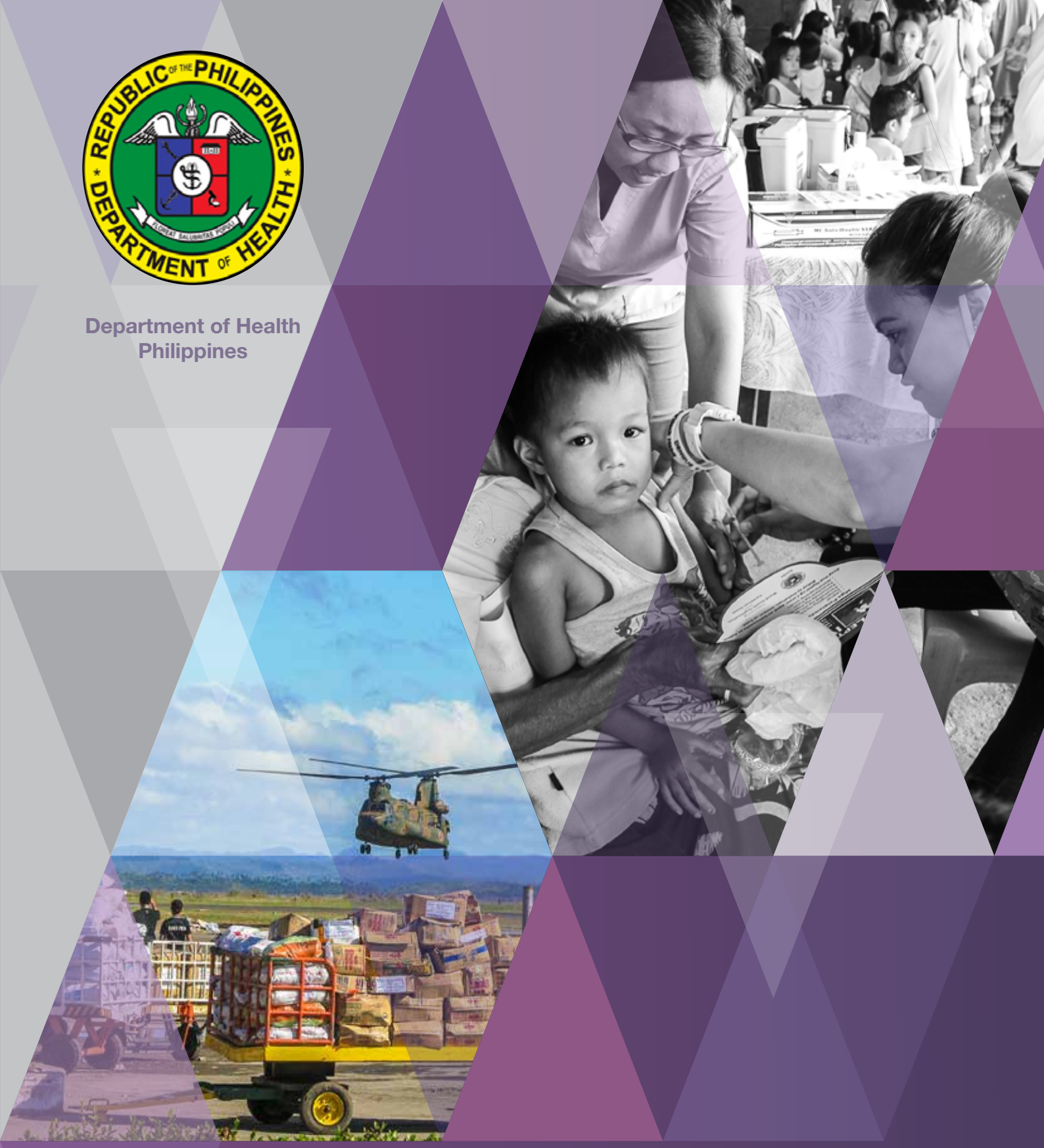
Philippines



MANUAL OF OPERATIONS

ON HEALTH EMERGENCY AND DISASTER RESPONSE MANAGEMENT

2015

Health Emergency Management Bureau

Acknowledgements

The completion of this Manual of Operations on Health Emergency and Disaster Response Management has been made possible through the combined efforts of individuals who have strived to contribute to this undertaking. The Health Emergency Management Bureau (HEMB) of the Department of Health (DOH) wishes to thank the following for their crucial contributions.

To the many men and women of HEMS, from the Regions, the DOH Hospitals, and the Central Office who provided significant inputs during consultative meetings, contributed to the review and development of protocols and procedures, our heartfelt gratitude: Dr. Jose Marie Castro, Dr. Rose Rempillo, Ms. Flor Panlilio, Dr. Romeo Bituin, Dr. Emmanuel Bueno, Dr. Edmundo Lopez, Director Maylene Beltran, Director Lyndon Lee Suy, Dr. Joel Buenaventura, Dr. Marlyn Go, Dr. Arnel Rivera, Dr. Ron Law, Engr. Aida Barcelona, Ms. Susan Juangco, Ms. Luzviminda Claveria, and Ms. Edylen Bea Gonzales;

To Ms. Eireen Villa, the project consultant, who conceptualized the outline, developed the framework, and wrote the contents ensuring that all vital details are duly incorporated and will be well-understood by the users of this manual;

To Dr. Carmencita Banatin, who envisioned the development of this manual after the Strategic Planning Workshop in February 2014 that reviewed the response to Typhoon Yolanda; she provided overall technical inputs and guidance and ensured that all pertinent policies and guidelines be incorporated in this manual, putting in all her expertise and experiences in her two decades in emergency management;

To Ms. Cynthia Diaz for handling the style editing and Mr. Timothy Laurie Ang for the layout and graphic design of this manual;

To the Field Epidemiology Training Program and Alumni Foundation, Inc (FETPAFI), led by its Chief Executive Officer, Dr. Agnes Pacho supported by Ms. Dianila Capasgordo, for providing the administrative support to the project;

Finally, our deepest gratitude goes to the World Health Organization technical staff who provided inputs and technical support during the course of the development of the manual: Dr. Gerardo Medina, Dr. Allison Gocotano, Ms. Julie Villadolid, and Atty. Abdel Disangcopan. But this will not push through without the continuous support of Dr. Julie Hall, the person behind all the different projects and assistance to the Department of Health in all the different emergencies and disasters we have encountered.

HEALTH EMERGENCY MANAGEMENT BUREAU

Foreword

The importance of a well-organized and effective response to any health emergency or disaster cannot be overemphasized. Any death, disability or disease prevented from the impact of these emergencies and disasters is worth all the effort, time and resources poured into the response. The recent calamities experienced by the country over the past decades, however, have shown that the level and adequacy of our responses varied widely across regions and LGUs, and in general had been wanting due to the mega-proportions of these recent disasters.

This Manual of Operations (MOOp) on Health Emergency and Disaster Response Management is borne out of the need for a more specific set of guidelines and procedures as the Department of Health bureaucracy responds to health emergencies and disasters. While the DOH has issued several policies and guides on health emergency and disaster in the past, their adequacy as operational references and guides was challenged during the onslaught of Yolanda in 2013. In the DOH-wide Strategic Planning Workshop on Health Emergency Response conducted early in 2014, the development of a Manual of Operations in Managing Health Emergency and Disaster Response was one of the identified "musts" to be developed and disseminated to all concerned. That document is now complete and ready for dissemination to the whole DOH family, from the Central Office to the Regions and its Hospitals.

The MOOp was designed to integrate the different policies and guidelines issued in the past relative to managing the response, several of which have been updated and levelled up as appropriate to guiding the concerned DOH offices in responding to a mega-disaster. Some guidelines were further detailed and operationalized, specifying the tasks and procedures which the different concerned offices must undertake from pre-impact, during impact, and post-impact. The MOOp also contains flowcharts, several forms and templates which can be used and referred to by the offices and teams involved in mounting the response. It is still far though from being perfect and complete and must be viewed as a "work in progress" but which can be enhanced as the DOH gains more operational experiences and clearer directions in handling the other types of hazards.

The usefulness of the MOOp can only be realized and maximized if you read it, use it, refer to it, and act on its guides and provisions prior to any incoming disaster or health emergency. I encourage each of you to take part in disseminating its content and ensuring that all those involved in any health emergency and response are able to access it and have an overall view of the key elements in mounting and implementing the response. A well-organized and effective response to any health emergency or disaster begins with knowing what need to be done, how to do them, who should carry them out, which ones to prioritize, when to implement them, for whom and with whom. It is hoped that this MOOp will guide you in these various aspects of health emergency and disaster response management.

Dr. Cirilo Galindez
Health Emergency Management Bureau

Message from the Secretary

Dr. Janette L. Garin
Secreatary of Health

Table of Contents

Abbreviations and Acronyms

ABS-CBN	Associated Broadcasting System- Chronicle Broadcasting Network
ACP	Advance Command Post
AFP	Armed Forces of the Philippines
AM	Amplified Modulation
AMP	Advanced Medical Post
AO	Administrative Order
APEC	Asia Pacific Economic Conference
ARD	Assistant Regional Director
ASAP	As Soon As Possible
ASEAN	Association of Southeast Asian Nations
ATM	Automated Teller Machine
BEmONC	Basic Emergency Obstetric and Newborn Care
BF	Breastfeeding
BFAR	Bureau of Fisheries and Aquatic Resources
BFP	Bureau of Fire Protection
BGAN	Broadband Global Area Network
BHDT	Bureau of Health Devices and Technology
BHS	Barangay Health Stations
BIHC	Bureau of International Health Cooperation
BLHD	Bureau of Local Health Development
BOC	Bureau of Customs
BOQ	Bureau of Quarantine and International Health Surveillance
CAMPOLAS	Cotrimoxazole, Amoxicillin, Mefenamic Acid, Paracetamol, ORESOL, Lagundi, Vitamin A and Skin Ointment
CBRN	Chemical, Biological, Radiological and Nuclear
CC	Carbon Copy
CBRNE	Chemical, Biological, Radiological, Nuclear and Explosive
CDRRHR	Center for Device Regulation, Radiation Health and Research
CDRRMC	City Disaster Risk Reduction and Management Council
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHD	Center for Health Development
CHO	City Health Office
CMs	Centimeters
CO	Central Office
COA	Commission on Audit
CRED	Center for Research on the Epidemiology of Disasters
DANA	Damage Assessment and Needs Analysis
DBM	Department of Budget and Management

DENR	Department of Environment and Natural Resources
DepEd	Department of Education
DFA	Department of Foreign Affairs
DILG	Department of the Interior and Local Government
DND	Department of National Defense
DO	Department Order
DOH	Department of Health
DOHRep	Department of Health Representative
DPCB	Disease Prevention and Control Bureau
DPO	Department Personnel Order
DPWH	Department of Public Works and Highways
DRRM	Disaster Risk Reduction Management
DRRMC	Disaster Risk Reduction and Management Council
DSWD	Department of Social Welfare and Development
EC	Evacuation Center
ECC	Emergency Coordinating Center
e-EDPMS	Electronic Essential Drug Price Monitoring System
EMT	Emergency Medical Technician
EOC	Emergency Operations Center
EOD	Emergency Officer-on-Duty
ER	Emergency Room
ESU	Epidemiology Surveillance Unit
EWARS	Early Warning Alert Response System
EXECOM	Executive Committee
FAQs	Frequently-Asked Questions
FDA	Food and Drug Administration
Fe	Iron
FHO	Family Health Office
FM	Frequency Modulation
FMT	Foreign Medical Team
FOC	Fixed Operations Center
GIDAs	Geographically Isolated and Disadvantaged Areas
GMA	Greater Manila Area
GOs	Government Offices
GS	General Staff
GSD	General Service Division

HEARS	Health Emergency Alert Reporting System
HEDRM	Health Emergency and Disaster Response Management
HEICS	Hospital Emergency Incident Command System
HEMB	Health Emergency Management Bureau
HEMS	Health Emergency Management Service
HH	Household
HEPO	Health Education and Promotion Officer
HEPRRP	Health Emergency Preparedness, Response and Recovery Plan
HFDB	Health Facility and Development Bureau
HHRDB	Health Human Resource Development Bureau
HHEMS	Hospital Health Emergency Management Service
HP	Horse Power
HPCS	Health Promotion and Communication Services
HPDPB	Health Policy Development and Planning Bureau
HPN	Hypertension
Hrs	hours
IC	Incident Commander
ICS	Incident Command System
ICT	Information and Communication Technology
IEC	Information, Education and Communication
ISO	International Organization for Standardization
IT	Information Technology
ITCZ	Inter-Tropical Convergence Zone
IU	International Unit
IYCF	Infant and Young Child Feeding
Kcal	Kilo Calorie
Km	Kilometer
KMITS	Knowledge Management Information Technology Service
L	Liter
LCD	Light-Emitting Diode
LCE	Local Chief Executive
LDRRMC	Local Disaster Risk Reduction and Management Council
LGC	Local Government Code
LGU	Local Government Unit
LHO	Local Health Office
LO	Liaison Officer

m	meter
MAM	Moderate Acute Malnutrition
MCI	Mass casualty incidents
mg	miligram
MHO	Municipal Health Office
ml	milliter
MHPSS	Mental Health and Psychosocial Support/Services
mins	Minutes
MMD	Materials Management Division
MMDA	Metro Manila Development Authority
MNP	Micro-Nutrient Powder
MNCHN	Maternal Newborn Health Care and Nutrition
MOA	Memorandum of Agreement
MOOE	Maintenance and Other Operating Expenses
MOOp	Manual of Operations
Mos	Months
MRU	Media Relations Unit
MAM	Moderately Acute Malnutrition
MUAC	Mid-Upper Arm Circumference
NBI	National Bureau of Investigation
NCMH	National Center for Mental Health
NCPAM	National Center for Pharmaceutical Access and Management
NDRP	National Disaster Response Plan
NDRRMC	National Disaster Risk Reduction and Management Council
NEC	National Epidemiology Center
NEDA	National Economic and Development Authority
NGO	Nongovernment Organization
NNC	National Nutrition Council
No.	Number
NSC	National Security Council
NSD	Normal Spontaneous Delivery
OCD	Office of Civil Defense
OpCen	Operations Center
OPD	Outpatient Department
OPV	Oral Polio Vaccine
OR	Operating Room
OSEC	Office of the Secretary of Health

PABX	Private Automatic Branch Exchange
PAGASA	Philippine Atmospheric, Geophysical and Astronomical Services Administration
PCG	Philippine Coast Guard
PDRRMC	Provincial Disaster Risk Reduction and Management Council
PHEMS	Provincial Health Emergency Management Service
PhilHealth	Philippine Health Insurance
PHIVOLCS	Philippine Institute of Volcanology and Seismology
PHO	Provincial Health Office
PHTO	Public Health Technical Office
PIE	Post-Incident Evaluation
PIO	Public Information Officer
PLDTCo	Philippine Long Distance Telephone Company
PMA	Philippine Medical Association
PNDF	Philippine National Drug Formulary
PNP	Philippine National Police
PNP-SOCO	Philippine National Police-Scene of the Crime Operations
PNRI	Philippine Nuclear Research Institute
PPE	Personal Protective Equipment
PRC	Philippine Red Cross
PRC	Professional Regulation Commission
PSP	Psycho-Social Processing
PSS	Psycho-Social Services
Q and A	Question and Answer
QMS	Quality Management System
QRF	Quick Response Fund
RA	Republic Act
RD	Regional Director
RDRRMC	Regional Disaster Risk Reduction and Management Council
REICS	Regional Emergency Incident Command System
RER	Reimbursement Expense Report
RESU	Regional Epidemiology Surveillance Unit
RH	Reproductive Health
RHA	Rapid Health Assessment
RHEMS	Regional Health Emergency Management Service
RHU	Rural Health Unit
RIS	Request and Issuance Slip
RITM	Research Institute for Tropical Medicine
RO	Regional Office

RUSF	Ready-to-Use Supplementary Food
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SARS	Severe Acute Respiratory Syndrome
Secs	Seconds
SIM	Subscriber Identity Module
SMS	Short Message Service
SO	Safety Officer
SOCO	Scene of the Crime Operatives
SOD	Sudden-Onset Disaster
SOP	Standard Operating Procedure
SPEED	Surveillance in Post-Extreme Emergencies and Disasters
SRR	Search, Rescue and Retrieval
4Ss	Space, stuff, staff, special services
START	SPEED Technical Assistance Response Team
Tab	Tablet
Tb	Tuberculosis
TODA	Tricycle Operators and Drivers Association
TV	Television
TWG	Technical Working Group
UHF	Ultra-High Frequency
UN	United Nations
VAC	Vitamin A Capsules
VHF	Very High Frequency
VIP	Very Important Person
WASH	Water, Sanitation and Hygiene
WFH	Weight for Height
WHO	World Health Organization
4Ws	Who, What, When, Where

Definition of Terms

All-Hazards	An approach to emergency management based on the recognition that there are common elements in the management of responses to virtually all emergencies, and that by standardizing a management system to address the common elements, greater capacity is generated to address the unique characteristics of different events
Capacity/ Readiness	A combination of all strengths and resources available within a community, society or organization that can reduce the level of risk or effects of a disaster
Casualty	Victims, both dead and injured, physically and/or psychologically
Command Post	Form of site-level emergency operations center, assembled as needed by the first agencies to respond to an event
Community	Consists of people, property, services, livelihoods and environment; a legally constituted administrative local government unit of a country, e.g., municipality or district, that is small enough to be able to identify its own leaders (to make participation meaningful) and large enough to control its resources, e.g., village, district, etc.
Complex Emergency	A form of human-induced emergency in which the cause of the emergency, as well as the assistance to the afflicted is complicated by intense level of political considerations
Disaster	A serious disruption of the functioning of a community or society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources
Disaster Recovery	The coordinated process of supporting disaster-affected communities in the reconstruction of the physical infrastructure and restoration of emotional, social, economic and physical well-being
Donation	Act of liberality whereby a foreign or local donor disposes gratuitously of cash, goods, articles, including health and medical-related items, to address unforeseen, impending, occurring or experienced emergency and disaster situations, in favor of the Government of the Philippines which accepts them
Donors	All persons, countries or agencies that may contract and dispose of cash, goods or articles, including health and medical-related items, to address unforeseen, impending, occurring or experienced emergency and disaster situation
Emergency	An actual threat to public safety and/or public health; unforeseen or sudden occurrence that demands immediate action
Hazard	Any potential threat to public safety and/or public health; any phenomenon which has the potential to cause disruption or damage to people, their property, their services or their environment, i.e., their communities. The four classes of hazards are natural, technological, biological and societal hazards
Hazard-prone Community	A community that experiences a large number of hazard events

Health Emergency Management Health Sector	An organization of agencies each with a health unit primarily devoted to and united to provide state-of-the-art, appropriate and acceptable technical assistance and/or direct services on health emergency preparedness and response to any entity – international or national
Major Emergency	Any emergency where response is constrained by insufficient resources to meet immediate needs hence DOH comes in to support either by logistics or manpower
Mass Casualty Incident	Any event resulting in a number of victims large enough to disrupt the normal course of administrative, emergency and health care services
Mass Casualty Management	Management of victims of a mass casualty event to minimize loss of lives and disabilities
Mass Casualty Management System	Groups of units, organizations and sectors that work jointly through standard consensus procedures to minimize disabilities and loss of life in a mass casualty event through the efficient use of all existing resources
Mental Health	A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community
Networking	An approach to broaden the resources available to a person to achieve his personal and professional goals while supporting others to achieve theirs
Partner Agencies	Multi-sectoral body composed of different departments of the government and institutions to ensure multi-sectoral participation in the development, updating and sharing of a national risk map based on the Disaster Risk Reduction and Management Information System and Geographic Information System, and which can be used as policy, planning and decision-making tools
Preparedness	Pre-disaster actions and measures being undertaken within the context of disaster risk reduction and management based on sound risk analysis, as well as pre-disaster activities to avert or minimize loss of life and property, such as, but not limited to, community organizing, training, planning, equipping, stockpiling, hazard mapping, insuring of assets, and public information and education initiatives (RA10121)
Recovery Management	A process by which a disaster-affected community is restored to an appropriate level of functioning
Risk	Anticipated consequences of a specific hazard affecting a specific community (at a specific time); the level of loss of damage that can be predicted to result from a particular hazard affecting a particular place at a particular time; probable consequences to public safety of a community being exposed to a hazard (i.e., death, injury, disease, disability, damage, destruction, displacement) • Type of hazard determines the kind of risks, e.g., floods cause few deaths but earthquakes cause many • Vulnerabilities and capacity to respond determine how much risk is in the community, i.e., how many deaths are likely, where they will occur and the kind of people likely to be killed (e.g., old, disabled)

Risk Management	A comprehensive strategy for reducing risk to public safety by preventing exposure to hazards (target group – hazards), reducing vulnerabilities (target group – elements of community), and enhancing preparedness, i.e., response capacities (target group– response agencies); a strategy for identifying potential threats and managing both the source of threats and their consequences
Single Command System	A system whereby the incident is managed by a leader coming from a single response unit or agency
Strategic	Deals with the concepts of relatively long term and big picture in relation to the pattern or plan that integrates an organization's major goals, policies and action sequences into a cohesive whole. Concept is always relative – what a local level of government sees as strategic from their perspective is likely perceived as tactical from the perspective of a more senior government
Stress	A state where one's coping mechanism is not enough to maintain balance or equilibrium
Surge Capacity	The health care system's ability to rapidly expand beyond normal services to meet the increased demand for qualified personnel, medical care, and public health in the event of large-scale public emergencies or disasters (Agency for Healthcare Research and Quality, USA, 2005)
Tactical	Refers to those activities, resources and maneuvers that are directly applied to achieve goals. Compare with "strategic" above.
Terrorism	The premeditated use or threatened use of violence or means of destruction perpetrated against innocent civilians or non-combatants, or against civilian and government properties, usually intended to influence an audience (Memorandum No. 121)
Unified Command System	A system whereby the incident is managed by a group of individuals coming from several units or agencies with jurisdiction over the incident, and is involved in the decision-making and planning process. Insures plan is communicated and supported by all resources.
Vulnerabilities	Characteristics and circumstances of a community, system or asset that make it susceptible to the damaging effects of a hazard (RA10121)

Introduction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Introduction

I. Background/Rationale

In view of the frequent, unrelenting occurrence of disasters of varying causes and magnitudes in the country, the Department of Health (DOH) over the past two decades had issued several policies and guidelines which aimed to address the requirements of a well-organized and effective response. The adequacy of these policies and guides however was tested and challenged during Yolanda which was of mega category that rendered the country's response seemingly insignificant considering the more than 6,000 deaths recorded, thousands of people injured, and many still missing to this day.

This Manual of Operations (MOOp) on Health Emergency and Disaster Response Management (HEDRM) is borne out of the need to consolidate these existing policies and guidelines into a single document for easy reference by those involved in response management. Policies and guides that were assessed inadequate to meet the required response for a mega-disaster were updated and modified, while those that remain valid were further detailed with clearer instructions. In view of the evolving nature of response situations, which may necessitate updates and modifications as some stages, the MOOp is modular in design to allow modification of some portions and integration of new chapters or updates in the future.

II. Objectives

Through this MOOp, it is hoped that redundancies of the previous guidelines across issuances are minimized and the policies are harmonized and set in sync with the overall health sector response that the DOH would like to put up for any mega-disaster that might hit the country again. Specifically, the MOOp aims to:

a. Describe the overall framework on which health and health-related emergency or disaster response management is anchored including the basic principles to be observed in designing/planning, implementing and managing a response.
b. Specify the policies, guidelines and procedures in carrying out each of the major components of a well-organized and effective response, namely; (i) management of the event or incident; (ii) management of the victim; (iii) management of the responders; (iv) management of information; and (v) management of non-human resources.
c. Provide checklists and tools for ready use and reference by the concerned officials/staff mandated/authorized to carry out the different tasks in health emergency or disaster response management.

III. Intended Users of the MOOp

This MOOp is primarily intended for the use of the DOH Central Office (CO), regional offices (ROs), and DOH hospitals as reference in planning, implementing and managing the response to any health and health-related emergency or disaster. It is directed to the concerned DOH offices/units that are mandated and authorized to be responsible for carrying out the needed response.

The secondary users of this MOOp are the other groups of stakeholders, particularly the members of the national/regional/local disaster risk reduction and management councils (DRRMC) as they integrate the health sector response into the country's/LGUs' overall response. The local, national and international development partners involved in emergency and disaster response are expected to also benefit from this document as reference.

The MOOp also provides information useful to the local government units (LGUs), particularly their local health offices as they become involved in coming up with their own response to emergencies and disasters in their respective localities. The LGUs are encouraged to adopt these guidelines as they deem fit to their local situation.

IV. Scope and Limitations

This MOOp contains the policies, guidelines and procedures in designing, planning, implementing and managing the necessary response to health and health-related emergencies and disasters. To be effective, however, most of these are anchored on a well-established preparedness program, in particular, the Health Emergency Preparedness Plan. The MOOp covers the five components vital to a well-organized and effective response: (i) management of the event or incident; (ii) management of the victim; (iii) management of the responders; (iv) management of information; and (v) management of non-human resources. The expected functions and tasks of each mandated office/unit officials and staff involved in putting up and implementing the response are translated into checklists for ready reference and use during any emergency or disaster. The scope and coverage of the MOOp, however, are mainly focused on and limited to aspects of response management as specified below:

- It focuses mainly on policies and guidelines relative to the management of the Response Phase, beginning from pre-impact, during and post-impact. It does not cover the Preparedness and the Post-Disaster Phase.
- It covers 80% of most common hazards (all-hazard approach) but does not include response to emerging/reemerging diseases and terrorism.
- It addresses the responsibilities and tasks of the DOH Central Office, regional offices, and the DOH hospitals, but mentions also how these will relate with what the LGUs and other groups of stakeholders will do or perform.
- Existing policies and guidelines that remain relevant, applicable and practical during each phase of the response constitute the bulk of the MOOp.
- Policies and guidelines already enhanced by concerned offices pertinent to each component of the response framework are included in the manual.

- Procedures and steps that have already been applied and proven useful in managing response during previous emergencies and disasters, as well as best practices identified in previous responses are incorporated in the MOOp.
- Policies and guidelines that still need further enhancement and official issuances are not incorporated unless these are recommended by the concerned offices and management for inclusion.

V. How to Use the MOOp

The MOOp has six chapters, five of which correspond to the different components of response management. The content and focus of each chapter are described below. Each chapter begins with a short introduction that explains the rationale of the component, specifies its objectives, and outlines the major policies relative to the component. The main body of each chapter contains the general and specific guidelines, operationalized into the specific steps to be carried out. Each chapter is supported by a set of checklists, flow charts, and other tools for ready use and reference during the event.

Chapter 1. Health Emergency and Disaster Response Management Framework

Chapter 1 outlines the legal context on which response management is anchored. It describes the overall framework of response management which includes the guiding principles, objective and major components of the response. These are illustrated in a diagram with a brief description of each component/element.

Chapter 2. Management of the Event/Incident

Chapter 2 discusses in detail the management of the event. It outlines the policy statements regarding the management of the event and describes the general and specific guidelines for the installation of the Incident Command System (ICS), establishment and running of the Operations Center (OpCen), the coordination mechanisms, and the Code Alert System and SPEED used as early warning alert response systems.

Chapter 3. Management of the Victims

Chapter 3 presents the overall policy in managing the victims during the response up to the early Recovery Phase. It summarizes the general and specific guidelines relative to managing mass casualty incidents (MCI), both pre-hospital (in the community) and in the hospital. It also discusses managing the victims in temporary shelters or evacuation centers. The hospital capacity in managing the surge of victims is taken into consideration, including the management of the dead. Also discussed are the basic and expanded package of services to be provided in these various settings, which include Health Services, Water Sanitation and Hygiene (WASH), Nutrition and Psychosocial Services (PSS).

Chapter 4. Management of Service Providers

Chapter 4 describes the policies, and the general and specific guidelines in identifying, mobilizing and deploying teams of responders or service providers in various categories of the event. These include responders during Special Events, Health Emergency or Disaster, and those for humanitarian assignment in other countries. This chapter also discusses the policies and guidelines in managing volunteers, both local and foreign.

Chapter 5. Management of Information System

Chapter 5 discusses the principles and guidelines in the management of the information system, with focus on data management, information management, knowledge management, and the overall documentation of the response. Knowledge management is focused on risk communication and media management during the Response Phase.

Chapter 6. Management of Non-Human Resources

Chapter 6 deals with the management of non-human resources and the listing of logistics. These include: primarily the drugs/medicines and equipment to be available as part of the response; the necessary transport, communication and other lifeline facilities to be kept intact and functional; and the finances that need to be mobilized during the response.

Chapter 1

Health Emergency and Disaster Response Framework


DOH
DOH

Chapter 1: Health Emergency and Disaster Response Framework

I. Introduction

The Center for Research on the Epidemiology of Disasters (CRED) ranked the Philippines third worldwide in terms of the number of reported natural disaster events in 2012, and with highest number of disaster-related mortalities. The Philippines' archipelagic makeup and geographic location make it most vulnerable to disasters and hazards, both natural and man-made.

- The Philippines is host to an average of 22 typhoons annually, usually resulting in severe/flash flooding in several parts of the country. Typhoon Yolanda in 2013 resulted in a total of 6,293 deaths on top of thousands others injured and missing and the massive devastation it inflicted on the overall economic growth and development of the country.
- There have also been several volcanic eruptions, given the 407 volcanoes in the country, 17 of which are active. In 1991, Mt. Pinatubo, despite being a non-active volcano, erupted, resulting in many deaths with a number of municipalities buried, making it as one of the worst volcanic eruptions in the decade.
- Located in the Pacific seismic belt, the Philippines has five earthquake occurrences daily, most of which are imperceptible. In 2013, Bohol Province and Cebu City experienced an earthquake with a magnitude of 7.2.
- The country is also beset by human-generated emergencies, such as maritime and air mishaps, conflagration, and armed political or religious conflicts, the most recent of which was the siege in Zamboanga City in 2013.

All these have resulted in gargantuan numbers of lost lives, and injured, disabled and unproductive individuals along with massive economic losses and destruction of properties and crops. Cognizant of the ill effects and adverse implications of disasters, the government has instituted measures and established mechanisms to be more responsive to disasters and emergencies. The DOH, as the primary government instrumentality for health concerns, is one of the major players in disaster and response management under the overall coordination of the National Disaster Risk Reduction and Management Council (NDRRMC).

II. Objectives

In general, this chapter provides a brief background on the legal foundation of the DOH's role in emergency and disaster response management and presents a comprehensive perspective of the components of a well-organized and effective response in health and health-related emergency or disaster. Specifically, this chapter aims to enable you, the response manager, to:

a. Appreciate the overall mandate of DOH and its instrumentalities in managing response to any emergency or disaster.
b. Identify the basic principles of an effective and efficient response.
c. Describe the key components constituting a well-organized response and the elements required for each response component.

III. Legal Mandate of the DOH in Emergency and Disaster Response

The 1991 Local Government Code (LGC) transferred the responsibility of delivering health care and services from the DOH to the LGUs. One the functions that remained with the DOH is disaster management focused on preparedness and prevention. The LGUs have the primary responsibility of providing immediate and direct response to disasters, but in cases where disasters have reached proportions beyond the capability of the LGUs, the national government takes control as stipulated under Section 105 of the Code:

> *"In the event of 'epidemic, pestilence and other widespread public dangers', the Secretary of the Department of Health may, upon the direction of the President and in consultation with the government unit concerned, temporarily assume direct supervision and control over health operations in any LGU for the duration of the emergency."*

Chapter 11 of the DOH Rules and Regulations Implementing the LGC of 1991 further incorporates the following provisions on the role of DOH on disaster management:

a. Defines 'widespread public dangers' to include situations in calamity areas and in relation to a displaced population [Section 43 (a)];
b. Establishes guiding principles, including:
   - The exercise of such authority with a view to enhancing and strengthening the capabilities of LGUs to provide health services and facilities to their constituents
   - The authority of DOH to have the final say in determining the presence of 'widespread public dangers' in a particular area or region [Section 44 (b) and (c)]
c. Establishes procedures, including those of:
   - Recommendation to the President for the issuance of an appropriate order directing the DOH to assume direct supervision and control over local health operations in affected areas
   - DOH performance of the functions of preparing, implementing and monitoring plans of action in such circumstances, and of evaluation of the local health situation [Section 45, (c) and (f)].

Over the past two decades, the DOH has come up with salient policies and guidelines that further defined its roles and functions in disaster response management in addition to the laws and executive orders that were passed over the same period.

- ***E.O. No. 102 s. 1999: "Redirecting the Functions and Operations of the DOH,"*** which transformed DOH from being the sole provider of health services to being a provider of specific health services and technical assistance as a result of the devolution of basic services to the LGUs. It tasked the DOH to serve as the national technical authority on health, one that will ensure the highest achievable standards of quality health care, health promotion and health protection, on which the LGUs, nongovernment organizations (NGOs), other private organizations, and individual members of civil society will anchor their health programs and strategies on. To fulfill its responsibilities concerning the Health Emergency Management functions under this mandate, the DOH shall:
  - Serve as the lead agency in health emergency response services, including referral and networking systems for trauma, injuries and catastrophic events.
  - Promote health and well-being through public information and provide the public with timely and relevant information on health risks and hazards.
  - Assume leadership in health in times of emergencies, calamities and disasters, and system failures.

- ***DOH A.O. No. 168 s. 2004: "National Policy on Health Emergencies and Disasters,"*** which prompted the formulation and implementation of a national policy framework for emergencies and disasters for the health sector in order to decrease mortality and promote physical and mental health, as well as prevent injury and disability on the part of both victims and responders. The AO sought to: (i) develop goals, strategies, plans and policies for ensuring an efficient system for managing emergencies and disasters in the health sector; (ii) improve the effectiveness of DOH systems, structures, capacities and mechanisms; (iii) build up the preparedness and response activities of both the public and private health facilities for administering mass casualty events; and (iv) strengthen links between partner agencies and stakeholders in responding to and managing emergencies and disasters in the country.

- ***DOH A.O. No. 155 s. 2004: "Implementing Guidelines for Managing Mass Casualty Incidents (MCI) During Emergencies and Disasters,"*** which tasked the DOH to implement a mass casualty management system and procedures for resource mobilization, field management and hospital reception to ensure a comprehensive and well-coordinated response in MCI.

- ***DOH A.O. No. 0017 s. 2007: "Guidelines on the Acceptance and Processing of Foreign and Local Donations During Emergency and Disaster Situations,"*** which set a rational and systematic procedure for the acceptance, processing and distribution of foreign and local donations that are exclusively for unforeseen, impending, occurring and experienced emergency and disaster situations.

- ***DOH A.O. No. 0024 s. 2008: "Adoption and Institutionalization of an Integrated Code Alert System Within the Health Sector,"*** which defined the Code Alert System that must be in place, specifically in the mobilization and deployment of resources, and described the expected levels of preparation and the most appropriate response by all facilities in emergencies and disasters. A previous AO (No. 182 s. 2001) was issued in 2001 for the Adoption and Implementation of the Code Alert System for DOH Hospitals During Emergencies and Disasters.

- ***R.A. No. 10121 s. 2010: "The Philippine Disaster Risk Reduction and Management System,"*** which aimed to strengthen the Philippine Disaster Risk Reduction and Management System, providing for the National Disaster Risk Reduction and Management Framework, institutionalizing the Disaster Risk Reduction and Management Plan and the appropriation of funds. This issuance established the NDRRMC as the multi-sectoral body overall in charge of emergency and disaster response and management, composed of heads of the 38 member agencies/organizations including the DOH. The RA called for, among other things, each member agency to: (i) establish a disaster office; (ii) maintain a functional operations center; (iii) mainstream disaster risk reduction management (DRRM) in all planning activities; and (iv) orient all their employees on DRRM.

- ***DOH A.O. No. 29 s. 2010: "Policies and Guidelines on the Establishment of Operations Center for Emergencies and Disasters,"*** which aimed to provide policies and guidelines in the establishment of an Operations Center (OpCen) at all levels from the national to the local government to ensure a well-coordinated response of the health sector. It sought to: (i) develop policies and guidelines on the establishment and management of an Operations Center; (ii) identify the functions of the OpCen at the different levels; (iii) set the minimum specification for the design of an OpCen and minimum standards for logistical requirements, human resource requirements, coordination mechanisms, and relationship among Operations Centers; and (iv) provide funds to sustain its functionality.

- ***DOH A.O. No. 0014 s. 2012: "Policy and Implementing Guidelines on Reporting in Emergencies and Disasters,"*** which aimed to provide guidance in ensuring an effective and efficient reporting mechanism for a responsive evidence-based decision-making process during emergencies and disasters. This enabled all reporting units at all levels of the health sector to submit timely, reliable and continuous reports of all health-related events and to standardize reporting mechanisms at all levels for emergencies/disasters. It also aimed to ensure consistency and compliance of all reporting units with the reporting mechanisms in emergencies and disasters.

- ***DOH A.O. No. 0013 s. 2012: "Policy and Guidelines on Logistics Management in Emergencies and Disasters,"*** which set the guidelines toward the effective and efficient management of logistics support at all levels of the health system in emergency or disaster situations. It also mandated the DOH to take the lead in formulating policies and plans for

logistics management in emergencies and disasters and, in coordination with members of the health sector, formulate guidelines, standards, procedures and protocols in relation to logistics management in emergencies and disasters with corresponding reporting systems and tools.

- ***DOH A.O. No. 2013-0014: "Policies and Guidelines on Hospitals Safe from Disasters,"*** which aimed to reduce disaster risks to ensure the protection and the continuous operation of hospitals and other health facilities, and save lives during emergencies and disasters. Specifically, it prepares the hospitals to address the operational challenges attendant to emergencies and disasters and to remain standing and functional by: (i) strictly enforcing national and local government safety regulations and codes in the construction, expansion, renovation, repair and rehabilitation of hospitals; (ii) inclusion in the hospital licensure requirements of a program for regular maintenance consistent with the most current Hospitals Safe from Disasters indicators; (iii) subjecting hospitals to yearly self-assessments and action planning to address their structural, non-structural, and functional vulnerabilities and capacities using the most current assessment tool; (iv) ensure surge capacity to be able to manage increased demand; and (v) utilize, build and strengthen partnerships and networks and develop corresponding mechanisms in times of emergencies and disasters.

- ***DOH A.O. No. 2014-0011: "Policies and Guidelines on the Implementation of Surveillance in Post Extreme Emergencies and Disasters (SPEED),"*** which aimed to institutionalize SPEED at all levels of health emergency and management response. SPEED as an early warning system is vital in detecting health conditions or diseases with outbreak potential and in accessing real-time information for prompt and appropriate response.

In June 2014, the NDRRMC also prepared and issued the National Disaster Response Plan which outlined the policies, key strategies and guidelines on response management, including the roles and functions of the different agencies. The DOH, in particular, was tasked to lead in the provision of Health, WASH, Nutrition and Psychosocial Services.

IV. Health Emergency and Disaster Response Framework

Given the above mandates and policies, the DOH uses the following framework in the overall management of health emergency and disaster response in the country

A. Overall Purpose of the Response

It is envisioned that a well-organized and effective response should redound to the overall well-being of the population at risk or those affected by disasters due to any hazard, and to minimize the incidence of related death, injury, disease and disability. It is therefore necessary that the design, implementation and management of the response be geared towards saving as many lives as possible, minimizing

the number of injured and disabled individuals, and preventing and controlling morbidities during and post disaster. In addition, the response should aim to rehabilitate and restore the physical, emotional and mental health of those affected and their family members and loved ones even after the onslaught of the emergency or disaster.

B. Principles in the Management of Response

There are basic principles to observe in designing, implementing and managing the response to any health emergency or disaster.

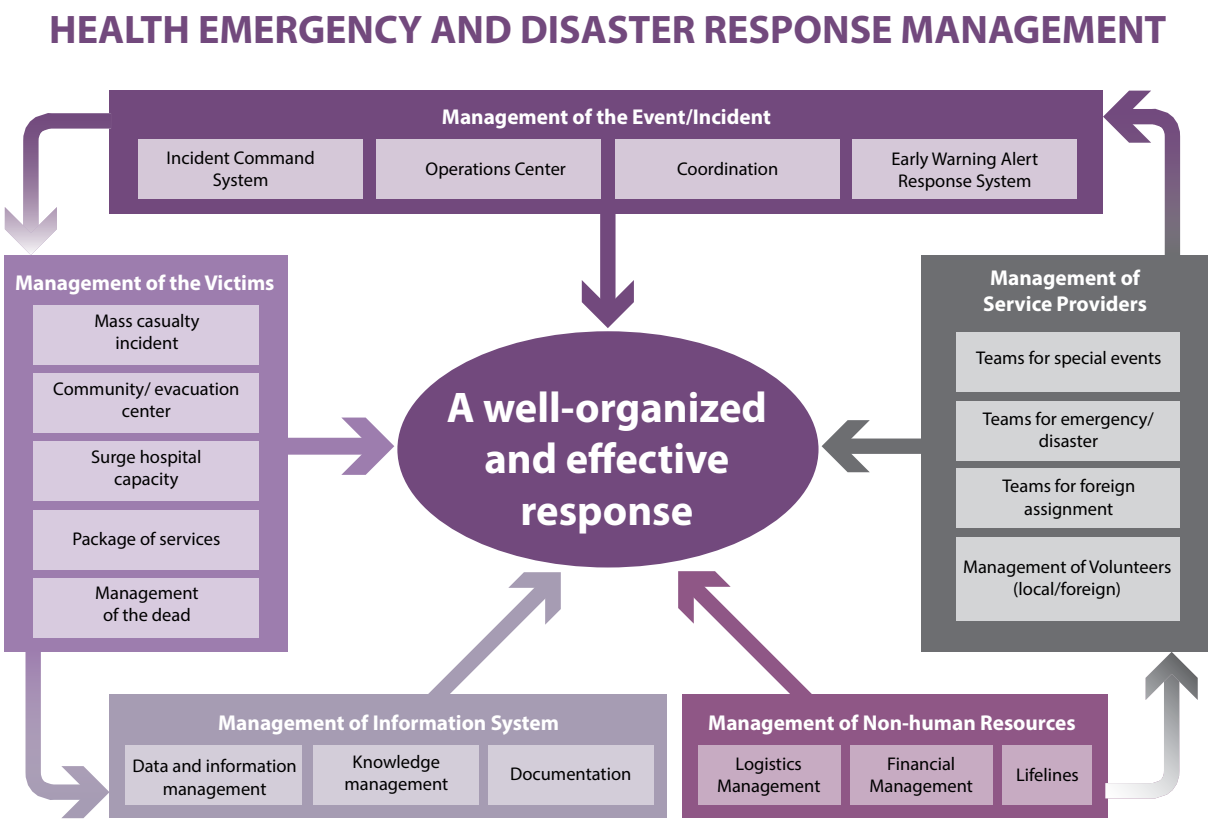
1. The response must be able to address a wide range of or multiple hazards that pose risks to the health of communities. The response must take an all-hazards approach, particularly in building up the core capacities in managing disasters. This is in consideration of the fact that most risk management measures are similar across varying types of hazards and that one deals with the same responders using the same system.
2. The response must be multi-level in coverage, taking into consideration the actions at the national, regional and local levels.
3. The response must be multi-sectoral in cognizance of the fact that the health sector cannot singly address all the needs and requirements of any health emergency or disaster. It is therefore important to adopt a whole-of-society, multi-sectoral and multi-institutional approach requiring coordination, collaboration and partnerships in all phases of the emergency or disaster response implementation.
4. The response should be proactive throughout the disaster risk management cycle – from prevention, preparedness, response and recovery – given the essential and interlinked contributions of each phase to the overall health status of the population at risk.
5. The response must be owned primarily by the national, regional and local governments with their full–pledge of commitment and corresponding investment to achieve and sustain the goal and objectives of the response.
6. The response must thrive on the empowerment and resilience of the community members as they are the driving force and primary actors of the response. Local partnerships, therefore, must be forged among the local governments, nongovernment organizations, private sector, and other stakeholders on the ground.
7. The response must be evidence-based, relying on the accurate, complete and timely results of the risk assessment as basis of decision-makers in identifying the appropriate response measures and actions to undertake.
8. The response must be supported with a strengthened national and local health care delivery system that will enable the delivery of Health Services, WASH, Nutrition and Psychosocial Services during the Response Phase up to the early Recovery Phase;
9. The response must observe and promote equity among all concerned through the identification and monitoring of the health status of vulnerable groups, disadvantaged or marginalized groups, and those in geographically isolated and depressed areas (GIDAs). It should also be able to detect pockets of low coverage of essential health services in areas at high risk of natural disasters.

10. The response must take prominence in the overall development agenda of the national, regional and local governments. This will be reflected in the continuous formulation and issuance of policies and guidelines, allocation of increasing budget for the implementation of the response, and regular monitoring of adherence and performance of all agencies mandated to implement and manage the response.

C. Components of Response Management

Figure 1 shows the major components of the response management, including the essential elements of each of these components.

Figure 1. Health Emergency and Disaster Response Management Framework



1. ***Management of the Event/Incident.*** The management of the event could either make or break the response. It sets the overall direction of the actions to be undertaken, holds the other key elements in place, and keeps them functional. The effective and efficient management of the incident requires the establishment and operationalization of four key elements which are multi-layered and multi-sectoral.

   - First is the establishment of the Incident Command System (ICS), which clearly establishes the chain of command in managing the event, the structure and lines of authority, and the roles and functions that each of the mandated offices/units or officials/staff has to carry out.
   - Second is the establishment and running of the Operations Center (OpCen), which

serves as the hub for coordination, communication, command and control, in close coordination with the Incident Command (IC).

- Third is setting up and sustaining intra/inter and multi-sectoral coordination at various levels of operation: local, regional, national and international.
- Fourth is the establishment of the EWARS that prompts appropriate levels and types of response measures according to levels of alert.

2. ***Management of the Victims.*** Management of victims covers both the living and the dead. It includes the provision of a package of services to the victims in various settings and situations and the provision of technical support in the management of the dead. There are five elements in the management of victims, as summarized below:

   - First is the management of mass casualty incidents, which includes both the pre-hospital and hospital care and services.
   - Second covers the management of displaced populations in the community and those placed in temporary shelters or evacuation centers.
   - Third is concerned with the surge capacity in hospitals, which necessitates the provision of extra space, staff, stuff and special services (e.g., fast discharge of in-patients, transfer of in-patients to other hospitals, etc.).
   - Fourth is the package of Health Services (public health including pre-hospital and hospital care), Water, Sanitation and Hygiene (WASH), Nutrition, and Psychosocial Services to be made available as part of the response.
   - Fifth is the management of dead where the specific role of the DOH is established relative to the other government agencies.

3. ***Management of Service Providers.*** This component provides support to the continuous delivery of the package of services by identifying, mobilizing and deploying appropriate and a sufficient number of teams on time, supported with continuous monitoring and evaluation. This entails the following elements:

   - First is the identification, mobilization and deployment of teams during special events. These are events that involve mass gathering of people at the local, sub-national and national levels. These may entail the presence of very important personalities (e.g., the President, other government officials, etc.) or international personalities (e.g., the Pope, etc.). These special events may also include international conferences/ summits that which the Philippines hosts (e.g., APEC, etc.). Appropriate response teams need to be mobilized and deployed for these events.
   - Second covers the guides and protocols on the identification, mobilization and deployment of response teams during health emergency or disaster. This involves the identification of the different types of response teams to be mobilized, their composition and tasks, and the expertise required of them. Teams include those needed to perform rapid health assessment (RHA), to deliver Health Services, WASH, Nutrition and Psychosocial Services, to provide medical services, and handle trauma cases, as well as teams to attend to the administrative and financial

needs of the operations.

- Third is the identification, mobilization and deployment of humanitarian teams to other countries requesting assistance from the Philippines.
- Fourth is the management of volunteers and partners, both local and foreign (Foreign Medical Teams).

4. ***Management of Information System.*** This component deals with the management of information that are essential in managing the response, from data collection, reporting, analysis and utilization as input to decision-making, to policy and guideline enhancement, prioritization of resources, etc. It also provides guidelines on knowledge management as information are disseminated/communicated to the general public and other groups of stakeholders, using risk communication approach with the proper management of the media. The overall process and documenting the response is also considered as part of managing the information system, including the conduct of Post-Incident Evaluation (PIE). The elements of this component are the following:

   - First is data and information management, particularly in identifying specific data to be collected and the different data sources, and the processing and consolidation of these data. These are part of the functions of the OpCens. This element also involves providing guidelines on the different types of reports to be prepared and submitted for specific purposes and the targeted users of said information.
   - Second element is knowledge management, with focus on the use of the risk communication approach in disseminating key messages to the DOH family, general public, and other groups of stakeholders. It also includes media management.
   - Third element provides guidelines in the overall documentation of the response, identifying those to be involved in the assessment and documentation. This section also includes a brief discussion on the Post-Incidence Evaluation (PIE) which is one of the tools in assessing and documenting the response.

5. ***Management of Non-human Resources.*** The last component of a well-organized and effective response is the proper management of non-human resources. Non-human resources encompass logistics, finances, and major transportation and communication equipment and facilities. The elements of this component are as follows:

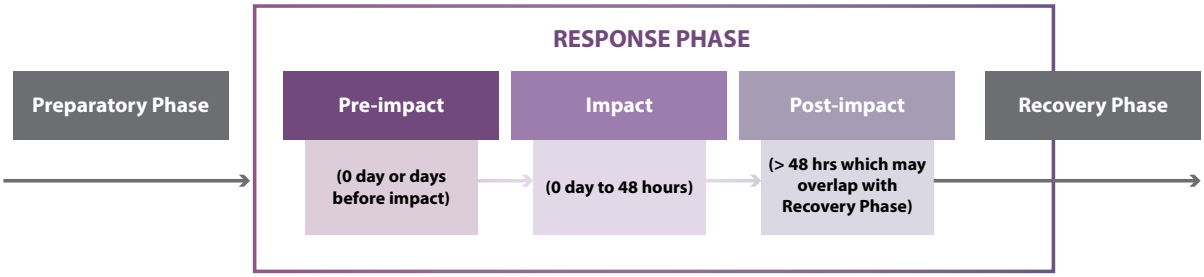
   - First is the need to ensure the availability, accessibility and equitable distribution of logistics. This necessitates the timely and proper stockpiling and prepositioning, warehousing, special procurement arrangements, and management of donated goods, commodities and equipment. This also includes the inter-hospital, inter-agency and inter-regional sharing of logistics.
   - Second is the establishment of mechanisms to facilitate the mobilization, allocation and release of funds, including: the utilization of petty cash, contingency fund, and Quick Response Fund; mobilization of PhilHealth financing; and mobilization and management of cash donations. Alternative mechanisms to facilitate the release and utilization of funds during an emergency are also elaborated.

- Third is ensuring the availability and accessibility to lifeline facilities, which include transportation, communication, and source of energy during the response. This section, however, is limited to the identification of these essential lifeline equipment and facilities, and recommended actions for alternative options when these are no longer functional as a result of the disaster.

V. The Response Phase

The major activities that are to be undertaken prior to impact, during impact, and post impact are described below. Although the focus of this MOOp is the management of the response itself, there are measures that are largely dependent on the extent of preparation done prior to the Response Phase, and several actions are also expected to extend to or overlap with the Recovery Phase.

Figure 2. Stages of the Response Phase



A. Pre-Impact Phase (Could be day or days before)

There are hazards with warning (e.g., typhoon, volcano, tsunami, lahar, etc.) which allow enough time for preparation. But there are also hazards that come without warning (e.g., earthquake, bombing, etc.), which put the affected population at higher risks. The Pre-impact Phase refers to the period immediately before the onset of the event. This is different from the Preparedness Phase during which the major activities include the development, review and testing of the disaster management and preparedness plan, trainings, drills, exercises, etc. During the Pre-impact Phase, the major activities at the are:

- Activation of all Response Plans
- Prepositioning of logistics/checking of all other logistics requirements
- Setting up stand-by teams/DOH reps in their respective areas of assignment
- Activation of the OpCens
- Coordination among concerned agencies (e.g., local, sub-national and National Disaster Risk Reduction and Management Councils (NDRRMC)
- Collecting and gathering data about the hazard/event and possible effect/impact.

B. Impact Phase or Occurrence of the Incident (0 hour to 48 hours)

This phase addresses the health service response for all emergencies to minimize the health impacts to individuals and the community. The key actions in this phase include:

- Immediate deployment of medical assets
- Rapid health assessment
- Activation of the appropriate plans and sub-plans
- Deployment of public health and/or welfare assets as required
- Coordination with local, regional or territory counter-disaster controllers
- Deployment of liaison staff to the emergency operations centers or crisis centers
- Continuing coordination with higher and lower levels

This phase will conclude when there is no further medical, public health or welfare response required at the emergency site, and further support will then be provided during recovery operations.

C. Post-impact (After 48 hrs and onwards which may overlap with Recovery Phase)

This phase involves continuing the operations commenced at the "during-disaster" phase and includes activities that lead to demobilization of resources. It addresses the process of returning an affected community to its normal level of functioning or "building back better" after an emergency. It is quite difficult to delineate when the response phase ends and the recovery phase begins, which may last for months or years. The duration of this phase varies according to the type of emergency/ disaster. Essential health tasks include:

- Continuous provision of public health, pre-hospital and hospital services (Health, WASH, Nutrition and Psychosocial Services)
- Provision of support in accordance with the Health Emergency Preparedness, Response and Recovery Plan (HEPRRP), and preparation of a Recovery and Rehabilitation Plan in coordination with the LGU
- Conduct of debriefing and PIE to serve as inputs to the enhancement of policies and guidelines to guide future prevention and preparation actions
- Inventory of all resources for replacement, repair or reconstruction
- Inventory of human resources providing support/aid and giving them recognition
- Deactivation of response teams once the local health office is fully functional

Chapter 2

Management of the Event/Incident


NAVY

Chapter 2: Management of the Event/ Incident

I. Introduction

A well-organized response requires efficient and effective management of the event itself. To ensure this, there must be a clear chain of command anchored on clearly stated policies and mandates that set the overall direction of the response. Effective management of the event also requires an Operations Center functioning 24/7. The OpCen serves as the hub for coordination, communication, command and control supported by a data collection and reporting system that generates timely and accurate information as basis for response actions. Intra, inter and inter-sectoral coordination should be established at each level of operation, while an Early Warning Alert Response System (EWARS) is needed to trigger appropriate actions to be carried out. These interrelated elements are expected to translate into a unified DOH response that forms part of the overall health sector response.

II. Objectives

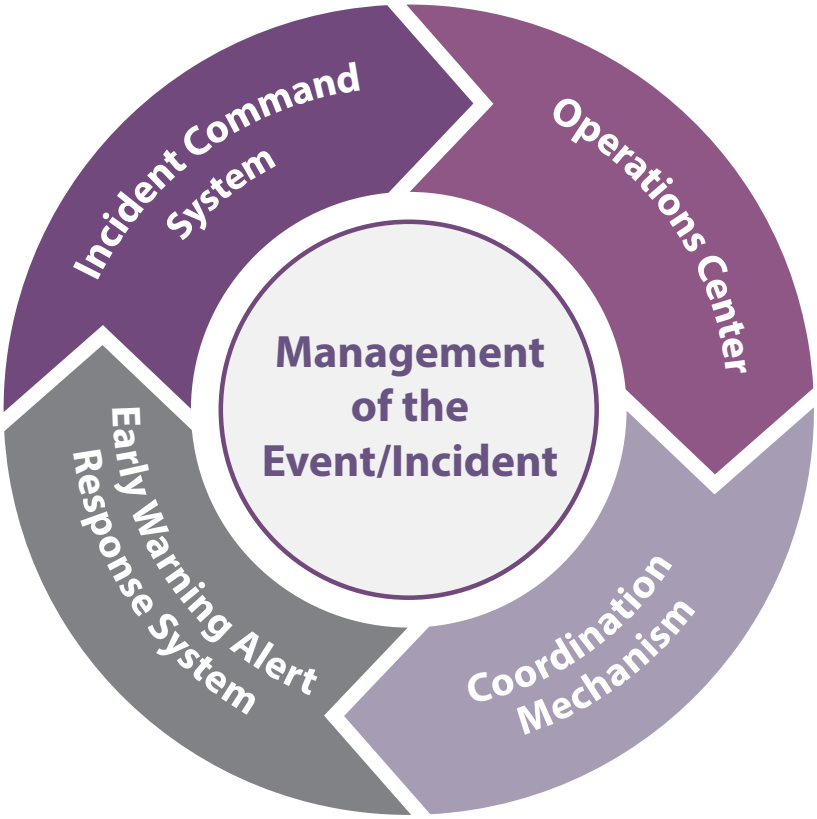
Chapter 2, in general, provides a comprehensive set of guidelines and procedures to help you manage any event or incident arising from most common hazards in the country. It is hoped that through this chapter, you will be able to:

a. Establish appropriate ICS structures at various levels of operation, with clearly defined mandates and roles of those involved in the chain of command.
b. Establish your own Operations Center as appropriate and run it according to the recommended guidelines and procedures.
c. Define the critical areas for coordination within the DOH family (inter), with other health entities (intra), and with other sectors (inter-sectoral).
d. Describe the EWARS for emergency and disaster response.

III. Key Elements in the Management of the Event/Incident

There are four elements that need to be established and operationalized in managing the event or incident. These are interconnected with one another, and the absence of one will most likely cause the management of the event to fail.

Figure 3. Elements of a Well-Managed Event/Incident



- The **Incident Command System (ICS)** requires the establishment of an organizational structure that clearly defines the key offices and officials responsible for the overall management of the event, with specific roles and functions to perform during pre-impact, impact and post-impact phase.
- An **Operations Center (OpCen)** has to be put up at all levels (national, regional and local) where real-time monitoring of the event takes place, data pertinent to the event are collected and analyzed, and the different response actions are decided upon, planned and followed up.
- A **Coordination Mechanism** must be clearly established within the DOH at the central and regional levels and in each hospital. This coordination goes beyond the DOH to the other agencies in the health sector, which include the NDRRMC family, LGUs, development partners, other government agencies, and NGOs, health sector and cluster partners, and other concerned institutions and entities in the private sector.
- The **Early Warning Alert Response System (EWARS)** must be in place to prompt and dictate the category of the event according to the level, magnitude and type of the emergency or disaster. Without it, the appropriateness, adequacy and timeliness of the response could not be guided or guaranteed.

IV. Policy Statements

Policy Statement 1:

The DOH Central Office, regional offices, and DOH hospitals must establish an ICS as required with a clearly defined chain of command, and with each designated personnel aware of his/her roles, competent in carrying out his/her assigned tasks, and physically available during the event.

Policy Statement 2:

The DOH Central Office, regional offices, and DOH hospitals must put up and run an OpCen 24/7, in close coordination with the Command Center, that serves as the hub for planning, coordinating and monitoring the progress and outcome of the event, and for collecting and reporting necessary data for response management. In case an RO or hospital lacks the capability to operate 24/7, it must be able to activate its OpCen upon declaration of a Code White alert.

Policy Statement 3:

The DOH Central Office, regional offices, and DOH hospitals must set up a well-defined coordination and communication line (i) within and among their own units, (ii) with the other DOH offices and facilities outside their units, and (iii) with other government agencies and other groups of stakeholders for specifically identified purposes and needs.

Policy Statement 4:

The DOH Central Office, regional offices, and DOH hospitals must comply with the harmonized set of code alerts and act appropriately.

V. Guidelines

A. Incident Command System

The use and importance of ICS in managing an event/incident are internationally accepted and recognized by all countries and all sectors at various levels. The goal of the ICS is to ensure that the response to health emergencies and disasters is well-coordinated, smoothly implemented, and provided in a timely manner. The ICS can be categorized into two: (i) the Single Command, which applies when there is only one department or agency that is mobilized to manage the event; and (ii) the Unified Command, which implies that more than one entity is involved, hence the need to unify the overall direction and command.

During any emergency or disaster, it is anticipated that the DOH will undergo an organizational shift to provide a well-organized response in sync with existing DOH policies and mandates. With the establishment of the ICS, there is an automatic exercise of mandates by the authorized structures and offices as previously defined. However, shifting and transition of the command is expected depending on the magnitude of the event and the extent of response that needs to be implemented.

1. General Guidelines

1.1 If the ICS is activated, there is an organizational shift to an "emergency mode," where concerned personnel assume positions which may or may not be their regular assignments. Likewise, their tasks will be different.

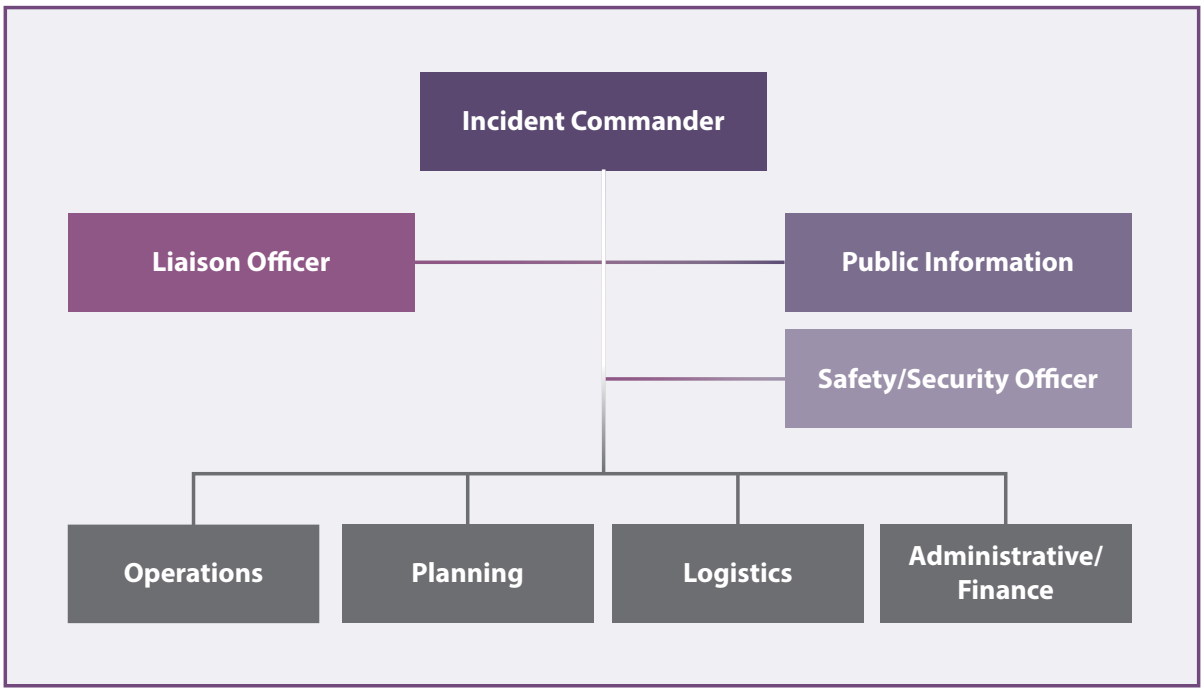
1.2 The same ICS structure can be established for any type of emergency or disaster (e.g., natural, technological, biological, societal, etc.), from different hazards in different settings (e.g., in the field, in an office, in a health facility like the hospital).

1.3 Under Code Alert White, the ICS is within the jurisdiction of the HEMB/HEMS Unit. The ICS for higher Code Alert levels involves other DOH offices, with the Secretary of Health/ regional director/chief of hospital as the Incident Commander (IC) at the respective administrative level.

1.4 In every ICS to be established, the chain of command must be clear. The Incident Commander is identified, and so are the other members of the command system, each with clearly defined roles and tasks. The lines of authority are clearly drawn and delineated with the levels of reporting properly linked.

1.5 In support of the IC is a basic structure with the following as staff members: Liaison Officer (LO), Public Information Officer (PIO), Safety Officer (SO), and the General Staff (GS) assigned for Operations, Planning, Logistics, and Administrative/Finance.

Figure 4. Basic ICS Organizational Structure



1.6 A Command Center (War Room) is where the members of the ICS chain of command meet regularly to discuss the event/incident at hand and make the necessary decisions particularly on what response actions to carry out. This must be easily accessible to, or situated near the OpCen.

1.7 The specific offices/units assigned in the ICS at the DOH Central Office, regional offices, and DOH hospitals may vary according to their peculiar situations and setups. However, each must be able to establish the basic positions required.

1.8 The ICS structure can be designed as modular, where units/positions can be easily merged or delineated depending on whether the Code Alert is raised or downgraded.

1.9 It is preferred that the Incident Commander is positioned in or near the OpCen to facilitate coordination and carrying out of actions.

1.10 The IC should always be physically present during the event. In his/her absence, anyone who is trained on ICS can act as IC position until a designated/mandated officer/ commander assumes the post.

1.11 The following are the major responsibilities of the General Staff structure:

Operations

- Organize and direct aspects relating to the management of victims.
- Carry out directives of the IC in terms of reducing mortalities and morbidities.
- Oversee the entire operation of the incident. Operations include field and hospital operations, public health concerns, health promotion, logistics, and team mobilization.
- Do a lot of coordination and directing and ensure that plans are put into action

Planning

- Organize and direct all aspects of planning, from an Initial Action Plan to a Continuing Plan as the incident develops.
- Ensure the compilation and distribution of critical information/data.
- Compile scenario/resource projections from all general staff chiefs and effect long-range planning

Logistics

- Oversee the entire logistical requirements needed to support response.
- Organize and direct those involved in providing the right logistics at the right time, right place, and right cost, maintenance of the physical environment, and provision of adequate levels of food, shelter and supplies to support the response teams.

Administrative/Finance

- Oversee and facilitate the acquisition of supplies and services necessary to carry out the response.
- Ensure availability of funds to support the operations.
- Monitor the utilization of financial assets and provide administrative support.
- Supervise the documentation of expenditures relevant to the emergency incident.

2. Specific Guidelines

2.1 Establishing the ICS at the DOH Central Office

a. The management of event at the DOH Central Office is governed by the same ICS structure regardless of the type of emergency or disaster, with the Secretary of Health as the Incident Commander.
b. The HEMB shall serve as Liaison Officer and the lead office for Operations during any type of emergency or disaster.
c. The Health Promotion and Communication Services (HPCS) or the designated spokesperson of the DOH shall serve as the PIO during any type of emergency or disaster.
d. The Safety/Security Officer is predetermined depending on the type of emergency; this is usually coordinated with the concerned technical office.
e. The Planning function shall be headed by the concerned technical office depending on the type of the emergency or disaster, e.g., the lead technical office for Planning in reemerging diseases is the Disease Prevention and Control Bureau (DPCB), while for radiation emergencies, it is the Bureau of Health Devices and Technology (BHDT).
f. The Logistics, Administrative and Finance functions shall be headed by the relevant mandated offices in charge of these concerns.
g. The number of DOH offices involved in each of the General Staff Functions (Operations, Planning, Logistics, Administrative/Finance) can be expanded depending on the Code Alert level, magnitude and type of the emergency or disaster. Hence, the positions need not be filled up all at once. Additional staff can be designated as the Code Alert is raised, and reduced once the Code Alert is downgraded.
h. All other DOH-CO offices including the DOH hospitals and regional offices can be called and mobilized to provide support during the emergency or disaster.
i. In the event that the DOH-CO is affected and paralyzed (Code Orange), the nearest functional regional office should take over and establish the ICS. All other ROs must come in to support as predetermined.

The following chart and table present the ICS structures and tasks of the offices involved, according to the Code Alert Level:

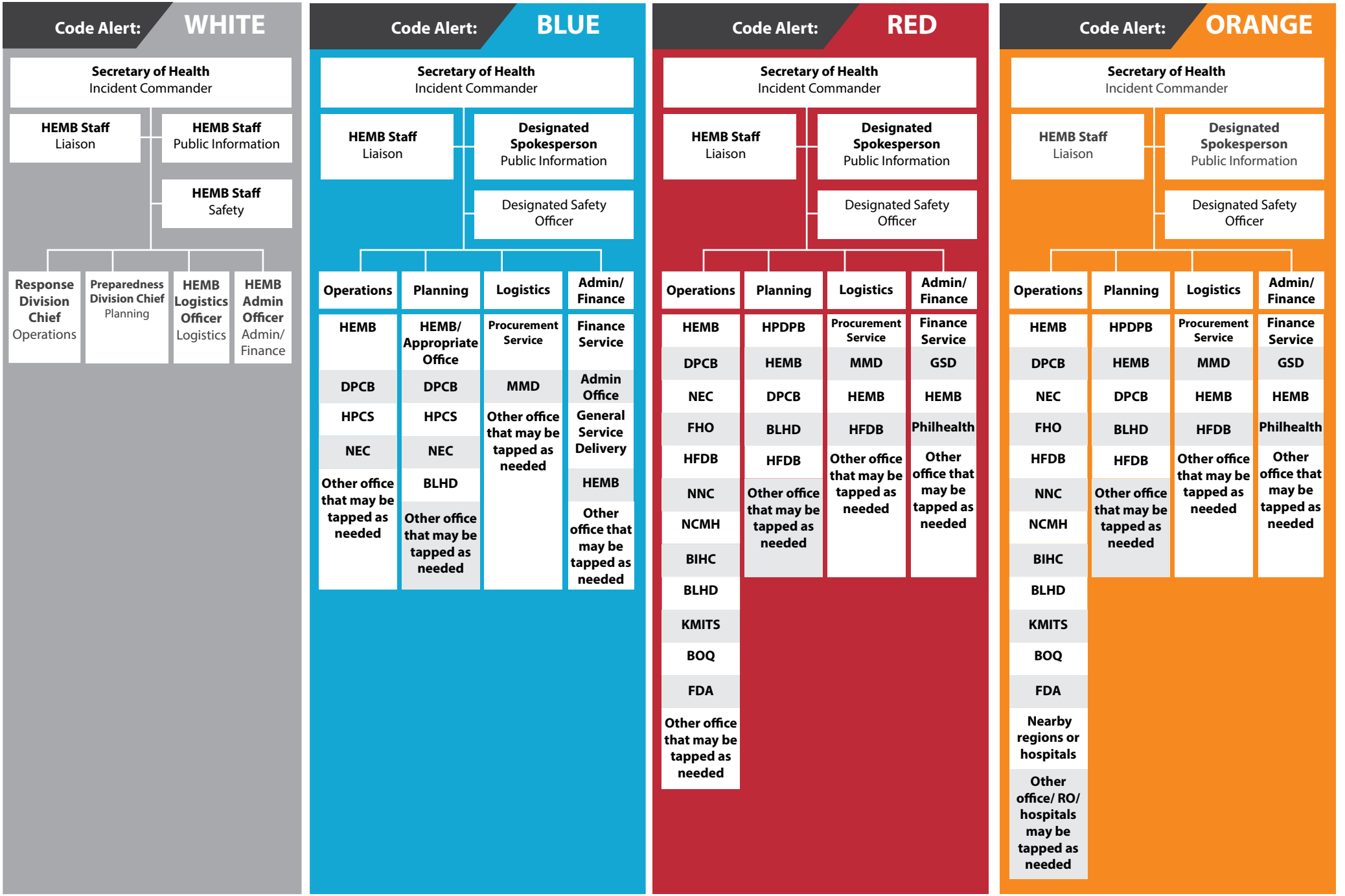

Code Alert: WHITE
Secretary of Health
Incident Commander
HEMB Staff
Liaison
HEMB Staff
Public Information
HEMB Staff
Safety
Response Division Chief
Operations
Preparedness Division Chief
Planning
HEMB Logistics Officer
Logistics
HEMB Admin Officer
Admin/ Finance
Code Alert: BLUE
Secretary of Health
Incident Commander
HEMB Staff
Liaison
Designated Spokesperson
Public Information
Designated Safety Officer
Operations
HEMB
DPCB
HPCS
NEC
Other office that may be tapped as needed
Planning
HEMB/ Appropriate Office
DPCB
HPCS
NEC
BLHD
Other office that may be tapped as needed
Logistics
Procurement Service
MMD
Other office that may be tapped as needed
Admin/ Finance
Finance Service
Admin Office
General Service Delivery
HEMB
Other office that may be tapped as needed
Code Alert: RED
Secretary of Health
Incident Commander
HEMB Staff
Liaison
Designated Spokesperson
Public Information
Designated Safety Officer
Operations
HEMB
DPCB
NEC
FHO
HFDB
NNC
NCMH
BIHC
BLHD
KMITS
BOQ
FDA
Other office that may be tapped as needed
Planning
HPDPB
HEMB
DPCB
BLHD
HFDB
Other office that may be tapped as needed
Logistics
Procurement Service
MMD
HEMB
HFDB
Other office that may be tapped as needed
Admin/ Finance
Finance Service
GSD
HEMB
Philhealth
Other office that may be tapped as needed
Code Alert: ORANGE
Secretary of Health
Incident Commander
HEMB Staff
Liaison
Designated Spokesperson
Public Information
Designated Safety Officer
Operations
HEMB
DPCB
NEC
FHO
HFDB
NNC
NCMH
BIHC
BLHD
KMITS
BOQ
FDA
Nearby regions or hospitals
Other office/ RO/ hospitals may be tapped as needed
Planning
HPDPB
HEMB
DPCB
BLHD
HFDB
Other office that may be tapped as needed
Logistics
Procurement Service
MMD
HEMB
HFDB
Other office that may be tapped as needed
Admin/ Finance
Finance Service
GSD
HEMB
Philhealth
Other office that may be tapped as needed

Table 1. Tasks of Designated Offices/Staff in Operations, Planning, Logistics and Administrative/Finance by Code Level

Area	Code Alert: WHITE	Code Alert: BLUE	Code Alert: RED	Code Alert: ORANGE
Operations	• Schedule regular meetings. • Obtain regular, timely, accurate information for decision-making. Get from Operations Center. • Send alert memo if necessary. • Get information on available logistics at all levels from the Logistics group. • Decide to add to prepositioned logistics to regions that might be affected; prepare to tap other sources. • Coordinate with partners and clusters depending on the impending threat. • Ensure enough staff at Operations Center plus standby teams: public health team and trauma team. • Prepare and disseminate health advisories.	• Ensure that Rapid Health Assessment is done, especially for affected provinces/cities • Perform continuous monitoring and gathering of data; analyze available information to serve as inputs for decision-making. • Organize your team and assign point persons to critical areas. Schedule daily (regular) meetings. • Decide where to prioritize support (provinces, cities, evacuation centers, hospitals), whether to send teams, how many to send, and place of deployment. • Decide establishment of SPEED in priority health facilities. • Review logistical requests/needs and discuss with the Logistics group to source out needs if unavailable in DOH warehouses. • Recommend transfer of funds. • Recommend health advisories, public information releases and press conferences. • Prepare reports and brief the Incident Commander and the General Staff.	• Do continuous monitoring and gathering of data/information. • Perform daily analysis of data/ information and decide if there is a need to change or improve plan or strategies. • For destroyed facilities, recommend to put up field hospitals or send teams to augment their staff. • Discuss with the Planning group the needed memo or guidelines to be issued in response to issues at hand. • Prioritize DOH concerns: Health, WASH, Nutrition, Psychosocial, and review services provided if adequate. • Have regular meetings on the clusters to maximize resources and share information. • Recommend manpower support, or send experts to affected regions/hospitals/operation centers. • Do continuous reporting and strategizing with the IC and other members of the General Staff.	• Do continuous coordination with all relevant departments and partners involved in operation. • Ensure provision of minimum or essential health services to affected population, equitably distributed but with special inclination towards the vulnerable population and geographically isolated and disadvantaged areas. • Ensure that people in evacuation centers and temporary shelters be provided Health, WASH, Nutrition and Psychosocial services and all systems to prevent occurrence of any type of epidemics. • Recommend support or takeover of affected area if needed, especially if the receiving hospitals are non functional. • Lead in the coordination of the deployment of medical, technical and support teams. • Send START Teams to activate SPEED. • Anticipate and address issues, concerns on a day-to-day basis. • Continuously report to and receive instructions from the IC.

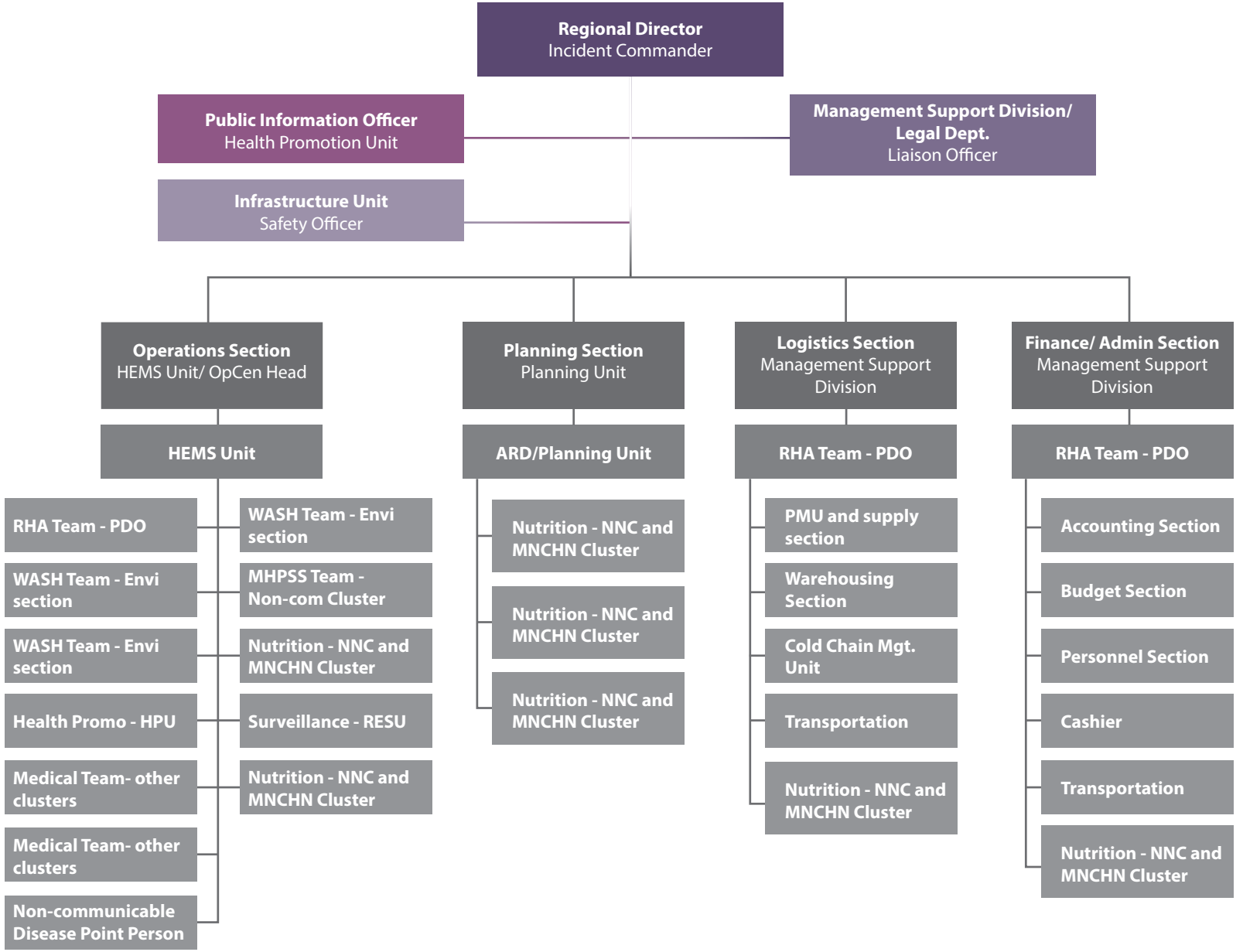
Planning	• In coordination with Operations, anticipate risks related to the hazard or event. • Check manpower resources and place them on standby.	• Develop the initial Incident Action Plan. • Develop interim policies and guidelines and disseminate as needed. • Together with other members of the General Staff, identify resource requirements and where to source them out, including manpower requirements.	• Continuously evaluate and update the plan. • Make projections,, including length of operation and needed resources to support the operation.. • Recommend/decide acceptance of volunteers. • Recommend/decide support for administrative needs.	• Continuously update the Action Plan. • Continuously develop the interim guidelines and protocols and disseminate these to all concerned. • Continuously identify needed resources, both logistics and manpower. • Make projections in terms of duration, magnitude of response, and logistic requirements, and coordinate with respective Logistics and Finance groups.
Logistics	• Check inventory of logistics in all the warehouses of DOH in coordination with MMD. • Check prepositioned logistics in all implementing agencies, most especially in areas that might be affected by the incident. • Review existing arrangement with forwarders, and inform them; tap other sources, such as NDRRMC, and other means. • Follow a system of tracking mobilized logistics. • Prepare staff for the packing and mobilization of logistical needs. • Review arrangements with suppliers and anticipate possible emergency procurement.	• Deploy logistics as requested or needed. • Review existing arrangement with forwarders and inform them; identify other sources, such as the military c/o N/RDRRMC, Philippine Coastguard, etc. • Review existing system with pharmaceuticals as regards emergency procurement. • Follow a system of tracking mobilized logistics. • Prepare staff for the packing and mobilization of logistical needs. • Source out logistic needs from other DOH warehouses, regional offices or hospitals. • Do emergency procurement for unavailable logistics or when critical stock level has been reached. • Coordinate regularly with Operations and other members of ICS.	• Continuously deploy logistics and continuously track those mobilized. • Do continuous procurement if needed. • Anticipate and project logistical needs and tap all sources, both internal and external. • Recommend sources of logistical requirements to the IC • Receive donations and inform Operations. • Set up a one-stop shop for emergency procurement to facilitate acceptance of procured drugs, medicines and equipment, and facilitate processing of payment.	• Deploy logistics persons to affected regions/hospitals to assist and augment their staff. • Set up areas to receive logistics in the airports or other points of entry. • Do continuous deployment, monitoring and tracking of logistics. • Actively identify all modes of transferring logistics (air, land and sea). • Do active projections of needed logistics and available sources. • Anticipate other logistical needs other than drugs and medicines, such as food, clothing of medical staff; linens for patients; housekeeping/cleaning materials, etc.

Administrative/ Finance	• Check availability of funds, including QRF. • Ensure availability of vehicles and drivers 24/7. • Have standby administrative staff, engineers, security and safety officers. • Anticipate escalation of incident and start preparing necessary documents in case petty cash will be needed.	• Make available petty cash for emergency procurement, for needs of responders and other administrative needs. • Sub-allot funds to regions and hospitals and other facilities or offices. • Facilitate processing of funds for liquidation, payment of goods, drugs, etc. • Make available needed transportation, communications, fuel and electricity. • Ensure continuous support in terms of vehicles, drivers, fuel and other administrative concerns.	• Establish a one-stop shop for processing of payments and provision of financial needs. • Ensure continuous provision of petty cash. • Facilitate payments, liquidations, per diem of response teams, and other administrative needs and requirements. • In coordination with Planning, recommend support to affected areas in terms of financial management. • Identify possible cash donors; receive cash donations.	• Deploy staff from the financial office to support and augment staff in affected areas. • Ensure continuous availability of petty cash. • Establish a one-stop shop for processing of payments and provision of financial needs. • Facilitate payments, liquidations, per diems of response teams, and other administrative needs and requirements. • Continuously source funds and accept cash donations. • Identifyand making arrangements for provision of support to responders in terms of food, accommodation and other special arrangements as needed.

2.2 Establishing the ICS in the ROs

a. Each RO is expected to establish its own ICS structure as it deems fit for managing response to all types of events depending on the alert level and based on the recommended ICS template.
b. The RO director shall be the IC regardless of the type of emergency and the Code Alert level (White, Blue or Red).
c. The rest of the key positions in the ICS structure shall be predesignated by the regional director (RD).
d. In the event that the RO is affected and paralyzed (Code Alert Orange):
    i. The RD of the nearest functional RO or predetermined buddy RO, together with his/her ICS Team, shall automatically take over and establish the ICS and should continuously inform the DOH-CO on the development and status of the response.
    ii. If there are no information or reports coming from the field and other sources (e.g., NDRRMC, partners, media, etc.), it indicates that the magnitude has reached the criteria for Code Orange, and the DOH-CO shall come in and take the lead in mounting the necessary response.
    iii. The DOH-CO shall lead in coordinating the assistance from other regions and other volunteers (local and international).

Figure 6. Recommended Incident Command Structure in the ROs for All Types of Emergencies and Disasters for All Codes

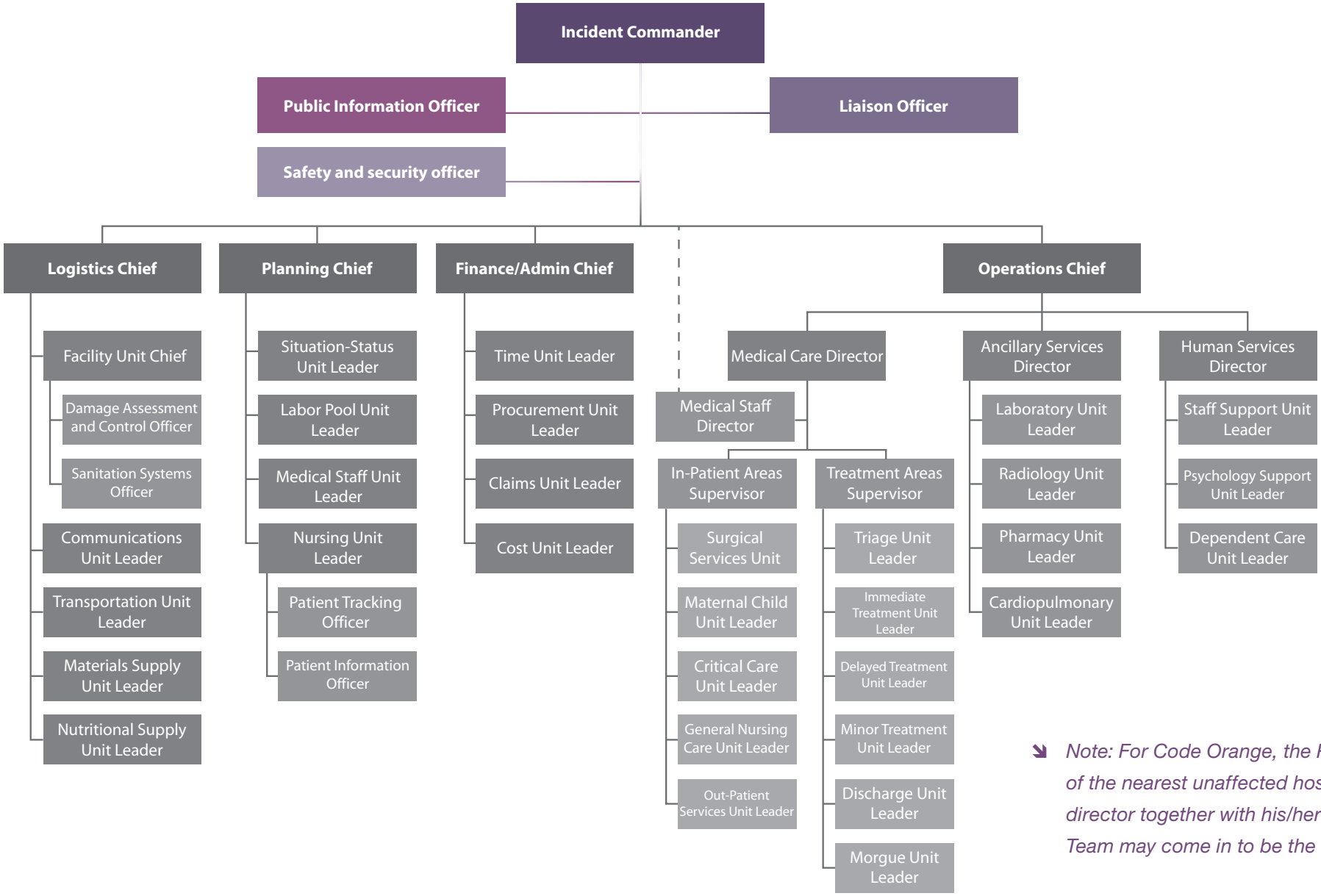


Note: For Code Orange, the RD of the nearest unaffected region or predetermined buddy RO together with his/ her ICS Team may come in to be the IC.

2.3 Establishing the ICS in the DOH Hospitals

a. Each DOH hospital is expected to establish its own ICS structure as it deems fit for managing response to all types of events depending on the alert level and based on the recommended ICS template.
b. The chief of hospital shall be the IC regardless of the type of emergency and the Code Alert level (White, Blue or Red).
c. The rest of the key positions in the ICS structure shall be predesignated by the chief of hospital.
d. In the event that the hospital is affected and paralyzed (Code Alert Orange):
    i. The RD or the chief of the nearest functional DOH hospital shall automatically take over as predetermined, and establish the ICS. The designated IC shall continuously inform the DOH-CO on the development and status of the response.
    ii. If there are no information or reports coming from the field and other sources (e.g., NDRRMC, partners, media, etc.), it indicates that the magnitude has reached the criteria for Code Orange, and the DOH-CO shall come in and take the lead in mounting the necessary response.
    iii. The DOH-CO shall lead in coordinating the assistance from other regions of the other clusters, and other volunteers (local and international).

Figure 7. Hospital Emergency Incident Command System Structure



Note: For Code Orange, the RD of the nearest unaffected hospital director together with his/her ICS Team may come in to be the IC.

3. Procedures in Activating the ICS

There is a need to activate the ICS at all levels. The ICS at higher levels are more strategic, giving guidance and support to the lower administrative levels. The ICS in the regions/DOH hospitals and LGUs, on the other hand, are more tactical in their roles and functions. In this regard, each office concerned must know if they are to take the role of gold (Strategic), silver (Tactical) or bronze (Tasking) positions and discuss when to activate their ICS.

Table 2. Steps/Tasks in ICS Activation Pre-During-Post Impact

	Pre-impact (A day or days before)	During Impact (0 hour to 48 hours)	Post-impact (After 48 hours and onwards)
With warning (typhoon, volcanic eruption, tsunami, rally, biological emergencies such as epidemics and radiological contamination and international events and activities)	• Activate the ICS (See Table 17). • IC to assume position and designate key members (could be predetermined or assigned). • Review and familiarize with Job Action Sheets. • Organize respective teams. • Instruct OpCen of any report or information needed. • Activate Command Center and schedule meetings; more often during the first days but gradually reducing in frequency as incident is managed. • Check all resources, both material and human resources.	• Conduct meetings to evaluate incoming reports, information from quad media and appropriate agencies (e.g., PAGASA for typhoon) • Develop, approve and disseminate Initial Incident Action Plan for implementation. • Make strategic decisions and overall guidance to the implementing facilities/offices in the field. • Establish database of all logistical resources available in all warehouses and other sources. • Identify all standby teams and have them ready for deployment already with needed supply and other needs. • Continue reporting to higher authorities and providing feedback. • Ensure reporting and documentation.	• Continuously conduct meetings to evaluate reports/information. • Regularly review plans, improving or amending them especially during the escalation of the incident. • Anticipate logistical requirements and ensure its continuous support both in logistics and human resources needed. • Continue reporting to higher authorities and providing feedback to the field. • Decide the start of recovery and rehabilitation phase and prepare plans. • Conduct post evaluation and review of response. • Ensure documentation
Without warning (earthquake, bombing, armed conflict, chemical accidents, mass casualty incidents especially those related to transportation accidents)	• Not applicable	• Same as above	• Same as above

4. Job Action Sheets for the Basic ICS Structure

This section contains the checklists of actions that the designated officers in the ICS structure – at the DOH Central Office, in the regional offices, and in the DOH hospitals – need to perform at different stages of the response. The following pages contain the checklists for the following IC officers:

1. For DOH Central Office
   - 4.1.1 DOH-CO Incident Commander
   - 4.1.2 DOH-CO Liaison Officer
   - 4.1.3 DOH-CO Public Information Officer
   - 4.1.4 DOH-CO Safety and Security Officer
   - 4.1.5 DOH-CO Planning Section Chief
   - 4.1.6 DOH-CO Logistic Section Chief
   - 4.1.7 DOH-CO Finance Section Chief
2. For Regional Offices
   - 4.2.1 DOH-RO Incident Commander
   - 4.2.2 DOH-RO Liaison Officer
   - 4.2.3 DOH-RO Public Information Officer
   - 4.2.4 DOH-RO Safety and Security Officer
   - 4.2.5 DOH-RO Operations Section Chief
   - 4.2.6 DOH-RO Planning Section Chief
   - 4.2.7 DOH-RO Logistics Section Chief
   - 4.2.8 DOH-RO Finance Section Chief
3. For DOH Hospitals
   - 4.3.1 DOH Hospital Incident Commander
   - 4.3.2 DOH Hospital Liaison Officer
   - 4.3.3 DOH Hospital Public Information Officer
   - 4.3.4 DOH Hospital Safety and Security Officer
   - 4.3.5 DOH Hospital Operations Section Chief
   - 4.3.6 DOH Hospital Planning Section Chief
   - 4.3.7 DOH Hospital Logistics Section Chief
   - 4.3.8 DOH Hospital Finance Section Chief

4.1.1 DOH-CO INCIDENT COMMANDER

Mission Be responsible for providing overall direction and managing the event. Give overall guidelines for operations, and, if needed, authorize evacuation and request for support/help.

Immediate Actions upon ICS Activation

- Initiate the ICS by assuming the role of the Incident Commander.
- Establish the Command Center or War Room where regular meetings will be conducted.
- Read this entire Job Action Sheet.
- Put on position identification vest.
- Appoint all positions of the General Staff.
- Distribute the following:
  - Job Action Sheets for each position
  - Identification vests for each position
  - Pertinent forms
- Appoint Command Staff: Public Information Officer, Liaison Officer, and Safety and Security Officer; distribute Job Action Sheets. (May be preestablished).
- Announce a Status/Action Plan meeting of all Command and General Staff chiefs to be held within 5 to 10 minutes.
- Assign someone as documentation recorder/aide.
- Receive status report and discuss the Initial Action Plan with Command and General Staff chiefs. Determine appropriate level of service during immediate aftermath with Operations Chief.
- Receive initial rapid health assessment report from field offices, OCD, partners or other agencies with Planning Chief. Mandate the OpCen for timely, regular reporting
- Obtain list of present resources at site or deployed, prepositioned logistics, and available logistics at warehouses from the Logistics Chief. Emphasize proactive actions with the Planning Section. Call for nationwide/region-wide projection report for 4, 8, 24 and 48 hours from time of incident onset. Adjust projections as necessary.
- Make an assessment of vulnerable areas based on pre-event data for the purpose of prioritization of resources and manpower.
- Assure that contact and resource information has been established with outside agencies through the Liaison Officer.

Intermediate Actions after ICS Activation up to Height of the Response

- Authorize resources as needed or requested by Command and General Staff chiefs.
- Designate routine briefings with General Staff chiefs to receive status reports and update the action plan regarding the continuance and termination of the action plan.
- Communicate status of preparation and response to higher levels, such as NDRRMC and the President. Represent the agency in all coordinating meetings or send a representative.
- Consult with General Staff chiefs on needs for manpower, logistical requirements and funds. Decide whether to receive and accommodate volunteers or Foreign Medical Teams (FMTs). Authorize plan of action.
- Approve media releases submitted by the PIO

Extended Actions When Response Has Already Scaled Down

- Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.1.2 DOH-CO LIAISON OFFICER

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Function as incident contact person for representatives from other agencies.

Immediate Actions

- Receive appointment from Incident Commander. Obtain packet containing Section's Job Action Sheet Receive appointment from Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests, and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain a briefing from Incident Commander.
- Establish contact with Operations Center, including its network and database of contact numbers. Get one or more aides as necessary from the Labor Pool
- Review and get oriented on existing NDRRMC family, members of the health sector, networks of hospitals, and other partners, including international groups such as the World Health Organization, etc. to determine appropriate contacts. Coordinate with Public Information Officer.
- Obtain information on needs of DOH and the regional offices responding to the event and whether these could be sourced from other agencies/partners. Likewise, respond also to what other groups, especially those in the health sectors, need. The following information should be gathered and relayed:
  - Any current or anticipated shortage of personnel, supplies, etc.
  - Any concerns regarding transportation requirements for delivering personnel and logistics to site.
  - Requirements in terms of lifelines such as communication, electricity, water, toilets, blood, generators, etc.
  - Any resources that have to be purchased outside the country.
  - Any resources to support surge capacity, especially for destroyed facilities such as field hospital, tents, etc.
- Establish contact with liaison counterparts of each assisting and cooperating agency. Keep government liaison officers updated on changes in and development of the incident. Attend coordination meetings at all levels.

Intermediate Actions

- Request assistance and information as needed through the network, health sector partners, and NDRRMC family.
- Respond to requests and complaints from incident personnel regarding inter-organization problems.
- Prepare to assist the Labor Pool with problems encountered in the volunteer credentialing process. For FMTS, coordinate with BIHC.

Extended Actions

- Assist in soliciting manpower from volunteer organizations, medical groups, etc. when appropriate.
- Inventory any material resources which may be sent upon official request, including method of transportation, if appropriate.
- Provide casualty data to the appropriate authorities in coordination with the PIO.
- Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.1.3 DOH-CO PUBLIC INFORMATION OFFICER

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Provide information to the media and the public. Ensure that all released information are timely and accurate.

Immediate Actions

- Receive appointment from Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Orient yourself on all data coming from all sources.
- Identify appropriate information relevant to the incident that need to be given to the public or to the media.
- Identify restrictions in contents of news from IC; ensure protection of patient identity.
- May form your own team coming from HEPOs other personnel.

Intermediate Actions

- Ensure that all news releases have the approval of the Incident Commander and are consistent and coming only from one source.
- Issue an initial incident information report to the news media with the cooperation of the General Staff chiefs, Operations Center, etc.
- Hold regular media briefings with the IC; more often during the first week, and declining in frequency as the incident progresses.
- Decide with a team on information needed for public information and safety.
- Develop a system of providing information to relatives especially in case of Mass Casualty Incident.
- Inform on-site media of the physical areas that they can have access to and those that are restricted. Coordinate with Safety and Security Officer.
- Contact other agencies at the scene to coordinate released information with respective PIOs.
- Inform Liaison Officer of actions.

Extended Actions

- Obtain progress reports from General Staff chiefs as appropriate.
- Notify media on a regular basis about important information, such as statistics on casualty status and response efforts being done by the agency including accomplishment reports especially in managing victims.
- Direct calls from those who wish to volunteer to Personnel or assigned office. Discuss with Operations to determine requests to be made to the public via the media.
- Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.1.4 DOH-CO SAFETY AND SECURITY OFFICER

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Monitor and assume authority over the safety of rescue operations and hazardous conditions. Organize and enforce scene/facility protection and security, including traffic security inside the CO.

Immediate Actions

- Receive appointment from Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests, and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain a briefing from Incident Commander.
- Implement the disaster plan emergency lockdown policy and personnel identification policy. May form your own team, such as engineers, safety personnel, and security group.
- Establish Security Command Post.
- Remove unauthorized persons from restricted areas, including vehicles
- Establish ambulance entry and exit route in coordination with security and transportation group.
- Secure the Operation and Command Center from unauthorized access.

Intermediate Actions

- Communicate with engineers or Damage Assessment Teams to secure and post non-entry signs around unsafe areas. Keep Safety and Security staff alert to identify and report to you all hazards and unsafe conditions.
- Secure areas evacuated to and from, to limit unauthorized personnel access.
- Initiate contact with fire and police agencies through the Liaison Officer, when necessary.
- Advise the Incident Commander and General Staff chiefs immediately of any unsafe, hazardous or security-related conditions.
- Assist Labor Pool and Personnel with credentialing/screening of volunteers. Prepare to manage large numbers of potential volunteers.
- Confer with Public Information Officer to establish areas for media personnel.
- Hold routine briefings with Incident Commander.
- Provide vehicular and pedestrian traffic control.
- Secure food, water, medical and blood resources.
- Inform Safety and Security staff to document all actions and observations.
- Hold routine briefings with Safety and Security staff.

Extended Actions

- Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.1.5 DOH-CO PLANNING SECTION CHIEF

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Organize and direct all aspects of planning, from an Initial Action Plan to a Continuing Plan as incident develops. Ensure the compilation and distribution of critical information/data. Compile scenario/resource projections from all general staff chiefs and effect long-range planning.

Immediate Actions

- Receive appointment from the Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests, and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain briefing from Incident Commander.
- Recruit a documentation aide and team from the Labor Pool.
- Appoint Planning Unit leaders: Situation-Status Unit Leader, Labor Pool Unit Leader. (May be preestablished).
- Brief unit leaders after meeting with Incident Commander.
- Provide for a Planning/Information Center.
- Ensure that the whole team collects and analyzes all data and information gathered.
- Ensure the formulation and documentation of an incident-specific Action Plan. Discuss the plan with Incident Commander and all General Staff chiefs.
- Call for projection reports (Action Plan) from all Planning Section unit leaders and General Staff chiefs for scenarios 4, 8, 24 and 48 hours from time of incident onset. Adjust time for receiving projection reports as necessary.
- Document/update status reports from all general staff chiefs for use in decision-making and for reference in post-disaster evaluation and recovery assistance applications.

Intermediate Actions

- Obtain briefings and updates as appropriate. Continue to update the Action Plan.
- Regularly present an updated Action Plan to the Incident Commander and the general staff chiefs for approval and implementation.

Extended Actions

- Continue to project and update Action Plan at appropriate intervals.
- May start drafting a Recovery and Reconstruction Plan if required, depending on the magnitude of the incident. For CO this would be in coordination with the RO and upon instructions from the NDRRMC. For the RO, this should be started right away in coordination with the LGU.
- Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.1.6 DOH-CO LOGISTICS SECTION CHIEF

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Oversee all logistical requirements needed to support response. Organize and direct those associated with maintenance of the physical environment and provision of adequate levels of food, shelter and supplies to support the medical objectives.

Immediate Actions

- Receive appointment from the Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests, and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain a briefing from Incident Commander.
- Organize your team and appoint Logistics Section unit leaders: Facilities Unit Leader, Communications Unit Leader, Transportation Unit Leader, Materials Supply Unit Leader; distribute Job Action Sheets and vests. (May be preestablished).
- Brief team leaders on current situation; outline action plan and designate time for regular briefing. Designate a one-stop shop for all procurements.
- Review all logistics available in warehouses. For CO, include all those available in all ROs and possibly hospitals.
- Review database on suppliers and contacts (including forwarder arrangements) and identify where resources could be obtained or procured ASAP.
- Establish Logistics Section Center preferably in proximity to EOC..
- Attend meeting with Incident Commander and all members of the General Staff to anticipate logistical needs.

Intermediate Actions

- Obtain information and updates regularly.
- Communicate frequently with Incident Commander and the Operations Chief.
- Obtain needed supplies with the assistance of the Finance Section Chief.
- Have a tracking system of all logistics distributed. For CO, this includes those given to hospitals, regions and partners. For RO, a detailed tracking should include LGU-provided logistics, preferably down to the municipal level.

Extended Actions

- Assure that all communications with regards to transmittal of logistics, including distribution lists, are copied to the Operations Center/HEMB.
- Document actions and decisions on a continual basis. Make an evaluation to serve as input to policy improvement and development of guidelines.
- Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Submit a final report to HEMB for inclusion into the final report.
- Other concerns.

4.1.7 DOH-CO FINANCE SECTION CHIEF

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Monitor the utilization of financial assets and provide administrative support. Oversee the acquisition of supplies and services necessary to carry out the agency's medical mission. Supervise the documentation of expenditures relevant to the emergency incident.

Immediate Actions

- Receive appointment from the Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests, and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain briefing from Incident Commander.
- Organize you own team (e.g., financial, administrative, other support services), and distribute work and functions (may be preestablished).
- Establish a Financial Section Operations Center. Ensure adequate documentation/ recording personnel.
- Be familiar with sources of funds (contingency funds, QRF funds, and other sources of emergency funds). Prepare petty cash depending on the magnitude of the incident.
- Establish a one-stop shop for the provision of support to responders, including other requirements such as petty cash, transportation, fuel, food, communications, etc.
- Develop your own plan to support the operations.

Intermediate Actions

- Approve a "cost-to-date" incident financial status report every eight hours summarizing financial data relative to personnel, supplies, and miscellaneous expenses. This can be adjusted to a daily report later or once a week as the incident is handled.
- Obtain briefings and updates from the Incident Commander as appropriate. Relate pertinent financial status reports to concerned chiefs.
- Schedule planning meetings to discuss updating the section's incident action plan and termination procedures.

Extended Actions

- Assure that all requests for personnel or supplies are copied to the HEMB in a timely manner for inclusion in the regular reporting and the final report.
- Document all financial cost of the operation. Ensure that all other facilities are properly provided with enough financial replenishment/support as available.
- Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.2.1 DOH-RO INCIDENT COMMANDER

Mission Be responsible for providing overall direction and managing the event in your region. Give overall guideline for operations, and, if needed, authorize evacuation and request for support/help.

Immediate Actions

- Initiate the Incident Command System by assuming the role of Incident Commander. Establish the Command Center or War Room where regular meetings will be conducted.
- Read this entire Job Action Sheet.
- Put on position identification vest.
- Appoint chiefs the General Staff. Distribute the four section packets which contain:
  - Job Action Sheets for each position
  - Identification vests for each position
  - Forms pertinent to section and positions
- Appoint officers of the Command Staff: Public Information Officer, Liaison Officer, and Safety and Security Officer. Distribute Job Action Sheets. (May be pre-established)
- Announce a status/action plan meeting of all Command and General Staff chiefs to be held within 5 to 10 minutes.
- Assign someone as documentation recorder/aide.
- Receive status report and discuss an Initial Action plan with Command and General Staff chiefs. Determine appropriate level of service during immediate aftermath with Operations Chief.
- Mandate the OpCen for regular and timely reporting as needed.
- Receive initial rapid health assessment report from field offices, RDRRMC partners or other agencies with Planning Chief. Obtain list of present resources at site or deployed, prepositioned logistics, and available logistics at warehouses from Logistics Chief. Emphasize proactive actions with the Planning Section. Call for nationwide/region-wide projection reports for 4, 8, 24 and 48 hours from time of incident onset. Adjust projections as necessary.
- Make an assessment of vulnerable areas based on pre-event data for the purpose of prioritizing resources and manpower.
- Assure that contact and resource information has been established with outside agencies through the Liaison Officer.

Intermediate Actions

- Authorize resources as needed or requested by Command and General Staff chiefs.
- Set routine briefings with General Staff chiefs to receive status reports, and update the action plan regarding the continuance and termination of the action plan.
- Communicate status of preparation and response to higher levels, such as the Secretary of Health and RDRRMC/PDRRMC/CDRRMC. Represent the agency in all coordinating meetings or send a representative.
- Consult with General Staff chiefs on needs for manpower, logistical requirements and funds in coordination with the CO. Decide whether to receive, accommodate and deploy volunteers or Foreign Medical Teams (FMTs). Authorize plan of action.

Extended Actions

- Approve media releases submitted by PIO.
- Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.2.2 DOH-RO LIAISON OFFICER

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Function as incident contact person for representatives from other agencies.

Immediate Actions

- Receive appointment from Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain a briefing from Incident Commander.
- Establish contact with Operations Center, including its network and database of contact numbers. Obtain one or more aides as necessary from the Labor Pool.
- Review and get oriented on the existing RDRRMC family, members of the health sector, networks of hospitals, and other partners including international groups to determine appropriate contacts. Coordinate with the Public Information Officer.
- Obtain information regarding needs of DOH and the regional offices responding to the event and whether these could be sourced from other agencies/partners. Respond, also to what other groups, especially those in the health sectors, need. The following information should be gathered for relaying.
  - Any current or anticipated shortage of personnel, supplies, etc.
  - Any concerns regarding transportation requirements for delivering personnel and logistics to site.
  - Requirements in terms of lifelines such as communication, electricity, water, toilets, blood, generators, etc.
  - Any resources that have to be purchased outside the country.
  - Any resources to support surge capacity especially with destroyed facilities such as field hospital, tents, etc.
- Establish contact with liaison counterparts of each assisting and cooperating agency. Keepi governmental liaison officers updated on changes and developments in the incident. Attend coordination meetings at all levels.

Intermediate Actions

- Request assistance and information as needed through the network, health sector partners, and the RDRRMC family.
- Respond to requests and complaints from incident personnel regarding inter-organization problems.
- Prepare to assist the Labor Pool group with problems encountered with volunteers. For FMTS, coordinate with CO through the BIHC.

Extended Actions

- Assist in soliciting manpower from volunteer organizations, medical groups, etc. when appropriate.
- Inventory any material resources that may be sent upon official request, including method of transportation, if appropriate.
- Supply casualty data to the appropriate authorities in coordination with the PIO.
- Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.2.3 DOH-RO PUBLIC INFORMATION OFFICER

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Provide information to the media and the public. Ensure that all released information are timely and accurate.

Immediate Actions

- Receive appointment from Incident Commander. Obtain packet containing sJob Action Sheets, identification vests and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Orient yourself on all data coming from all sources.
- Identify appropriate information relevant to the incident that need to be given to the public or to the media.
- Identify restrictions in contents of news from the IC; ensure protection of patient identity.
- May form your own team coming from HEPOS and other personnel.

Intermediate Actions

- Ensure that all news releases have the approval of the Incident Commander and are consistent and coming only from one source.
- Issue an initial incident information report to the news media in cooperation with the General Staff chiefs, Operations Center, etc.
- Establish a regular briefing of the media with the IC, more often during the first week, and declining in frequency as the incident progresses.
- Decide with a team on the information needed for public information and safety.
- Develop a system of providing information to relatives, especially in case of Mass Casualty Incident.
- Inform on-site media of the physical areas that they have access to, and those that are restricted. Coordinate with Safety and Security Officer.
- Contact other agencies at the scene to coordinate released information with respective PIOs.
- Inform Liaison Officer of action.

Extended Actions

- Obtain progress reports from General Staff chiefs as appropriate.
- Notify media on a regular basis about important information, such as statistics on casualty status and response efforts being done by the agency including accomplishment reports especially in managing victims.
- Direct calls from those who wish to volunteer to Personnel or assigned office.
- Discuss with Operations to determine requests to be made to the public via the media.
- Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.2.4 DOH-RO SAFETY AND SECURITY OFFICER

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Monitor and have authority over the safety of rescue operations and management of hazardous conditions. Organize and enforce scene/facility protection and security including traffic security inside the hospital.

Immediate Actions

- Receive appointment from Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain a briefing from Incident Commander.
- Implement the RO disaster plan emergency lockdown policy and personnel identification policy. May form your own team, such as engineers, safety personnel, and security group.
- Establish Security Command Post.
- Remove unauthorized persons from restricted areas.
- Establish vehicle entry and exit route in coordination with security and transportation group.
- Secure the Operations and Command Center, triage, patient care, morgue and sensitive or strategic areas from unauthorized access.

Intermediate Actions

- Communicate with engineers or Damage Assessment Teams to secure and post non-entry signs around unsafe/unsecured areas. Keep Safety and Security staff alert to identify and report to you all hazards and unsafe conditions.
- Secure areas evacuated to and from, to limit unauthorized personnel access.
- Initiate contact with fire and police agencies through the Liaison Officer, when necessary.
- Advise the Incident Commander and General Staff chiefs immediately of any unsafe, hazardous or security-related conditions.
- Assist Labor Pool and Personnel with credentialing/screening of volunteers. Prepare to manage large numbers of potential volunteers.
- Confer with Public Information Officer to establish areas for media personnel.
- Establish routine briefings with Incident Commander.
- Provide vehicular and pedestrian traffic control.
- Secure food, water, medicines/medical supplies, and blood resources.
- Instruct Safety and Security staff to document all actions and observations.
- Establish routine briefings with Safety and Security staff.

Extended Actions

- Observe all staff and volunteers for signs of stress and inappropriate behaviour. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief
- Other concerns

4.2.5 DOH-RO OPERATIONS SECTION CHIEF

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Organize and direct aspects relating to the management of victims. Carry out directives of the Incident Commander in terms of reducing mortalities and morbidities and covering all areas from the community, pre-hospital to hospital care.

Immediate Actions

- Receive appointment from the Incident Commander Obtain packet containing section's Job Action Sheets, identification vests and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain briefing from Incident Commander.
- Organize your team, which may include but need not be limited to, the following: public health, hospital operations, clusters (Health, Nutrition, WASH, Psychosocial); surveillance, etc. The composition will be adjusted based on the type of incident, its magnitude, and the level of needed response.
- Brief all Operations team leaders on current situation and develop the section's initial action plan. Designate a regular briefing schedule, including reporting.
- Establish Operations Section Center in proximity to the EOC.
- Be physically present at all times to conduct all meetings and planning with the group. Make timely decisions based on information at hand and strategize how to improve the response in order to handle the victims or prevent occurrence of epidemics, especially at evacuation centers.
- Decide whether to send teams from the regional office to neighbouring provinces and municipalities when reports show that the response is inadequate. Do this in constant coordination with the field office.

Intermediate Actions

- Designate times for briefings and update all Operations Team leaders to develop/ update section's action plan. Daily meetings may have to be conducted during the first week.
- Anticipate needed resources and staff and coordinate with the Logistics, Finance and Planning heads during meetings. Tap the health sector and the regional clusters to assist in the response.
- May send teams to monitor the response or send experts to help in the strategy.
- Brief the Emergency Incident Commander routinely on the status of the Operations Section and receive directions.

Extended Actions

- Ensure that all communications are copied to the Operations Center/HEMB. Document all actions and decisions.
- Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.2.6 DOH-RO PLANNING SECTION CHIEF

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Organize and direct all aspects of planning, from the Initial Action Plan to a Continuing Plan as the incident develops. Ensure the compilation and distribution of critical information/ data. Compile scenario/ resource projections from all General Staff chiefs and perform long-range planning.

Immediate Actions

- Receive appointment from the Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain briefing from Incident Commander.
- Recruit a documentation aide and team from the Labor Pool
- Appoint Planning Committee members (May be preestablished).
- Brief unit leaders after meeting with Incident Commander.
- Provide for a Planning/ Information Center.
- Ensure that the whole team collects and analyzes all data and information gathered
- Ensure the formulation and documentation of an incident-specific Action Plan. Discuss Plan with Incident Commander and all general staff chiefs.
- Call for projection reports (Action Plan) from all Planning Section unit leaders and General Staff chiefs for scenarios 4, 8, 24 and 48 hours from time of incident onset. Adjust time for receiving projection reports as necessary.
- Document/update status reports from all general staff chiefs for use in decision-making and for reference in post-disaster evaluation and recovery assistance applications.

Intermediate Actions

- Obtain briefings and updates as appropriate. Continue to update the Action Plan.
- Regularly present an updated Action Plan to the Incident Commander and the general staff chiefs for approval and implementation.

Extended Actions

- Continue to project and update Action Plan at appropriate intervals.
- May start drafting a Recovery and Reconstruction Plan if required depending on the magnitude of the incident. For the RO, this should be started right away in coordination with the LGU.
- Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.2.7 DOH-RO LOGISTICS SECTION CHIEF

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Oversee all logistical requirements needed to support response. Organize and direct those associated with maintenance of the physical environment and the provision of adequate levels of food, shelter and supplies to support the medical objectives.

Immediate Actions

- Receive appointment from the Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests, and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain a briefing from Incident Commander.
- Organize your team and appoint Logistics Section unit leaders: Facilities Unit Leader, Communications Unit Leader, Transportation Unit Leader, and Materials Supply Unit Leader. Distribute Job Action Sheets and vests. (May be preestablished).
- Brief team leaders on current situation; outline the action plan and designate time for regular briefing. Designate a one-stop shop for all procurements.
- Review all logistics available in warehouses.
- Review database on suppliers and contacts (including forwarder arrangements) and identify where resources could be obtained or procured ASAP.
- Establish the Logistics Section Center, preferably in proximity to the EOC.
- Attend meetings with Incident Commander and all members of the General Staff to anticipate logistical needs.

Intermediate Actions

- Obtain information and updates regularly.
- Communicate frequently with Incident Commander and the Operations Chief.
- Obtain needed supplies with the assistance of the Finance Section Chief.
- Have a tracking system of all logistics distributed. For RO, a detailed tracking should include LGU-provided logistics, preferably down to the municipal level.

Extended Actions

- Ensure that all communications with regards to transmittal of logistics, including distribution lists, are copied to the Operations Center/HEMB.
- Document actions and decisions on a continual basis. Make an evaluation to serve as inputs to improving policy and developing guidelines.
- Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Prepare a final report to be submitted to HEMB for inclusion in the final report.
- Other concerns.

4.2.8 DOH-RO FINANCE SECTION CHIEF

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Monitor the utilization of financial assets and provide administrative support. Oversee the acquisition of supplies and services necessary to carry out the agency's medical mission. Supervise the documentation of expenditures relevant to the emergency incident.

Immediate Actions

- Receive appointment from the Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain briefing from Incident Commander.
- Organize you own team: (e.g., financial, administrative, other support services), and distribute work and functions (may be preestablished).
- Establish a Financial Section Operations Center. Ensure adequate documentation/ recording personnel.
- Be familiar with sources of funds (contingency funds, QRF funds, and other sources of emergency funds). Prepare petty cash in accordance to the magnitude of the incident.
- Establish a one-stop shop for the provision of support to responders including other requirements such as petty cash, transportation, fuel, food, communications, etc.
- Develop your own plan to support the operations.

Intermediate Actions

- Approve a "cost-to-date" incident financial status report every eight hours summarizing financial data relative to personnel, supplies and miscellaneous expenses. This can be adjusted to a daily report later or once a week as the incident is handled.
- Obtain briefings and updates from Incident Commander as appropriate. Relate pertinent financial status reports to concerned chiefs.
- Schedule planning meetings to discuss the updating of the section's incident action plan and termination procedures.

Extended Actions

- Ensure that all requests for personnel or supplies are copied to the HEMB in a timely manner for inclusion in regular reporting and for the final report.
- Document all financial cost of the operation. Ensure that all other facilities are properly provided with enough financial replenishment/support as available.
- Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.3.1 DOH HOSPITAL INCIDENT COMMANDER

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Provide overall direction and manage the event. Give overall guidelines for operations, and, if needed, authorize evacuation and request for support/help.

Immediate Actions

- Initiate the Incident Command System by assuming role of Incident Commander. Establish the Command Center or War Room where regular meetings will be conducted.
- Read this entire Job Action Sheet.
- Put on position identification vest.
- Appoint chiefs for the General Staff. Distribute the four section packets which contain:
  - Job Action Sheets for each position
  - Identification vests for each position
  - Forms pertinent to section and positions
- Appoint officers for Command Staff: Public Information Officer, Liaison Officer, and Safety and Security Officer. Distribute Job Action Sheets. (May be preestablished)
- Announce a status/action plan meeting of all Command and General Staff chiefs to be held within 5 to 10 minutes.
- Assign someone as documentation recorder/aide.
- Receive status report and discuss an initial action plan with Command and General Staff chiefs. Determine appropriate level of service during immediate aftermath with Operations Chief.
- Receive initial rapid health assessment reports with Planning Chief. Mandate the OpCen for timely, regular reporting
- Obtain inventory of available logistics at warehouses from Logistics Chief. Emphasize proactive actions with the Planning Section. Call for hospital-wide projection report for 4, 8, 24 and 48 hours from time of incident onset. Adjust projections as necessary.
- Make an assessment of vulnerable areas in the hospital based on the hazard or incident.
- Ensure that contact and resource information have been established with outside agencies through the Liaison Officer.

Intermediate Actions

- Authorize resources as needed or requested by Command and General Staff chiefs.
- Designate routine briefings with General Staff chiefs to receive status reports and update the action plan regarding its continuance and termination.
- Communicate status of preparation and response to higher levels, such as your superior and the Secretary of Health. Represent the agency in all coordinating meetings or send a representative.
- Consult with General Staff chiefs on needs for manpower, logistical requirements, and funds. Receive and accommodate volunteers or Foreign Medical Teams (FMTs) as deployed by the CO or RO.

Extended Actions

- Approve media releases submitted by PIO.
- Observe all staff, volunteers and patients for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.3.2 DOH HOSPITAL LIAISON OFFICER

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Function as incident contact person for representatives from other agencies.

Immediate Actions

- Receive appointment from Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain a briefing from Incident Commander.
- Establish contact with Operations Center, including its network and database of contact numbers. Obtain one or more aides as necessary from the Labor Pool.
- Review and orient yourself on existing members of the health sector, networks of hospitals, and other partners, including LGUs, to determine appropriate contacts. Coordinate with Public Information Officer.
- Obtain information regarding needs of the hospital and whether these could be sourced from other agencies/partners. The following information should be gathered for relay:
  - Any current or anticipated shortage of personnel, supplies, etc.
  - Any concerns regarding transportation requirements for delivering personnel and logistics to site.
  - Requirements in terms of lifelines, such as communication, electricity, water, toilets, blood, generators, etc.
  - Any resources that have to be purchased outside the country.
  - Any resources to support surge capacity especially with destroyed facilities such as field hospital, tents, etc.
- Establish contact with liaison counterparts of each assisting and cooperating agency. Attend coordination meetings at all levels.

Intermediate Actions

- Request assistance and information as needed through the network, health sector partners, and network of hospitals.
- Respond to requests and complaints from incident personnel regarding inter-organization problems.
- Prepare to assist the Labor Pool group with problems encountered in the volunteer credentialing process.

Extended Actions

- Assist in soliciting manpower from volunteer organizations, medical groups, etc. when appropriate.
- Inventory any material resources that may be sent upon official request, including method of transportation, if appropriate.
- Supply casualty data to the appropriate authorities in coordination with the PIO.
- Observe all staff, volunteers and patients for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.3.3 DOH HOSPITAL PUBLIC INFORMATION OFFICER

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Provide information to the media and the public. Ensure that all released information are timely and accurate.

Immediate Actions

- Receive appointment from Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Orient yourself on all data coming from all sources.
- Identify appropriate information relevant to the incident which need to be given to the public or the media.
- Identify restrictions in contents of news from IC; ensure protection of patient identity.
- May form your own team coming from HEPOs and other personnel.

Intermediate Actions

- Ensure that all news release have the approval of the Incident Commander and are consistent and coming only from one source.
- Issue an initial incident information report to the news media with the cooperation of the General Staff chiefs, Operations Center, etc.
- Establish a regular briefing of the media with the IC, more often during the first week, and declining in frequency as the incident progresses.
- Decide with the team on the information needed for public information and safety
- Develop a system of providing information to relatives of victims especially in case of Mass Casualty Incident.
- Inform media of the physical areas that they have access to and those that are restricted. Coordinate with the Safety and Security Officer.
- Inform Liaison Officer of the action.

Extended Actions

- Obtain progress reports from General Staff chiefs as appropriate.
- Notify media on a regular basis about important information, such as statistics on casualty status and response efforts being done by the hospital, including accomplishment reports, especially in managing victims.
- Direct calls from those who wish to volunteer to Personnel or assigned office. Discuss with Operations to determine requests to be made to the public via the media.
- Observe all staff, volunteers and patient for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.3.4 DOH HOSPITAL SAFETY AND SECURITY OFFICER

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Monitor and have authority over the safety of rescue operations and hazardous conditions. Organize and enforce scene/facility protection and security including traffic security inside the hospital.

Immediate Actions

- Receive appointment from Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain a briefing from Incident Commander.
- Implement the hospitals' disaster plan emergency lockdown policy and personnel identification policy. May form your own team such as engineers, safety personnel and security group.
- Establish Security Command Post.
- Remove unauthorized persons from prevent their entry in restricted areas, including the emergency room.
- Establish ambulance entry and exit route in coordination with security and transportation group.
- Secure the Operations and Command Center, triage, patient care, morgue and sensitive or strategic areas from unauthorized access.

Intermediate Actions

- Communicate with engineers or Damage Assessment Teams to secure and post non-entry signs around unsafe areas. Keep Safety and Security staff alert to identify and report all hazards and unsafe conditions to you.
- Secure areas evacuated to and from, to limit unauthorized personnel access.
- Initiate contact with fire and police agencies through the Liaison Officer, when necessary.
- Advise the Incident Commander and General Staff chiefs immediately of any unsafe, hazardous or security related conditions.
- Assist Labor Pool and Personnel with the credentialing/screening of volunteers. Prepare to manage large numbers of potential volunteers.
- Confer with Public Information Officer to establish areas for media personnel.
- Establish routine briefings with Incident Commander.
- Provide vehicular and pedestrian traffic control.
- Secure food, water, medical and blood resources.
- Instruct Safety and Security staff to document all actions and observations.
- Establish routine briefings with Safety and Security staff.

Extended Actions

- Observe all staff, volunteers and patient for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.3.5 DOH HOSPITAL OPERATIONS SECTION CHIEF

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Organize and direct aspects relating to the management of victims. Carry out directives of the Incident Commander in terms of reducing mortalities and morbidities inside the hospital.

Immediate Actions

- Receive appointment from the Incident Commander Obtain packet containing section's Job Action Sheets, identification vests and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain briefing from Incident Commander.
- Organize your team, which may include but need not be limited to the following: Medical Staff Director, Medical Care Director, Ancillary Services Director, and Human Services director. The composition will be adjusted based on the type of incident, its magnitude, and level of needed response.
- Brief all Operations team leaders on current situation and develop the section's initial action plan. Designate regular briefing schedule including reporting.
- Establish Operations Section Center in proximity to EOC.
- Be physically present at all times to conduct all meetings and planning with the group. Make timely decisions based on information at hand and strategize how to improve the response to handle the victims.
- Decide whether to request for additional teams coming other hospitals. This may be necessary during a mass casualty incident, or surge capacity, especially if some of the hospital personnel are themselves victims of the disaster. Do this in consultation with the IC.
- May tap the hospital networking in cases where transfer would be more beneficial to patients or for a higher level of service needed. (Only if available. But in the event that you are the only existing hospital, you will try to handle everything until the next option will be available.)

Intermediate Actions

- Designate times for briefings and update all Operations Team leaders to develop/ update section's action plan. It may be necessary to hold daily meetings during the first week.
- Anticipate needed resources and staff; coordinate with Logistics, Finance and Planning Heads during meetings. Tap the health sector and the national clusters to assist in the response.
- May receive teams in case of surge capacity.
- Brief the Emergency Incident Commander routinely on the status of the Operations Section and receive directions.

Extended Actions

- Ensure that all communications are copied to the Operations Center/HEMB. Document all actions and decisions.
- Observe all staff, volunteers and patients for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.3.6 DOH HOSPITAL PLANNING SECTION CHIEF

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Organize and direct all aspects of planning from an Initial Action Plan to a Continuing Plan as incident develops. Ensure the compilation and distribution of critical information/data. Compile scenario/resource projections from all General Staff chiefs and effect long-range planning.

Immediate Actions

- Receive appointment from the Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain briefing from Incident Commander.
- Recruit a documentation aide and team from the Labor Pool.
- Appoint Planning unit leaders: Situation-Status Unit Leader, Labor Pool Unit Leader, Medical Staff Unit Leader, and Nursing Unit Leader. (May be preestablished).
- Brief unit leaders after meeting with Incident Commander.
- Provide for a Planning/Information Center.
- Ensure that the whole team collects and analyzes all data and information gathered.
- Ensure the formulation and documentation of an incident-specific Action Plan. Discuss plan with Incident Commander and all General Staff chiefs.
- Call for projection reports (Action Plan) from all Planning Section unit leaders and General Staff chiefs for scenarios 4, 8, 24 and 48 hours from time of incident onset. Adjust time for receiving projection reports as necessary.
- Document/update status reports from all General Staff chiefs for use in decision-making and for reference in post-disaster evaluation and recovery assistance applications.

Intermediate Actions

- Obtain briefings and updates as appropriate. Continue to update the Action Plan.
- Regularly present an updated Action Plan to the Incident Commander and the General Staff chiefs for approval and implementation.

Extended Actions

- Continue to project and update Action Plan at appropriate intervals.
- May start drafting a Recovery and Reconstruction Plan if required, depending on the magnitude of the incident. For hospitals, this should include damages in the facilities, whether structural or non-structural, with corresponding approximate costs of the structure and equipment.
- Observe all staff, volunteers and patients for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

4.3.7 DOH HOSPITAL LOGISTICS SECTION CHIEF

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Oversee all logistical requirements needed to support response. Organize and direct those associated with maintenance of the physical environment and provision of adequate levels of food, shelter and supplies to support the medical objectives.

Immediate Actions

- Receive appointment from the Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests, and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain a briefing from Incident Commander.
- Organize your team and appoint Logistics Section unit leaders: Facilities Unit Leader, Communications Unit Leader, Transportation Unit Leader, Materials Supply Unit Leader, and Nutritional Supply Unit Leader. Distribute Job Action Sheets and vests. (May be preestablished).
- Brief team leaders on current situation. Outline action plan and designate time for regular briefing. Designate a one-stop shop for all procurements.
- Review all logistics available inside the hospital and the warehouse.
- Review database on suppliers and contacts (including forwarder arrangements) and identify where resources could be obtained or procured ASAP.
- Establish Logistics Section Center, preferably in proximity to the EOC.
- Attend meetings with Incident Commander and all members of the General Staff to anticipate logistical needs.

Intermediate Actions

- Obtain information and updates regularly.
- Communicate frequently with the Incident Commander and Operations Chief.
- Obtain needed supplies with the assistance of the Finance Section Chief.
- Have a tracking system for all logistics distributed and given. All patients provided with free logistics should be properly recorded in coordination with the Finance Committee.

Extended Actions

- Ensure that all communications regarding transmittal of logistics, including distribution lists, are copied to the Operations Center/HEMB.
- Document actions and decisions on a continual basis. Make an evaluation to serve as inputs for improvement of policy and development of guidelines.
- Observe all staff, volunteers and patients for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Submit a final report to be HEMB for inclusion in the final report.
- Other concerns.

4.3.8 DOH HOSPITAL FINANCE SECTION CHIEF

Position Assigned To: _____

You Report To: _____ (Incident Commander): _____

Command Center: _____ Contact No.: _____

Mission Monitor the utilization of financial assets and provide administrative support. Oversee the acquisition of supplies and services necessary to carry out the agency's medical mission. Supervise the documentation of expenditures relevant to the emergency incident.

Immediate Actions

- Receive appointment from the Incident Commander. Obtain packet containing section's Job Action Sheets, identification vests and forms.
- Read this entire Job Action Sheet and review organizational chart.
- Put on position identification vest.
- Obtain briefing from Incident Commander.
- Organize you own team: Procurement Unit Leader, Claims Unit Leader, and Cost Unit Leader; or financial, administrative, support services. Distribute work and functions (May be preestablished).
- Establish a Financial Section Operations Center. Ensure adequate documentation/ recording personnel.
- Be familiar with sources of funds (contingency funds, QRF funds, and other sources of emergency funds). Prepare petty cash depending on the magnitude of the incident.
- Establish a one-stop shop for the provision of support to responders including other requirements such as petty cash, transportation, fuel, food, communications, etc…
- Develop your own plan to support the operations.

Intermediate Actions

- Approve a "cost-to-date" incident financial status report every eight hours summarizing financial data relative to personnel, supplies and miscellaneous expenses. This can be adjusted to a daily report later or once a week as the incident is handled.
- Obtain briefings and updates from Incident Commander as appropriate. Relate pertinent financial status reports to concerned chiefs.
- Schedule planning meetings to discuss updating the section's incident action plan and termination procedures.

Extended Actions

- Ensure that all requests for personnel or supplies are copied to the HEMB in a timely manner for inclusion in regular reporting and the final report
- Document all financial cost of the operation. Ensure that all other facilities are properly provided with enough financial replenishment/support as available.
- Observe all staff, volunteers and patients for signs of stress and inappropriate behavior. Report concerns to Psychosocial Teams. Provide for staff rest periods and relief.
- Other concerns.

B. Operations Center

An Operations Center (OpCen) helps fulfill the requirements of the principles of emergency preparedness and emergency management. It ensures the continuous operation of an organization or agency in the midst of any emergency or disaster as it serves as the hub for command, control, communication and coordination in close coordination with the IC. In general, the OpCen aims to:

- Facilitate the collection and analysis of data in order to have accurate and reliable information as basis for making decisions and setting the overall direction of the response, prioritizing resources, and identifying and planning appropriate interventions to protect life and property.
- Disseminate information, early warning, and guidelines to all concerned implementing agencies and individuals as they mount up the response.
- Continue monitoring the development of the event/incident and the progress of the response in the affected areas, and inform the IC and other members of the chain of command accordingly;

The OpCen is expected to operate 24/7 and should continue to operate until the Recovery Phase, during which recovery and restoration plans are already being put into action.

1. General Guidelines

1.1 The OpCen at the DOH Central Office, being the overall coordinating center, shall operate 24/7, working closely with the Command Center or War Room in times of emergencies/ disaster.

1.2 Each OpCen established in the regional offices and DOH hospitals must operate 24/7. In areas where existing capability cannot operate 24/7, the OpCen must at least be activated on a Code Alert White.

1.3 The LGUs are highly encouraged to establish their own OpCen, especially those highly at risk to emergencies and disasters.

1.4 A strategically located alternate OpCen, a mirror-image of the DOH-CO OpCen, is to be established in Metro Manila, Luzon, Visayas and Mindanao;

1.5 OpCens may vary depending on their location and functions. Physically, an OpCen could be a fixed or non-fixed structure, and by function, it can serve as a facility for emergency operations or for coordinating.

1.6 Regardless of the type, all OpCens shall be adequately and properly equipped with the following in order to function and execute the desired response: (i) a dedicated space; (ii) appropriately trained staff; (iii) necessary equipment, supplies and materials; (iv) set of updated standard operating procedures; and (v) allocated amount to sustain operations. As much as possible, there must be more than adequate communication equipment and transportation facilities.

1.7 In major emergencies and disasters, an on-site OpCen serving the Health Sector Component can be established in coordination with LGUs that will direct the operations and manage the event.

1.8 All OpCens, to be effective and efficient, shall establish good communication and coordination with all concerned groups of stakeholders.

2. Specific Guidelines

2.1 Functions of the OpCen

a. Monitor all health and health-related events on a 24/7 basis, including all national and local events, mass gatherings, and international events with potential impact to a particular area or the country as a whole.
b. Monitor all DOH implementation and prepared response efforts to the activation of Code Alerts (White, Blue, Red, Orange).
c. Prepare timely reports as needed by the situation and properly disseminate these to all concerned units and agencies, e.g., heads of the health offices (Central Office, regional offices, LGUs), national, sub-national and local DRRMC, and other concerned offices.
d. Coordinate all health-related response efforts to major health emergencies and disasters.
e. Facilitate the issuance of appropriate warnings to all concerned health offices and facilities in anticipation of impending emergencies.
f. Coordinate and monitor the mobilization of technical experts and all types of medical teams needed in emergencies and disasters.
g. Coordinate and monitor the mobilization of all logistical requirements of the DOH needed in the affected region.
h. Deploy Emergency Officers to report for duty at the appropriate Disaster Response Management Operations Center if the Red Alert status is activated and serve as the liaison with their OpCen (e.g., OCD offices at national and regional levels, LGU Command Centers, etc.).
i. Ensure that communication equipment (e.g., radio, mobile phones) are always available, functional and ready for use in emergencies and disasters.
j. Utilize various information and communication technologies (ICT) in the dissemination of early warning and other appropriate information to stakeholders and the public.
k. Address public queries appropriately and serve as the hotline as the need arises.
l. Document all health emergencies and disasters and ensure proper storage and filing of all important documents.

2.2 Types of OpCen

2.2.1 By Function

a. ***Emergency Coordinating Center (ECC).*** This is usually a fixed structure established at the national level, complete with all the necessary requirements needed in any coordinating/operations center, operating 24/7 to monitor the occurrence of any event. This can transition to an OpCen once an emergency

or disaster has occurred.

b. ***Emergency Operations Center (EOC).*** This refers to operations centers that serve as a coordination, communication, command and control facility when there is an emergency or disaster. This can be established at the national level but it is more relevant at the regional and local levels. Most often, an EOC is established on-site where the emergency or disaster happens. Hence, there can be more than one EOC established at any given time. Its main functions include: (i) collect, gather and analyze data; (ii) disseminate data to concerned decision-makers or IC; and (iii) coordinate all actions related to the response.

2.2.2 By Physical Location

a. ***Fixed Operations Center.*** This refers to an operations center that is structurally and strategically located in a pre-identified area to provide command, control and coordination during emergencies and disasters.

b. ***Non-fixed Operations Center.*** This refers to an operations center that is built or used when there is a break in the usual cycle of operation and there is an utmost need to activate the place as an operations center in order to provide command, control and coordination. Examples of these are: (i) Advance Command Post; (ii) Mobile Operations Center; and (iii) Emergency Operations Center.

2.3 Elements of an OpCen

For an OpCen to function to its full capacity, it has to have certain general attributes of space, staff and stuff. The following should be considered in identifying and setting up an Operations Center:

2.3.1 Physical Structure - Space

a. Safety from hazards and ease of security
b. Adequate electrical, water and sewage systems
c. Sufficient space for all functions with a mix of open and closed work spaces:
    i. Secure storage area
    ii. Secure space for staging materials and human resources pending for deployment (optional)
    iii. Open work space for management, operations, logistics and planning functions
    iv. Closed work space available for teleconferences, breakout groups, and policy group meetings (can be located in nearby rooms)
    v. Controllable space for media briefings (nearby or off-site)
    vi. Staff rest area with food preparation, storage, cleanup and eating areas
d. Adequate wall space for big whiteboards or equivalent

e. Adequate lighting, ventilation, heating and cooling capacity
f. Toilet/personal hygiene area
g. Appropriate location:
    i. Accessible by public transportation
    ii. Reasonably close to partners, supporting and cooperating agencies
    iii. Has adequate parking
    iv. Access to all entrances, exits, and windows easily secured

2.3.2 Staff Complement

a. The number of staff that will man/run the OpCen depends on the Code Alert level. Ideally, an OpCen should be manned daily by at least two staff as Emergency Officers-on-Duty (EOD) with the presence of a supervisor. The following are the duties and responsibilities of these staff.

Table 3. Duties and Responsibilities of Emergency Officers-on-Duty

Duties/ Responsibilities	Emergency Officer-on-Duty 1	Emergency Officer-on-Duty 2
Upon assumption of duty	• Receive endorsements from the outgoing EODs and lead in the endorsement to incoming EODs. • Get oriented on what transpired in the past few days. • Review the following: ↘ Endorsement logbook ↘ Previous HEARS Plus • Know the DOH officers-on-duty during weekends and holidays. • Be aware of the stock level of the logistical supply of the office. • Answer/log incoming and outgoing telephone and cell phone calls, and radio and text messages. • Answer all calls coming from superiors and important persons. • Answer inquiries from the public and refer accordingly when necessary. • Decide on all issues in coordination with EOD2 or with superiors if necessary. • Refer matters that need the attention or action of the Division Chief or designate. • Review the completeness of the reports prepared by the EOD2. • Report and document any problems encountered during the tour of duty to the Division Chief or designate. • Personally have the HEARS signed by the Director or designate and answer any inquiries on the HEARS.	• Together with the EOD 1, receive endorsements from the outgoing EODs. • Review the endorsement logbook and previous HEARS on what have transpired during the past few days. • Know the DOH officers-on-duty during weekends and holidays. • Answer/log incoming and outgoing telephone and cell phone calls and radio messages. • Answer inquiries from the public and refer to superior accordingly when necessary. • Relay information/matters that need immediate action to the EOD1. • Perform functions in close coordination with the EOD1.

Monitoring of the following	• Reports coming from UHF/VHF radio • Telephone calls requiring DOH intervention • Emergencies and disasters by personally calling regions, hospitals and other agencies affected • Internet reports related to health from local as well as international sources • OCD website, GMA, ABS-CBN and other TV and radio network websites	• Radio • Television • News/print media • Status of communication by conducting daily radio checks, referring any radio communication
Reporting/ Documentation	• Report to Division Chief at 6:00 am and 6:00 pm and to the Director at 8:00 am and 8:00 pm, with or without monitored events. • In coordination with EOD2 , prepare the following reports: Flash Reports, HEARS, Typhoon Alerts • Review, analyze and evaluate, for 24 hours, rapid assessment reports, followup reports, delayed reports, and reports on other reportable events. • Determine necessary data to be incorporated into all reports; verify reports if needed. • Ensure proper documentation of all reportable events, including the updating of the monthly monitoring board.	• Report to EOD1 on the incidents he/she had monitored. • Prepare the following reports for review by EOD1 for its completeness and veracity: ↘ Daily HEARS Plus ↘ Flash Report ↘ Memorandum, etc. • File and update documents and data. • Make detailed documentation of all reportable events. • Put detailed important information on the white board on all ongoing operations.
Coordination/ Dispatching	• Be responsible for coordinating with the following ↘ DOH Central Office ↘ DOH implementing arms: regions and hospitals ↘ Field Medical Commander in case of Mass Casualty Incidents ↘ Other members of DRRMC family ↘ Private hospitals regarding status of patients, including needs/concerns ↘ Other GOs, NGOs, private organizations, etc. • For Metro Manila, lead in the dispatching of teams for MCI to the site in coordination with the Medical Controller or Division Chief; for regions, lead in the dispatching of rapid assessments teams.	• Assist the EOD 1 in contacting agencies and facilities. • Update database of important facilities and organizations. • Get continuous updates until final report is submitted.

Administrative duties	• Be responsible for other administrative concerns after office hours, during weekends and holidays, such as: ↘ Signing of trip tickets for urgent/official trips ↘ Approval of the Requisition and Issue Request of drugs/medicines and other medical supplies ↘ Preparing Department Personnel Orders (DPOs) of teams dispatched • Perform other duties stated in the endorsement checklist.	• Be responsible for faxing reports, memorandums, etc. to concerned agencies, and documenting these. • Check/record cell phone account balance and incoming text messages. • Follow up status of the following: ↘ Department Order ↘ Memorandum • Update report, etc. • Encode PLDT bills • Prepare Request and Issuance Slip (RIS) • Prepare daily accomplishment report.
Other duties	• Ensure proper decorum in the office after office hours and during weekends and holidays. • Recommend raising and lifting of Code Alert.	• Ensure orderliness/ cleanliness of the OpCen. • Perform other errands assigned by the EOD1 in relation to office work. • Conduct Internet researches.

b. However, the staff in terms of number and composition changes as the Code Alert is raised. The following is the recommended staff complement according to Code Alert level:

Table 4. Recommended OpCen Staff Complement by Code Alert Level

Code Alert	Staff Complement
WHITE	At least 2 staff with a supervisor; driver and security guard to assist, with 2 relievers on standby
BLUE	3 teams with supervisors with each team composed of 4 emergency officers–on-duty for 24 hours rotated every 3 days, with a driver/security guard to assist. Incoming team on standby.
RED	A team comprising the following and is on duty for 24 hours, rotated every other 3-4 days and is relieved by the next team with the same composition. • Team leader/assistant team leader • Data encoder/collector (SPEED) • Logistics EOD • Communications EOD (in charge of line list) • Team Mobilization EOD • Driver/security guard to assist • Administrative officer
ORANGE	A team comprising the following and is on duty for 24 hours, rotated every other 3-4 days and is relieved by the next team with the same composition. • Team leader/assistant team leader • Data encoder/collector (SPEED) • Logistics EOD • Communications EOD (in charge of line list) • Team Mobilization EOD • Driver/security guard to assist • Administrative officer

An emergency officer-on-duty must have the following knowledge, attitude and skills:

i. Knowledge
   - Aware of the organizational setup and existing resources of the office or agency
   - Aware of the existing policies, guidelines, protocols and procedures in relation to response to emergencies and disasters
   - Familiar with partner agencies and proper communication with appropriate offices in times of emergencies and disasters

ii. Attitude
   - A team player
   - Can handle and cope with stress
   - Resourceful

iii. Skills
   - Can operate necessary communication equipment such as radio (base and handheld), telephone, cell phone, broadband global access network
   - Computer-literate
   - Good networking skills
   - Decision-making skills

c. Tasking of OpCen Staff (depending on Code Alert level)

The following table outlines the specific personnel assigned in the OpCen by Code Alert Level and enumerates the tasks of each personnel assigned.

Table 5. Tasks of OpCen Personnel by Code Alert Level

Code Alert White	Code Alert Blue	Code Alert Red or Orange
Supervisor • Oversee the completion of tasks of the EOD. • Review, analyze, and correct as needed the outputs of the EODs. • Provide assistance in decision-making for matters concerning the Operations Center. • Report to the division chief/ head of office any issue that needs immediate attention and action. • Perform other relevant tasks as may be requested.	**EOD 1** • Act as supervisor and oversee the entire operation. • Coordinate with the regional office and other partners • Analyze and synthesize all incoming and outgoing communication together with the whole team. • Be responsible for the final HEARS report. • Elevate all issues and concerns and make recommendations. • Report to division chief and head of office.	**Note:** • In CODE ORANGE, the functions of the staff remain the same as under Code Red Alert but the number of staff increases as other members may be pulled out from other offices. The composition of the team includes: team leader, assistant team leader, 2-3 data collectors/encoders, 2-3 Logistics members and 2-3 Communications staff

EOD 1 • Receive endorsements from the outgoing EODs and lead in the endorsement to incoming EODs. • Monitor reports coming from all forms of media and ensure proper documentation of all reportable events. • Report to the Division Chief and Head of Office daily with or without monitored events. • In coordination with EOD2, prepare the following reports: Flash Reports, HEARS, Alert Memo. • Coordinate with DOH Central Office, regional offices, hospitals, other members of NDRRMC family, and partners. • During team mobilization, dispatch teams for MCI to the site in coordination with the Division Chief; for regions, lead in the dispatching of rapid assessment teams. • Perform other administrative concerns after officer hours, during weekends and holidays, such as signing trip tickets for urgent/official trips, and approving the requisition and issue of drugs and medicines.	**EOD 2** • Together with EOD1, evaluate all incoming information (e.g., text messages, fax, email) and decide together with the team what should be included in the HEARS report. • Monitor SPEED website and do some initial analysis. Coordinate with affected regions especially those with non-validated reports. Consult and coordinated with SPEED team what should be included in HEARS.	**Team Leader** • Assume the role of OpCen supervisor. • Oversee the entire operation of OpCen and ensure that the contingency backup plans are put into action if considered necessary. • Manage issues and concerns relative to the disaster and refer matters to the Head of Office with recommendations for possible actions. • Coordinate the mobilization of technical experts and all types of emergency teams to respond to emergencies and disasters. • Oversee the logistical requirement of DOH needed in the affected regions. • Coordinate directly with ROs, DOH hospitals, and other members of the health sector concerning the protocols and details of operations. • Update the division chiefs and the Head of Office on operations status and concerns. • Prepare an endorsement to the team leader of the incoming duty group.
EOD 2 • Monitor reports coming from all forms of media. • Be responsible for all communications through radio bases. • Report to EOD1 all incidents monitored. • Prepare the following reports for review by EOD1 for its completeness and veracity: Daily HEARS Plus, Flash Report, Alert Memorandum, etc. • File and update documents and data. • Assist EOD1 in contacting agencies and facilities. • Be responsible for all other admin matters, such as faxing documents, and checking cell phones and emails • Perform other errands assigned by EOD in relation to office work	**EOD 3** • Be responsible for the Logistics component of the operation. • Ensure that all logistical support to the affected areas are included in the report. This will cover the following: DOH logistical mobilization from Central Office, HEMB and other programs; Regional Office's support to LGUs; and other regional offices mobilizing logistics to the affected regions. Donations will have a separate table. • Monitor teams and other human resources mobilized to support the affected LGU; medical teams separate from technical team.	**Assistant Team Leader** • Assume the role of the Information Management and Report Supervisor • Oversee and manage reports received • Analyse and interpret all reported data and ensures the validity as well as the accuracy of reports received • Develop a Health Situation Report of the event duly approved by the Team Leader for the Division Chiefs and Head of Office to be disseminated to all concerned offices and agencies • Develop a power point presentation of the event for the use of the Division Chief or Office Head as needed • Perform additional duties as may be required by the Team Leader

	EOD 4 • Ensure that all mortalities and morbidities reported (NDRRMC, media, etc.) are conveyed to the regions and validated. Before reporting to NDRRMC as validated this should be discussed and approved by the team. • Monitor events and perform other administrative work, such as updating the whiteboard, logging the text messages received, etc. • Perform any other assignment that will be given by the EOD1.	**Data Collector/ Encoder** • Gather, consolidate and encode needed data for proper reporting and recording, including SPEED. • Make initial analysis of reports and refer to the Information Management and Report Supervisor. • Check the veracity of the reports received and compare with other pertinent data. • Prepare reports using appropriate tools/forms or as instructed by the Information Management and Report Supervisor.
		Logistics Staff • Conduct the annual inventory and regularly update inventory reports of available supplies in the warehouse as frequently as needed. • Coordinate with the Material Management Division (MMD) at the Central Office and NDRRMC regarding the mobilization of drugs, medicines, medical supplies, etc. • Prepare logistics reports for all concerned. • Monitor the transfers of logistics to affected regions. • Manage donations coming from international and local donors. • Coordinate with the Bureau of International Health Cooperation (BIHC) and MMD regarding the acceptance and processing of donations.
		Communications Staff • Monitor all radio transceiver and telephone/cellular phone operations; log incoming and outgoing communications. • Handle communication function problems. • Screen/observe legitimacy of reports coming from UHF/VHF radio. • Be in charge of verifying the list of casualties to the Regional Office and submitting the completed tally to NDRRMC.

		Administrative Staff • Augment or support all personnel assigned in different work areas. • Collect additional data needed to support monitoring of other implementing events. • Be In charge of all administrative work, such as management of the food allowance and the like.
		Drivers • Act as administrative support. • Schedule and organize trips based on priority. • Ensure the maintenance and condition of the available vehicle and facilitate requests as necessary. • Transport resources, supplies and personnel if needed. • Prepare incident reports as necessary.

2.3.3 Equipment and Supplies - Stuff

The OpCen must be equipped with the following:

a. Physical Facilities. Refer to the work station for the staff, pantry and preferably also sleeping quarters.

b. General Office and Communication Equipment. Refer to telephone, mobile phone, fax machine, TV set, AM/FM transistor radio, computer with printer and internet connection, tables and chairs, generator set, and office supplies.

c. Reference materials. Refer to policies, guidelines, procedures, plans, directories, forms, maps, inventories, maps, health facility data base, and other information resources.

d. Transport Facility. Refers to access to vehicles for movement of logistics.

Table 6. List of Physical Facilities, Equipment and Materials in the OpCen

Type	Specific Items	
Physical Facilities	• Monitoring station • Communication area • Work station • Conference room	• Quarters • Sanitary and lodging area • Storage room • Pantry
Communication Equipment	• Landline • Cell phone • Base radio • Handheld radio • Fax machine • Satellite phone	• LCD television • Computer (desktop, laptop) • Printer • Xerox machine • Scanner • LCD projector
Operations Equipment	• Wall clock • Conference table and chairs • Book shelves and cabinets	• Air conditioning unit • Electric fan • Generator
Office Supplies	• White board • Bulletin boards • Cork boards • Cassette recorder • Extension cords • Stamps • Staplers • Staple remover • Scissors • Pushpins • Paper clips • Masking tape • Scotch tape	• Fastener • Flashlights/emergency light • Logbook • Copy paper • Cartolina • Manila paper • Whiteboard marker • Ballpen • White board eraser • Puncher • Laminating machine • File binder • File system box
Food Service	• Hot beverage containers, cups, bowls • Food preparation/serving equipment • Food storage • Stove	• Refrigerator/freezer • Dishwashing supplies • Pitchers, glasses or paper cups • Garbage bins • Water dispenser
Sanitary and Lodging	• Toiletries • First aid kit • Linens and beddings • Cot beds	
Reference Materials	• Checklist (standard operating procedures/guidelines) • EOC Contingency Plan • Local area, regional and national Maps • Updated directory • Emergency and contingency plans • Resource inventory	

3. How to Activate and Run the OpCen

Table 7. Steps/Tasks in Activating the OpCen Pre- During- Post Impact

Pre-Impact (A day or days before)	During Impact (0 hour to 48 hours)	Post-Impact (After 48 hours and onwards)
• Activate or continue operation 24/7. • Identify needed staff based on the Code Alert level. • Ensure that all staff are oriented as to their tasks based on the OpCen Manual guideline. • Ensure availability of all communication lines and other lifelines. • Support the Command Center and the IC if activated. • Continue monitoring (24/7) quad media, social networks, all agencies of the government, and all other reliable sources. • Analyze data and prepare reports as needed. • Provide Flash Reports if necessary. • Send Alert Memos to regions, hospitals and LGUS. • Monitor preparedness done (OpCen activation, Code Alert levels, ready teams, OpCen staff availability, logistics prepositioned or standby, etc.) by all implementing facilities. • Coordinate with disaster offices (NDRRMC/RDRRMC/ PDRRMC/ CDRRMC) partners, and cluster members for information and available resources. • Coordinate with Logistics section for all available resources. • Answer queries from the public and provide necessary health advisories. • Prepare timely and updated reports and Power Point presentations that might be needed by higher authorities. • Report to superiors regularly.	• Continue monitoring 24/7. • Recommend elevation, downgrading or lifting of alert codes anytime during the entire operation. • Adjust staffing based on the code. • Record/update all reports from all implementing offices and include in the daily reports. • Coordinate with the field offices for important data needed (deaths, logistics, accomplishments, status of health facilities, drugs and medicines, etc.) and as required by OCD. • Coordinate for RHA reports. • Coordinate with appropriate DRRMCs for updated reports from other sectors. • Receive requests for augmentation of logistics and/or team and submit to operations or offices assigned for team deployment. • Continuously report to superiors and manage the preparation of reports and documentation.	• Continue monitoring (24/7) all response efforts for reporting purposes and documentation. • Ensure that all aspects of operations in the OpCen are adequate and sufficient (staff, communications and fuel, food, rest etc.) • Continue preparation of Power Point presentation and other reports needed for evaluation, submission to higher authorities and relevant offices. • Continue providing support to the Command Center and the IC. • Monitor and track logistical mobilization and deployment of teams. • Continue processing requested logistics by affected areas. • Continue coordination with appropriate bureaus/offices for requests pertaining to their respective mandates. • Determine and send representatives to Operations Centers of OCD and affected areas. • Assist in the preparation of the Recovery and Rehabilitation Plan by providing needed reports.

C. Coordination

Coordination is the process during which the different autonomous entities come together to deliberate on certain agenda to achieve an agreement or a common result. In any health or health-related emergency or disaster, coordination is needed to ensure a systematic, timely, comprehensive and effective health sector response. The desired level of coordination in a health or health-related emergency or disaster is when health partners are convened to discuss issues and information collected, decide what actions to take, mandate and assign responsibilities to appropriate offices/units, establish follow-up mechanisms, assess and evaluate, and make the necessary adjustments. In particular, coordination aims to:

- Ensure the timely collection, reporting and sharing of information among all concerned partners to help involve organizations and people to work harmoniously with minimal friction and wasting of resources.
- Guarantee the systematic acquisition, mobilization, deployment and application of human and logistical resources necessary to meet the requirement of the threat or impact of an emergency or disaster.
- Establish the direction and the points of command, control and communication during emergency and disaster response and ensure that these are observed and sustained throughout.

Strong coordination among partners is achieved when the process has been established long before any event/incident. This means that the list of potential partners has been contacted and oriented, and meetings with them have already started and are regularly undertaken. The impact of coordination on emergency management is of great concern throughout the duration of the emergency or disaster, but is particularly critical during the initial phase of the disaster response. The lack of communication hampers the flow of information and causes a delay in response activities. These result in slow, inefficient and ineffective response with duplication of services, wastage of resources, unsolved gaps, and failure to address needs.

1. General Guidelines

1.1 In any health or health-related emergency or disaster, coordination must be clearly defined and established at all levels: within the DOH family at the Central Office, at the regional level, in the retained hospitals, in the local health offices, and among health offices across levels.

1.2 The DOH, however, cannot mount the response alone. External coordination with multi-sectoral groups must be established. Among the immediate and essential entities to coordinate with are: the N/R/LDRRMC, the LGUs, other private groups and organizations, and the international community.

1.3 Coordination is a continuing process. It begins even prior to the occurrence of the event and shall continue until the rehabilitation period.

1.4 The major points or areas for coordination among the different entities involved during

any emergency or disaster are in: (i) collection and sharing of data and sharing of vital information among the key decision-makers and key players; (ii) mobilizing, transporting, monitoring and sharing of logistics; (iii) mobilization, sharing, deployment and monitoring of teams.; and (iv) discussion of operational issues and concerns.

1.5 These points and purposes of coordination among concerned parties must be clearly defined and established. Expected inputs and outputs during coordination must be specified and the process to be followed concretely outlined and understood by those concerned.

1.6 A well-established and functioning coordination necessitates explicitly mandated and authorized officials, clear communication lines, and well-defined roles and functions of each involved party.

1.7 The agencies or entities involved in the coordination depend largely on the type of emergency or disaster. Designated response coordinators must therefore be familiar with the different agencies to be tapped and mobilized to facilitate the coordination of the response.

2. Specific Guidelines

2.1 Purpose of Coordination

It must be realized that the overall purpose of coordination is to come up with a systematic, comprehensive and effective response to any health or health-related emergency or disaster. Specifically, coordination aims to:

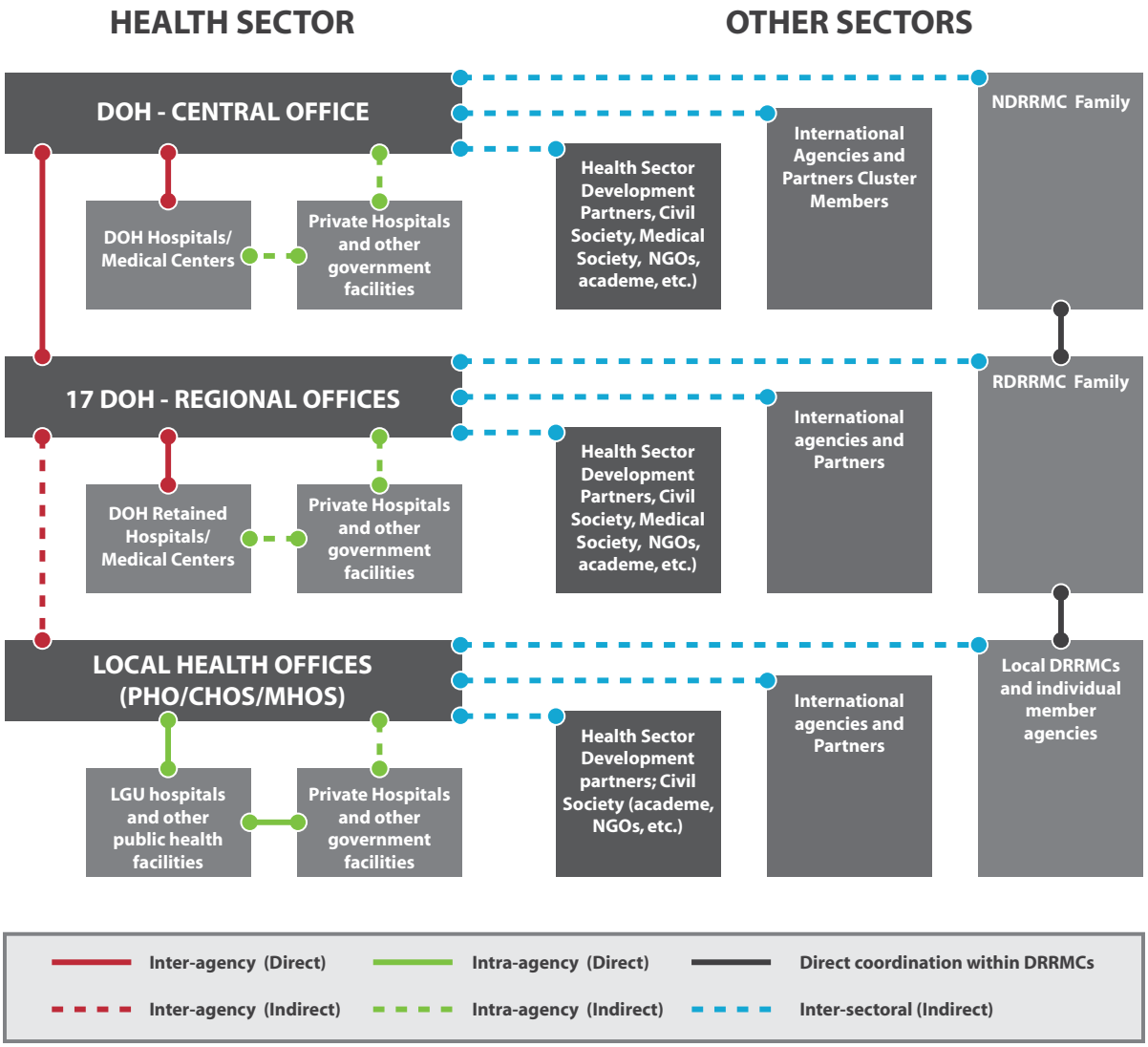
a. Monitor all health and health-related events on a 24/7 basis, including all national and local events, mass gatherings, and international events with potential impact to a particular area or the country as a whole.
b. Guide decision-makers in identifying appropriate intervention measures and facilitate the implementation of these measures and the delivery of services at various levels.
c. Ascertain the timely mobilization, proper prioritization and maximum utilization of resources, and minimization of wastage.

2.2 Levels of Coordination

a. Coordination must be established at each level: national, regional, local and hospital levels.
b. Intra-agency coordination within the DOH family (CO, ROs and hospitals) must be strengthened and the different offices/units mandated to take part in the response.
c. Inter-agency coordination of DOH with other concerned agencies and groups of stakeholders within the health sector where DOH is a member, likewise, must be established..
d. Inter-sectoral coordination, which is between the health sector where DOH is the lead and other sectors, must also be strengthened.

The following illustrates the levels of coordination and the major entities/stakeholder groups to be part of the coordination.

Figure 8. Inter-Intra Agency and Inter-Sectoral Coordination



2.3 Points/Areas of Coordination

There are basically four concerns that must be properly coordinated during any emergency or disaster. These include: (i) data collection and information sharing; (ii) team mobilization, deployment and sharing; (iii) logistics mobilization, transport, allocation and utilization; and (iv) addressing issues and concerns on other aspects of the response.

a. ***Coordinating Data Collection and Information-Sharing.*** The purpose of coordination relative to information deals with the timely submission of data and reports, ensuring that these are verified and validated, that necessary information are reported and shared to the right entities in a timely manner, and decisions and actions are undertaken.

b. ***Coordination for Team Mobilization.*** During the response phase, various teams are identified and mobilized to provide services and support to disaster-stricken areas. Deployment of these teams will be based on the results of the Rapid Health Assessments done by the region/s affected or on the judgment of the authorities. The magnitude and severity of the damages incurred in the disaster greatly affect the number of teams deployed. Team mobilization must be coordinated not only during emergencies and disasters but also during national and special events (e.g., Black Nazarene, Independence Day celebration, State of the Nation Address, etc.).

c. ***Coordination for Logistics Mobilization.*** Mobilization of logistics is a vital response of the department that will help decrease mortalities and morbidities during major emergencies and disasters. Thus, coordination with the concerned parties is important to be able to provide the right logistics at the right place and time in order to maximize resources and prevent wastage.

d. ***Coordination for Other Operational Issues and Concerns.*** The purpose of coordination goes beyond concerns regarding information sharing, logistics mobilization, and team mobilization. In managing the event, a lot more matters and issues need to be discussed and decided upon by those in the ICS chain of command. As mentioned earlier, the desired level of coordination is when the concerned offices/agencies are meeting and arriving at a decision or consensus to be able to mount the most-needed response to any emergency or disaster. These issues may relate but not be limited to the following:

- Identification and planning of alternative measures where the standard interventions may no longer be working or adequate enough
- Review and approval of proposed or recommended response actions that may run contrary to existing policies and guidelines of DOH programs (e.g., acceptance of milk donations, accepting donations from tobacco corporations)
- Assigning replacements to formerly designated officials/staff in the chain of command
- Actions or measures that may require political negotiations or security clearances or approvals
- Releasing sensitive information that may jeopardize the response

2.4 Offices/Agencies to Coordinate with During Emergencies and Disasters

Proper coordination requires appropriate referral and transaction with the agencies concerned with the emergency and disaster. Thus, HEMB/HEMS units at all levels should be knowledgeable about the proper offices/agencies to coordinate with depending on the type of hazard encountered.

Table 8. Summary of Agencies to Coordinate With by Type of Hazard

Hazard	Intra-Agency Level	Inter-Agency Level
Natural	• Health Facility and Development Bureau (HFDB) • Regional Offices • DOH-Retained Hospitals • Clusters (Health, WASH, Nutrition, MHPSS)	• NDRRMC Council Members ↘ OCD ↘ PHIVOLCS ↘ MMDA ↘ PAGASA ↘ PRC
Biological	• National Epidemiology Center (NEC) • Disease Prevention and Control Bureau (DPCB) Environmental and Occupational Health Office • Health Promotion and Communication Services (HPCS) • Regional Offices • DOH-Retained Hospitals	• OCD • Bureau of Fire (BFP) • Bureau of Fisheries and Aquatic Resources (BFAR)
Technological	• DPCB Environmental and Occupational Health Office • Regional Offices • DOH-Retained Hospitals	• BFP • Philippine Coast Guard (PCG) • Department of Environment and Natural Resources (DENR)
Societal	• Regional Offices • DOH-Retained Hospitals	• Philippine National Police (PNP) Health Service • Department of National Defense (DND)/Armed Forces of the Philippines (AFP) • MMDA • LGU Health Department
Special Event	• Bureau of International Health Cooperation (BIHC) • NEC	• Philippine Red Cross (PRC) • PNP Health Services • AFP • PHIVOLCS • PAGASA • BFAR • Philippine Nuclear Research Institute (PNRI)

3. Coordination Steps/Tasks During an Emergency or Disaster

The following summarizes the steps in operationalizing the coordination during disaster.

Table 9. Steps/Tasks in Operationalizing Coordination Pre- During- Post Impact

Levels of Coordination	Pre-Impact (A day or days before)	During Impact (0 hour to 48 hours)	Post-Impact (After 48 hours and onwards)
Intra-Agency (within DOH at all levels)	• Disseminate code alert level. • Activate OpCen. • Position standby team. • Preposition logistics. • Determine available buffer stock.	• Determine extent of damages. • Monitor status of health facilities. • Deploy additional team of responders.	• Determine status of damaged/ rehabilitated health facilities. • Monitor status of health services provided. • Provide logistics. • Mobilize teams. • Perform SPEED.
Inter-Agency (DOH with health sector)	• Ensure available logistics in local health offices, development partners. • Obtain list of contact persons and contact numbers.	• Mobilize FMTs with DFA. • Mobilize local volunteers with NGOs, other groups.	• Monitor status of health services provided. • Mobilize teams
Inter-Sectoral (between DOH and non-health sectors)	• Determine path, estimated speed, volume, landfall of typhoon with PAGASA. • Ensure availability and schedule of transport to areas.	• Ensure logistics augmentation with assistance from OCD (C130) especially transport and communication facilities.	• Ensure logistics augmentation with assistance from OCD (C130). • Assess damaged lifelines (roads and bridges, airports, seaports, etc.)

D. Early Warning Alert Response System

Most emergencies and disasters are unpredictable, but they are not totally unexpected. While some events that trigger disasters may occur without warning, some can be expected several hours before they happen. For the latter, there are Early Warning Alert Response Systems (EWARS) in the country with which to alert the public about oncoming events, like typhoon signal, NOAH and GALE warning, volcanic alert, tsunami alert, etc. Examples of EWARS in the DOH include the following:

- Alert Memo
- Short messageing service
- Integrated Code Alert System
- Surveillance Post Extreme Emergencies and Disasters (SPEED)

An EWARS is needed to forewarn everyone concerned about an impending emergency or disaster and the progress of the magnitude of the event. It is important that:

- Every concerned office/agency must be aware of the EWARS schemes, and ensure that

these are disseminated and observed

- Each early warning system is applied.
- Once the alert is activated, every concerned agency/office must implement, observe and disseminate the alert system.

D.1. ALERT MEMO

This memorandum is prepared to ensure timely and accurate early warning dissemination by the DOH-CO to the ROs and DOH Hospitals or by the ROs to the LGUs covered to ensure appropriate preparedness and response. It encloses information that warns the public on certain hazards that may lead to problems concerning health. The conditions for issuing an Alert Memorandum in the Philippines include but are not limited to the following: (i) any weather disturbance monitored; (ii) alert on possible paralytic poisoning; (iii) tsunami warning; (iv) volcanic activity, and others.

Table 10. Frequency and Intended Recipients of Alert Memo

Frequency of Reporting	Intended Recipient
• For tsunami and volcanic activities, provide alert memo upon monitoring of the event. • For weather disturbances, provide alert memo whether the weather disturbance is inside or outside the Philippine Area of Responsibility. • Another alert memo will be done subsequently once an escalation of the monitored weather disturbance occurs. Sending of alert memo may be through e-mail or fax.	• RO Directors/Chiefs of Hospitals • RHEMS/PHEMS Coordinators • RO Directors/Chiefs of Hospitals

D.2. SMS REPORTING

This is applicable to DOH officials and managers who own a mobile connected to a specific network. This process of reporting makes use of Short Message Service (SMS), electronic mail (email), and paper-based form. It is prepared and presented to convey information related to an incident monitored at regular intervals. This method of reporting is commonly used in giving situational reports and updates to the Head of Office and or designate.

Table 11. Frequency and Intended Recipient of SMS Report

Frequency of Reporting	Intended Recipient
• SMS reporting starts upon awareness of a big event and continues until the event is under control. Frequency of reporting varies depending on the progress of the event monitored.	• Any user of the identified network who is included in the list of SMS recipients of HEMB-OpCen

D.3. SURVEILLANCE IN POST-EXTREME EMERGENCIES AND DISASTERS

Surveillance in Post-Extreme Emergencies and Disasters (SPEED) is an early warning disease surveillance system activated only post-disaster or during extreme emergencies and deactivated once the disaster or emergency is over. The SPEED is designed primarily to: (i) detect early any unusual increase of communicable and non-communicable conditions related to emergencies and disasters; (ii) monitor health trends for appropriate public health action; and (iii) enable identification of appropriate response to handle the emergency. This is a tool by health emergency managers for decision-making in disaster response. It monitors 21 health conditions on a daily basis using SMS or the Internet. It has a special feature of "alert" messaging so that diseases with outbreak potential can be sent to identified and authorized personnel real-time. Likewise, report generation is automated to facilitate rapid response.

D.3.1 Guidelines in Implementing SPEED

D.3.1.1 Composition and Functions of the SPEED Team at the National and Regional Levels Pre-Impact, During and Post-Impact

SPEED Teams are organized to undertake surveillance in post extreme emergencies and disasters at the national, regional and provincial levels. Table 12 specifies the tasks to be done by the SPEED Team before, during and after impact.

Table 12. Composition and Tasks of SPEED Team at the National and Regional and Local Levels

Pre- During- Post Impact

Responsible Person	Pre-Impact (A day or days before)	During Impact (0 hour to 48 hours)	Post-Impact (After 48 hours and onwards)
Composition and Tasks of SPEED Team at the National and Regional Levels			
SPEED Point Person	• SPEED Point Person • SPEED System Administrator • SPEED Help Desk	• Recommend SPEED activation. • Recommend priority reporting facilities. • Recommend START deployment.	• Supervise OpCen in generating SPEED data. • Do SPEED analysis and reporting. • Oversee START operations once activated.
SPEED System Administrator	• Check functionality of IT system. • Check and update facility codes. • Provide user's name and log-in names. • Do troubleshooting	• Check functionality of IT system. • Check and update facility codes. • Provide user's name and log-in names. • Do troubleshooting.	• Check functionality of IT system. • Check and update facility codes. • Provide user's name and log-in names. • Do troubleshooting.
SPEED Help Desk	• Ensure availability of FAQ references.		• Answer queries. • Monitor data flow. • Do preliminary analysis.

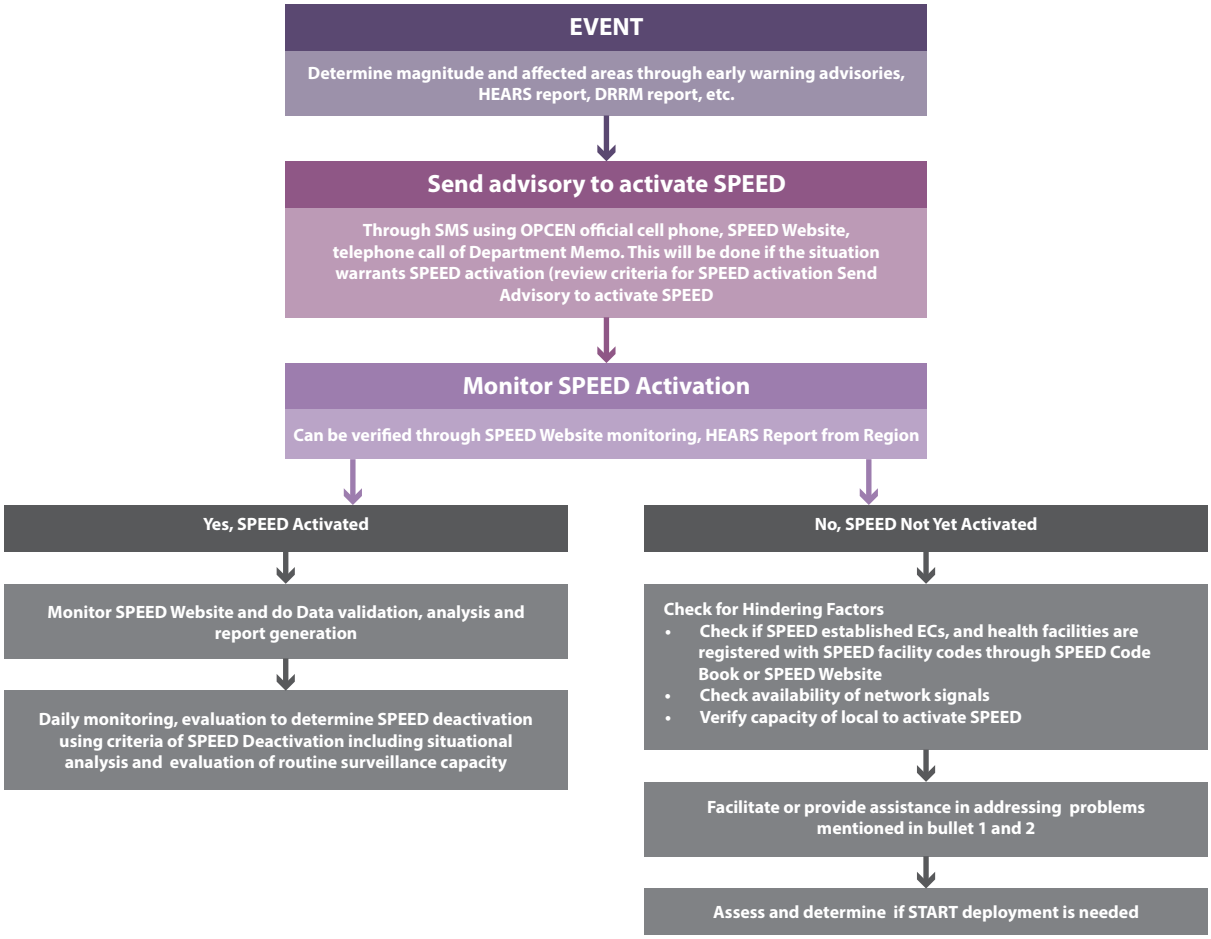
Composition and Task of SPEED Team at the Local Level			
SPEED Team Leader	• Convene SPEED Team. • Conduct refresher orientation. • Check availability of SPEED materials.	• Activate SPEED. • Deploy SPEED reporters at the evacuation centers/ hospitals. • Do constant communication to hospital SPEED reporter/point person.	• Address SPEED concerns. • Do SPEED data analysis and reporting. • Identify challenges and concerns. • Recommend need for START deployment. • Perform coordination with PHOs, hospitals, partners for support.
SPEED Reporter	• Review SPEED materials and flow of report. • DO SMS test.	• Ensure availability of SPEED Reporting Forms. • Confirm availability of network signal. • Suggest other modality of reporting.	• Summarize daily consultations in the EC/health facility of assignment. • Fill up the SPEED Reporting Form. • Send SMS report.
SPEED Data Manager	• Review SPEED reporting system. • Review SPEED Web application.	• Create health facility codes. • Assist/provide user's name and log-in name to LGU.	• Assist in data validation. • Generate SPEED data for information. • Give facility codes to assigned reporters/ medical team.

D.3.1.2 Process/Steps in SPEED Implementation

At the National/Regional Level/Hospitals

The following chart outlines the steps in the activation of SPEED post-emergency/ disaster at the national and regional level.

Figure 9. SPEED Activation Process at the National, Regional and Provincial Levels

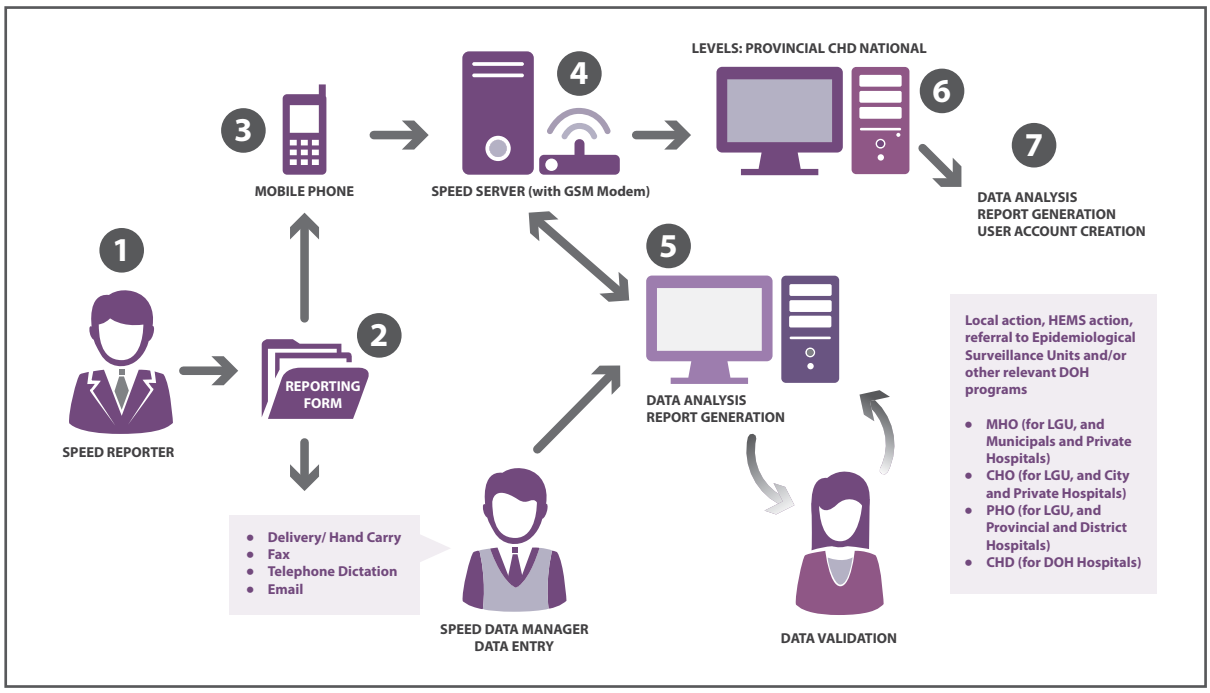


At the Local Level

At the local level, SPEED activation is dependent on the functionality of the communication network. The following charts illustrate the steps in SPEED activation at the local level under two scenarios: Scenario 1 is when the communication network is functionall and Scenario 2 is when the communication lines have broken down.

SPEED: Step by Step if Communication Network is Functional

Figure 10a. SPEED Activation at the Local Level If Communication Network Is Functional



SPEED: Step by Step if Communication Network is NOT Functional

Figure 10b. SPEED Activation at the Local Level If Communication Network Is Nonfunctional

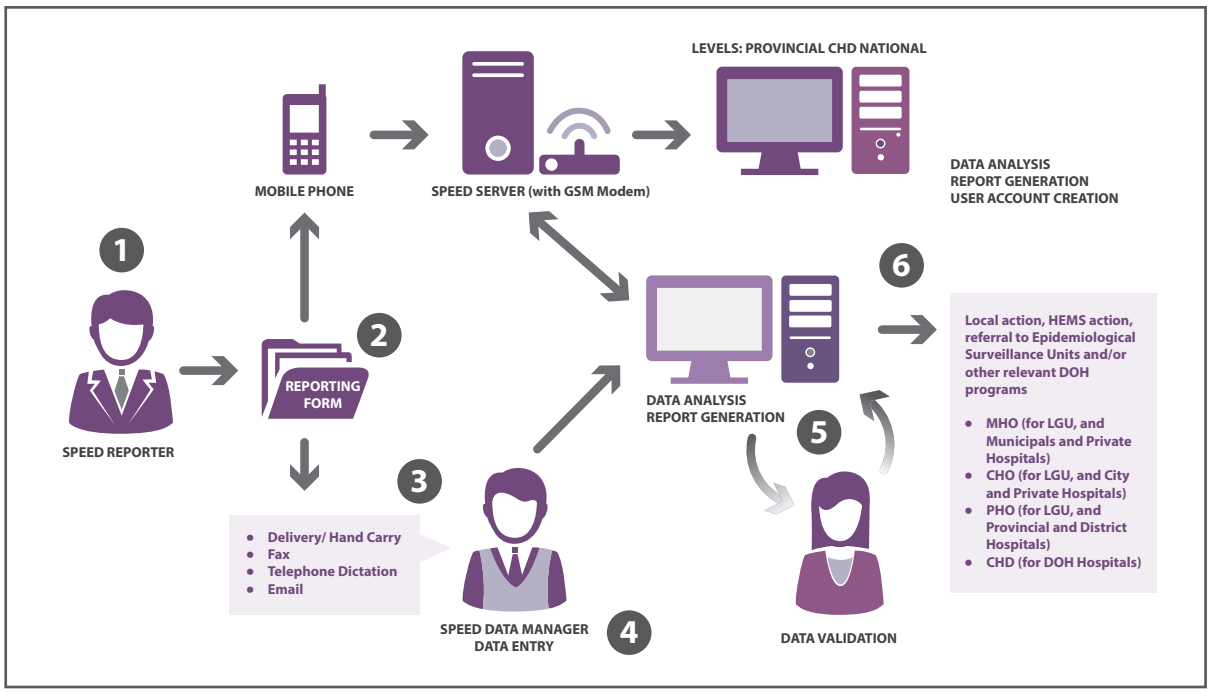


Figure 11. Flow of Data Collection: Steps in SPEED Data Collection and Reporting

There are other modalities for sending SPEED Daily Reports and Immediate Notification Alerts in the event that text messaging does not work.

D.3.2 Organizing and Deployment of the START

The SPEED Technical Assistance Response Team (START) is a rapid deployment group equipped with SPEED technical skills and resources. It is guided by the following principles: (i) mobilized as an augmentation in affected areas where services and resources cannot meet the demands to activate SPEED; (ii) serves as an additional support to the Regional Health Office or LGU in managing the emergency or disaster; and (iii) respects the existing laws and policies of the LGU as mandated by the Local Government Code.

D.3.2.1 Purpose of START

The general objective of START is to activate SPEED ideally within the first 48 hours in areas where local responders are victims and cannot function. Specifically, the START is expected to:

a. Provide leadership in SPEED implementation in terms of technical skills and logistics.
b. Ensure proper coordination and networking.
c. Provide crash courses to identified SPEED data managers and reporters.
d. Ensure proper transition before disengagement.

D.3.2.2 Composition of the START

Members of the START are to be selected from among the SPEED-trained personnel and shall be composed of at least five members, namely: the HEMS Coordinator or Assistant Coordinator; ESU Coordinator or Assistant ESU Coordinator; SPEED Focal Person; and any SPEED-trained staff at the national, regional and provincial level.

D.3.2.3 Process and Steps in START

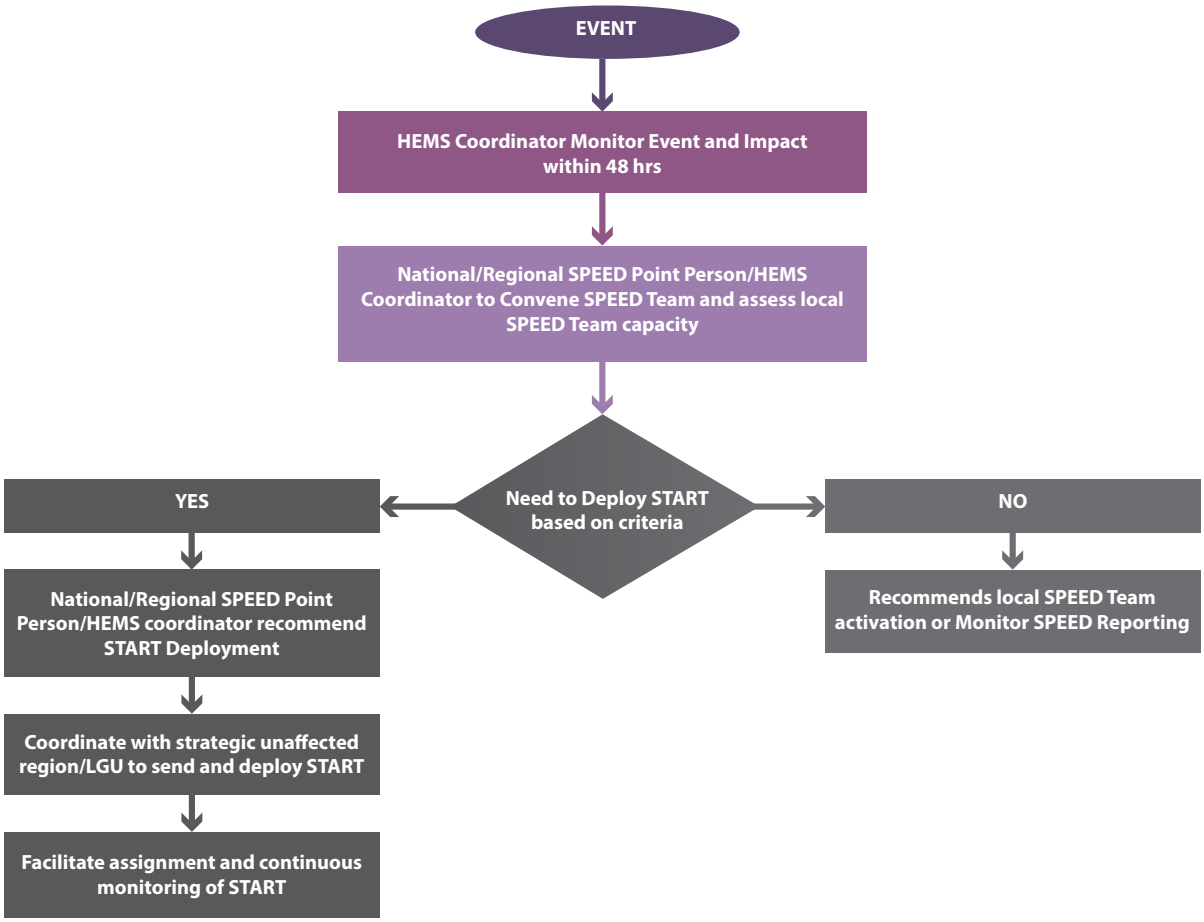
Criteria for START Deployment

a. The local authorities of the affected area send a written or verbal request to the next higher levels based on the following situations. If it is Code ORANGE, the CO/RO can send START:
   - In affected areas where there are no SPEED-trained personnel
   - In regions without previous experience in activating SPEED
   - In regions with inadequate human resources due to the effect/ magnitude of the disaster
b. The higher administrative level (national or regional office) issues an order to deploy the START from the perspective of being proactive, when activation criteria are met but affected areas are unable to activate SPEED, especially during cases of unprecedented magnitude of disaster and evidenced by a rapid assessment of the situation.

Steps and Tasks in START Deployment

The following chart outlines the process in the deployment of the START at the local level.

Figure 12. Process in the Deployment of the START



Tasks of START Members

Table 13. Tasks of the Members of START Pre- During- Post Impact

Responsible Person	Pre-Impact (A day or days before)	During Impact (0 hour to 48 hours)	Post-Impact (After 48 hours and onwards)
SPEED Point Person/ HEMS Coordinator	• Review roster of START trained staff. • Establish contacts with START members. • Determine if the event warrants SPEED activation. • Determine if the event meets START Deployment Criteria. • Develop deployment plans and strategies subject to continuous review when needed. • Start coordination with the Regional HEMS Coordinator.	• Recommend START deployment. • Organize/reorganize team. • Facilitate administrative requirements. • Assess capacity in terms of human resources and logistics.	• Conduct pre-deployment orientation and tasking among START members. • Oversee implementation of all deployed START. • Follow up or receive reports from the Team Leader.
START Team Leader		• Assist in the mobilization of necessary logistics and resources needed. such as communication equipment. • Review basic SPEED mechanics, e.g., flow of reporting, diseases for reporting, disease definitions, and reporting forms.	• Coordinate with the CHD/LGU upon arrival. • Oversee the overall operation including safety and security of the START. • Establish SPEED physical setup. • Decide with HEMS Coordinator on the priority SPEED reporting facilities. • Prepare and submit to the RD/ARD/PHO/CHO/ MHO a daily SPEED Report in coordination with Regional HEMS and RESU. • Coordinate/network with all stakeholders with regard to START activities. • Continuously assess local SPEED team as regards SPEED implementation and provide recommendations for further assistance. • Finalize the disengagement of the START together with the Regional Office/Local Health Office. • Address identified concerns or refer to higher level if necessary.
START Team Member		• Assist in the mobilization of necessary logistics and resources needed, such as communication equipment. • Review basic SPEED mechanics, e.g., flow of reporting, diseases for reporting, disease definitions, and reporting forms.	• Conduct orientation and training on SPEED. • Coach and mentor data managers and reporters. • Register the newly set up health facilities into the SPEED System. • Initially perform data collection, SPEED reporting and validation. • Prepare a descriptive report identifying operational issues, concerns and gaps and raise these to team leaders for action through accomplished monitoring tool templates.

START Deployment Arrangement

For DOH Central Office: START deployment shall be through DOH-HEMB to any affected area which meets the deployment criteria.

For Regional Health Office: Neighboring CHDs shall be the first to assist the affected area based on the zonal/cluster division of the DOH (Luzon, Visayas and Mindanao).

For Local Government Unit: Deployment of START shall follow inter/intra-local health zone/cluster agreement.

For International Partners: Assistance shall be requested by or through the Department of Health.

Criteria for START Disengagement

The START can be disengaged once the SPEED system in the disaster-affected areas is already established and functional. Specifically, the following conditions should be met before disengagement:

- Presence of designated SPEED Focal Person to oversee the continuous implementation of SPEED at the level where assistance was provided.
- Available and accessible local human resources and/or logistics enough/ required for SPEED implementation.

D.3.2.4 Coaching and Mentoring Agenda by the START

For SPEED Reporters

a. Know the definition of the 21 health conditions.
b. Fill up SPEED forms:
   - Ensure that consultations from identified reporting facilities are translated into SPEED forms.
   - Send correctly formatted SMS.
   - Set frequency of reporting.
c. Ensure that SPEED data are reported daily at 4:00 pm or the agreed time.
d. Explain that SMS is the preferred modality but ensure the availability of other modes of submission of data if SMS not available.
e. Orient and distribute SPEED forms and laminated guide.

For SPEED Data Managers

a. Definition of the 21 health conditions
b. Assignment of Health Facility Code
c. Data collection (online encoding)
d. Data validation

e. Data analysis with emphasis on:
   - Data description according to time, place and person
   - Looking for trends and breach of thresholds

f. Report writing

g. Feedback (presentation at coordination meeting and HEARS daily reporting)

h. Data management

D.4. INTEGRATED CODE ALERT SYSTEM

The Code Alert System of the DOH is a mechanism for the provision of health services during emergencies and disasters. It describes the conditions that govern the expected levels of preparation and the most suitable responses by all concerned, particularly during mass casualty situations and in anticipation of any untoward incident relative to the emergencies or disasters monitored. Its overall objective is to provide guidance in ensuring proper and timely raising and downgrading of code alert for an effective and efficient response during emergencies and disasters.

1. General Guidelines

1.1 There should only be one Code Alert System for all health offices/agencies and facilities involved in providing response to any health emergency or disaster.

1.2 For national events with potential for mass casualty incidents (e.g., election, New Year, etc.) and national security concerns, the Code Alert Level shall be declared by the Secretary of Health upon the recommendation of the HEMB Director.

1.3 All Regional Office Directors and Chiefs of Hospitals have the authority to raise, downgrade or lift the Code Alert Level based on their particular situation in the area and according to provisions in AO 2008-0024.

1.4 Every entity involved in providing response must be given proper orientation on these codes, and the conditions when these are to be raised or downgraded.

1.5 Proper staffing must be put in place as demanded by each level of the Code Alerts.

1.6 The HEMB Central Office takes the lead in designing and updating the Code Alert System and is primarily responsible for its dissemination and adoption by all concerned agencies and units.

2. Specific Guidelines

2.1 Types of Code Alerts

There are four types of codes – White, Blue, Red and Orange – which are used to alert the concerned officials/staff of the DOH Central Office, ROs and hospitals during any emergency or disaster depending on the type of the hazard, their magnitude, and the extent of response expected to be carried out.

a. Code WHITE

This is the lowest code, an early warning or standby alert status to prepare for an

impending threat or incident. All preparedness activities are put into action, such as activating the Operations Center, preparing standby teams for deployment, etc.

b. Code BLUE

This is a response level alert for 50% agency resource mobilization. This means that teams have been mobilized to augment existing regular day-to-day resources. Likewise, logistics are mobilized to affected areas or to treat patients.

c. Code RED

This is a response activation alert for full mobilization of the affected office or facility and all its resources need to be mobilized.

d. Code ORANGE

This is a response activation alert of the whole Department of Health, as in mega disaster situations and catastrophic events where a whole-of-society approach is a must. Logistical needs including manpower will need to be mobilized and augmented from outside sources.

2.2 Code Alert Criteria in Relation to ICS Activation

Table 14. Tasks of the Members of START Pre- During- Post Impact

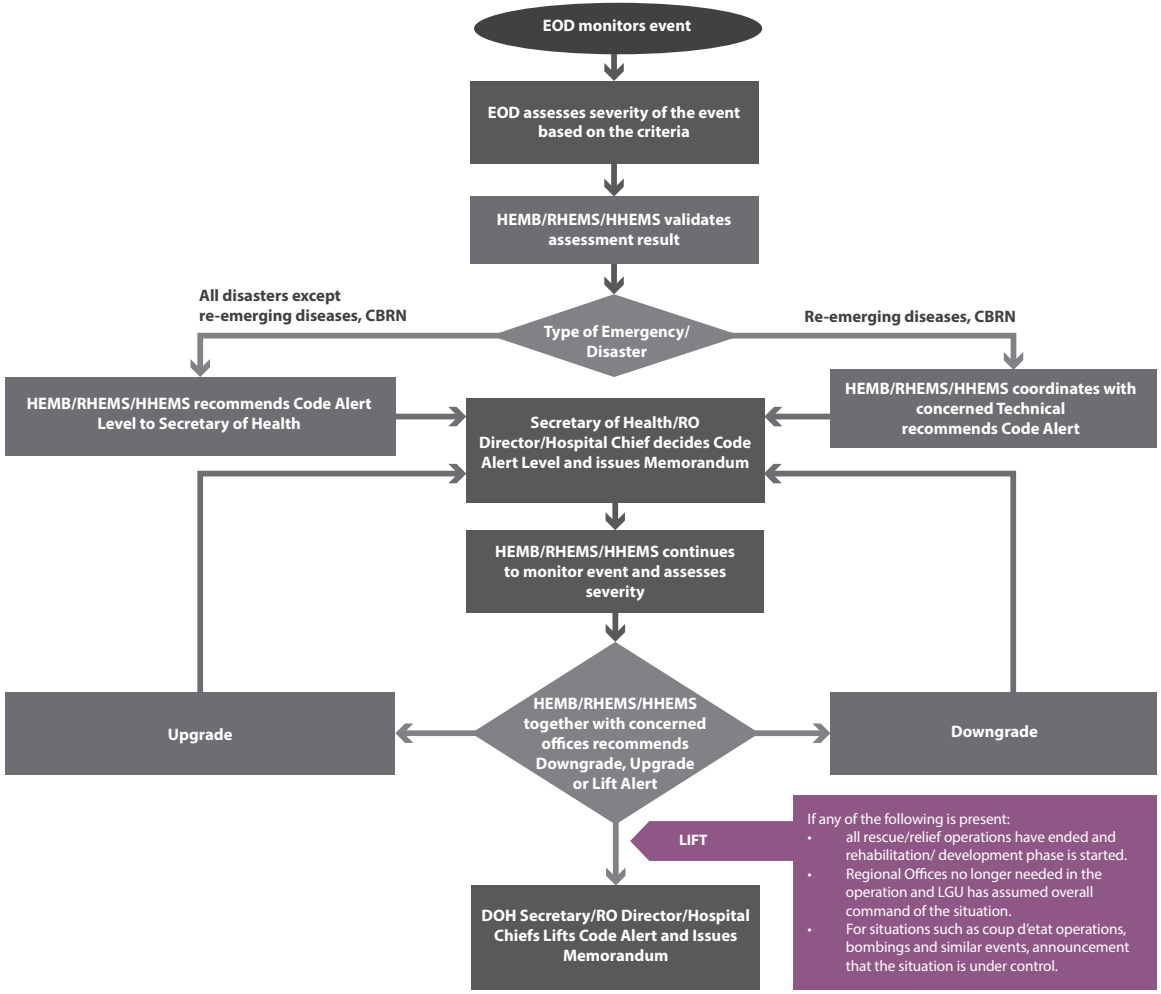
	Code White	Code Blue	Code Red	Code Orange
Criteria	• Strong possibility of a military operation e.g. coup attempt/ armed conflict which have a national implication • Any planned mass action or demonstration which have a national implication or potential for an MCI especially happening in Metro Manila • Forecast Typhoons/ITCZ accompanied with heavy rains/ flooding; signal number not a requirement • National elections and other political exercises • National events, holidays or celebrations with potential for MCI • Any emergency with potentially 10-50 casualties (deaths, injuries) in Metro Manila • Notification of reliable information of terrorist/ attack activities • Emergencies concerning political figures or foreigners with implications on national government • Unconfirmed report of reemerging diseases, e.g., bird flu, SARS, etc.	Conditions for Adopting Code Blue: Any condition mentioned in Code White plus any of the two below: • Mobilization of DOH resources (national or regional) is needed (manpower, materials, etc.) • 30-50% health facilities in the areas affected or damaged • No capability of the LGU and/ or lack of resources of the Region to fully/completely respond/support the affected area • Magnitude of the disaster based on geographic coverage and number of • affected population (more than 30%) • Any Mass Casualty Incident (MCI) with 50-100 casualties irrespective of color code • High case fatality rate for epidemics • Confirmed human-to-human transmissions of avian flu or SARS	Conditions for Adopting Code Red: Any natural, manmade, technological or societal disaster, where all of the following are present: • Declaration of disaster to the affected area, magnitude of which is beyond the capacity of the region to support the operations • 100 or more casualties in one area • Health personnel in the region not capable to handle entire operation; need for external support to initially manage the situation • Mobilization of the health sector needed • Mobilization of key offices in DOH needed • Uncontrolled human-to-human transmission of SARS/avian flu	Conditions for Adopting Code Red (for Mega Disasters as Ty Yolanda, Catastrophic Events): Any natural, manmade, technological or societal disaster, where all or any three of the following are present: • All lifelines down (communications, transportation, power, water, food supply) • More than 5000 deaths/injured • More than 50% of staff unable to report for work, especially those delivering critical functions • More than 50% of health facilities are damaged and non-functional or main hospital compromised and unable to render health services • No information within 24 hours post disaster • Breakdown in chain of command • Isolation of the affected areas • Uncontrolled human-to-human transmission of SARS/avian flu

Incident Commander System: Activation:	• Not recommended	• Maybe activated per area depending on local assessment and evaluation	• Yes definitely	• Yes definitely
Incident Commander recommended **- CO** **- RO** **- Hospital**	 • Secretary of Health • RO Director • Chief of Hospital	 • Secretary of Health • RO Director • Chief of Hospital	 • Secretary of Health • RO Director • Chief of Hospital	 • Secretary of Health • Cluster Head/ RD of nearest functional RO/RD • Chief of nearest functional Hospital
Cluster Activation	• Not recommended	• Maybe activated per area depending on local assessment and evaluation	• Yes definitely	• Yes definitely

3. Procedures in Raising and Downgrading Code Alert

To synchronize the efforts of the HEMB/HEMS personnel in anticipation of health emergencies, disasters, and mass casualty incidents, a Code Alert System must be in place, specifically in the mobilization and deployment of its staff. The mechanism will allow appropriate management staffing/ composition and services to be available at all times, including the responsibilities of each member of the team.

Figure 13. Process in Declaring Code Alert Levels



WHITE

Any one of the following:

- Strong possibility of military operation (e.g., coup attempt, armed conflict)
- Mass action or demonstration
- Forecast typhoons (signal 2 up)
- National or local elections
- National event/holidays with potential for MCI
- Emergency w/ potential 10-50 casualties
- Terrorist attack
- Any hazard that may result in emergency

BLUE

Any condition in Code White plus 2 below:

- Mobilization of DOH resources
- 30-50% health facilities affected incapability of LGU to respond
- Geographic coverage and affected population >30%
- MCI with 50-100 casualties
- High case fatality rate for epidemics
- Confirmed human-human transmission of Avian flu/SARS

RED

Any natural, manmade, technological or societal disorder, with all present:

- Declaration of disaster in area
- >100 casualties in 1 area
- Regional health personnel incapable of handling entire operation
- Mobilization of health sector needed
- Mobilization of DOH key offices
- Uncontrolled human to human transmission of Avian flu/SARS

ORANGE

Any natural, manmade, technological or societal disaster, where all or any three of the following are present:

- All lifelines down (communications, transportation, power, water, food supply)
- More than 5000 deaths/injured
- More than 50% of staff unable to report for work, especially those delivering critical functions
- More than 50% of health facilities are damaged and non-functional or main hospital compromised and unable to render health services
- No information within 24 hours post disaster
- Breakdown in chain of command
- Isolation of the affected areas
- Uncontrolled human to human transmission of SARS/ Avian Flu

Table 15. Procedures in Activating the Integrated Code Alert System for the Department of Health (A.O. 0024)

CODE ALERT LEVEL: CODE WHITE

HEMB CENTRAL OFFICE	HOSPITAL	REGIONALOFFICES	DOH CENTRAL OFFICES
1. Conditions for Adopting Code White: • Strong possibility of a military operation, e.g., coup attempt/armed conflict, with national implication • Any planned mass action or demonstration with a national implication or potential for an MCI especially happening in Metro Manila • Forecast Typhoons/ITCZ accompanied with heavy rains/flooding; signal number not a requirement • National elections and other political exercises • National events, holidays or • celebrations with potential for MCI • Any emergency with potentially 10-50 casualties (deaths, injuries) in Metro Manila • Notification of reliable information of terrorist/ attack activities • Emergencies concerning political figures or foreigners with implications on national government	1. Conditions for Adopting Code White: • Strong possibility of a military operation within the area/ region, e.g., coup attempt • Any planned mass action or demonstration within the catchment area • Forecast typhoons/ITCZ accompanied with heavy rains/ flooding, the path/diameter of which will affect the area; signal number is not a requirement • National or local elections and other • political exercises • National events, holidays, or local celebrations in the area with potential for MCI • Any emergency with potentially 10-50 casualties (deaths, injuries) within the catchment area of the hospital • Any other emergency (earthquake, flooding, etc.) affecting the hospital	1. Conditions for Adopting Code White: • Strong possibility of a military operation, e.g., coup attempt within the region • Emergencies that pose a public threat, whether accidental or intentional, such as biological epidemics), chemical (spill), and radiological threat • Notification of ongoing epidemic by LGU, with adequate measures by local health personnel • Any planned mass action or demonstration in the assigned area • Forecast typhoons/ITCZ accompanied with thunderstorms, heavy rains/ flooding the path of which will affect the region; the signal number is not a requirement • National or local elections and other political exercises • National events, holidays or regional/ local celebrations with potential for MCI • Any emergency with potential 10-50 casualties (deaths, injuries)	1. Conditions for Adopting Code White: • Strong possibility of a military operation, e.g., coup attempt/armed conflict with national implication • Any planned mass action or demonstration with national implication or potential of an MCI happening in Metro Manila • Forecast typhoons/ITCZ accompanied by heavy rains/flooding; signal number not a requirement • National elections and other political exercises • National events, holidays or • Celebrations with potential for MCI • Notification of reliable information of terrorist/attack activities

CODE ALERT LEVEL: CODE WHITE

HEMB CENTRAL OFFICE	HOSPITAL	REGIONALOFFICES	DOH CENTRAL OFFICES
2. Human Resource requirements for responding to the Code: • Emergency Officer-on-Duty (EOD) 1 and 2 • Driver and Security Guard to assist at the Operations Center • Reliever 1 and 2 (next day EODs) on standby • Response Division Chief or designate on continuous monitoring and will serve as Medical Controller for Mass Casualty Incident • All other staff on standby mode in the event of elevation of the code	2. Human Resource requirements for responding to the Code: • First response team ready for dispatch to include the following: ↘ 2 doctors preferably surgeon, Internist, anaesthesiologist, etc. ↘ 2 nurses ↘ 2 first aider/EMT ↘ Driver • Second response team should be on call. • The following should be available for immediate treatment of incoming patients: ↘ General surgeons ↘ Orthopedic surgeons ↘ Anaesthesiologists ↘ Internists ↘ ER/OR nurses ↘ Ophthalmologists ↘ Otorhinolaryngologists ↘ Infectious specialists • Emergency service personnel, nursing personnel and administrative personnel residing at the hospital dormitory shall be placed on call status for immediate mobilization and in the event of elevation of the code.	2. Human Resource requirements for responding to the Code: • 2 Emergency Officers-on-Duty (EOD) at the Operations Center that should be functioning 24/7 • Driver • DOHRep to be physically present at their assigned provinces or assigned cities/municipalities • Regional HEMS Coordinator on call and on proactive monitoring and continuous coordination with the Regional Director • One Rapid Assessment Team ready for dispatch to include the following: ↘ DOH Representative/HEMS LGU ↘ Nurse ↘ Driver • All other regional personnel should be placed on standby for immediate deployment if warranted and in the event of elevation of the code.	2. Human Resource requirements for responding to the Code: • Concerned Division Chiefs or alternates of the following offices should be on standby: ↘ Material Management Division ↘ Finance Service ↘ Administrative Service ↘ Procurement and Logistics Service ↘ National Epidemiology Center ↘ Health Promo and Communication Services ↘ Media Relations Unit ↘ Disease Prevention and Control Bureau ↘ Health Facility and Development Bureau ↘ Bureau of Quarantine and International Health Surveillance for Pandemic

CODE ALERT LEVEL: CODE WHITE

HEMB CENTRAL OFFICE	HOSPITAL	REGIONALOFFICES	DOH CENTRAL OFFICES
3. Other requirements: • EOD 1 to check all medicines, supplies available in CO warehouse and regional warehouses to include prepositioned drugs/medicines. • EOD 1 and 2 to do proactive monitoring (quad media, social network, from partners and other agencies). • EOD 1 to send alert memo to the regions, hospitals and other facilities that might be affected or needed to respond or receive patients. • HEMB Director or Response Division Chief to alert key officials as needed. • HEMB Director to coordinate with the NDRRMC and/or the Office of Civil Defense. • Response Division to coordinate with pertinent offices in the Central Office for additional drivers, additional transportation vehicles and opening the warehouse etc. • EOD 1 to inform appropriate office in the Central Office regarding particular emergencies in relation to their office, e.g., National Epidemiology Center, regarding outbreaks for confirmatory report. • EODs to monitor the regions on a 24-hour basis with regards to their preparations and compliance to the Code Alert. • HEMB OpCen to prepare reports pertinent to the event on a regular basis and distributed via email and/or hard copies to EXECOM; ensure that NDRRMC is informed of actions taken. • HEMB Director to attend all coordinating meetings at OCD and inform the Secretary of the evolution of the incident or other requirements needing his attention. NO Need for ICS activation at this code	3. Other requirements: • Activate the hospital's Operations Center. It should continuously report and coordinate with the Regional and DOH Central Operations Center. • Ensure that emergency medicines (especially for trauma needs) be made available at the emergency room. • Review availability of medicines and supplies in the operating rooms; increase to meet sudden requirements. • Make available other needs such as X-ray plates, laboratory requirements, etc. and should not be required to be purchased by victims. • Personnel department to prepare for mobilization of additional staff. • Finance department to ensure availability of funds in cases of emergency purchases and the like. • Logistics department to coordinate with possible suppliers for additional requirements. • Dietary department to open and meet the need of the victims as well as the health personnel on duty. • Security force to institute measures and stricter rules in the hospital. NO Need for ICS activation at this code	3. Other requirements: • Activate the Regional Operations Center on 24/7 with adequate staff and communications means. • Do proactive monitoring for any development. • Report to HEMB-OpCen daily and as necessary. • Require update from field as necessary. • Finance Division to ensure availability of funds in cases of emergency purchases and the like; needs of responders for deployment; other administrative needs. • Logistics Section to be aware of all logistics available in the warehouse and to coordinate with possible suppliers for additional requirements. • Transport section to ensure availability of vehicles and drivers. • Ensure that all teams (RHA teams. Medical, surveillance. Environmental, Promotion, Psychosocial etc.) to be mobilized will be properly equipped with all their requirements including their physical needs. These teams are on standby/ on call for immediate mobilization. • Intensify IEC campaign through health advisories. • Coordinate regularly with all LGUs in your area and determine their preparedness. • Coordinate with regional hospitals for their preparedness and availability of back-up teams. NO Need for ICS activation at this code	3. Other requirements: All respective offices mentioned above should check the following: • Availability of any medicines, supplies etc. that could be used or shared in response to the emergency • Available guidelines, treatment protocols etc. needed in the event their program will be involved. • Templates on health advisories that could be used and possible replications if necessary • Availability of their technical staff in the event their expertise will be needed in the field No need for ICS activation at this Code

CODE ALERT LEVEL: CODE BLUE

HEMB CENTRAL OFFICE	HOSPITAL	REGIONALOFFICES	DOH CENTRAL OFFICES
1. Conditions for Adopting Code Blue Any condition mentioned in Code White plus any of the two below: • Mobilization of DOH resources (national or regional) is needed (manpower, materials, etc.) • 30-50% health facilities in the area affected or damaged. • No capability of the LGU and/or lack of resources of the region to fully/ completely respond/support the affected area. • Magnitude of the disaster based on geographic coverage and number of affected population (more than 30%). • Any Mass Casualty Incident (MCI) with 50-100 casualties irrespective of color code.	1. Conditions for Adopting Code Blue Any of the following conditions: • When 20-50 casualties (red tags) are suddenly brought to the hospital. • Any internal emergency/disaster in the • hospital which brings down their operating capacity (i.e., vital areas) to 50% or which would require evacuation of patients and setting up of a Field Hospital. • For conditions other than MCI, the influx of patients is beyond the capacity of the hospital to handle.	1. Conditions for Adopting Code Blue Any of the following conditions: • 50-100 casualties irrespective of tags for MCI. • Declaration of epidemic either by LGU or DOH • Declaration of calamity in any province in the region • Presence of evacuation centers/ temporary shelters estimated to last for more than a week which has public health implications • Magnitude of the disaster based on geographic coverage and number of affected population (more than 30%) • Any condition that would require • mobilization of resources of the entire region	1. Conditions for Adopting Code Blue Any condition mentioned in Code White plus any of the two below: • Mobilization of DOH resources (national or regional) is needed (manpower, materials, etc.) • 30-50% health facilities in the area affected or damaged • No capability of the LGU and/or lack of resources of the region to fully/ completely respond/support the affected area • Magnitude of the disaster based on geographic coverage and number of affected population (more than 30%) • Any Mass Casualty Incident with • 50-100 casualties (mortalities plus injuries) irrespective of color code • High case fatality rate for epidemic

CODE ALERT LEVEL: CODE BLUE

HEMB CENTRAL OFFICE	HOSPITAL	REGIONALOFFICES	DOH CENTRAL OFFICES
2. Human Resource requirements for responding to the Code: • Response Division Chief or HEMB Director should be physically present at OpCen. • EOD 1 and 2 plus next team or at least 4 EOD • Driver and security guard to assist at the Operations Center. • Incoming EODs on call for immediate mobilization. • Logistics Officer or alternate to go on duty. • At least one DOH representative to go on duty to NDRRMC if required and/or requested.	2. Human Resource requirements for responding to the Code: • HEMS Coordinator to be physically present at the hospital. • On-Scene Response Team • Medical Officer in charge of the Emergency Room • All residents of theDepartment of Orthopedics • Medical Officer in charge of the Operating Room • Surgical team on duty for the day • Surgical team on duty the previous day • Mental health professionals • All anesthesiology residents • Toxicologist, chemical experts for poisoning and/or chemical cases (if available) • All third and fourth year residents • Administrative Officer or designate • Nursing supervisor on duty • All OR nurses • Social workers • Dietary personnel • Officer in charge of supplies at the CSR • The entire security force and • Institutional workers on duty	2. Human Resource requirements for responding to the Code: • RHEMS Coordinator to be physically present at OpCen • Rapid Health Assessment Teams and other appropriate teams (RHA) • 3 teams on standby • (environmental/surveillance/medical) • EOD 1 and 2 for the OpCen • Logistics Officer • Finance Officer as necessary • Health Promotions Officer as necessary • Driver • All other regional staff on standby for immediate mobilization • All DOH REPS in the affected area should be available in the area of assignment. Prioritize affected areas on the path of typhoon	2. Human Resource requirements for responding to the Code: • Director or designate to be present at the respective offices ↘ Material Management Division ↘ Finance Service ↘ Administrative Service ↘ Procurement and Logistics Service ↘ National Epidemiology Center ↘ Health Promotion and Communication Services ↘ Media Relations Unit ↘ Disease Prevention and Control Bureau ↘ Health Facility and Development Bureau ↘ Bureau of Local Health Development ↘ Bureau of Quarantine & International Health Surveillance ↘ Food and Drug Administration In the event that the Command Center is activated a representative for offices concerned in the response should be available on an 8-hr or 24-hr basis as so required.

CODE ALERT LEVEL: CODE BLUE

HEMB CENTRAL OFFICE	HOSPITAL	REGIONALOFFICES	DOH CENTRAL OFFICES
3. Other requirements: • Activate Code Blue for HEMB and prepare necessary documentation • Activate ICS in HEMB • Coordinate with the following: ↘ Implementing agencies (hospitals, region, central office) for possible dispatching of teams or experts ↘ NDRRMC and other sectors for other concerns e.g. transportation, etc. ↘ MMD regarding supplies available at DOH ↘ Different DOH Central Offices for personnel augmentation to the Operations Center and for other technical support • Prepare possible drugs and medicines needed for movement to affected area • Prepare emergency procurement if needed drugs/medicines not available • Check all possible means of transportation, e.g., with NDRRMC, air cargo, etc. • Anticipate need of medical teams and other experts. • Prepare all needed reports and • presentations required, especially for emergency NDRRMC meetings. • Orient staff to be deployed to NDRRMC and those additional staff to augment the OpCen. • Plan for support to the affected region in cases of long-term emergencies.	3. Other requirements: All those mentioned in Code White plus: • Activate Hospital Emergency Incident Command System (HEICS). • Make available the other needs of victims apart from medicines and supplies depending on the disaster. • The Chief of Hospital/Medical Center or his designate should make proper coordination with other hospitals for networking and/ or possible transfer of patients. • Incident Commander should assign a Safety Officer, to ensure safety and security, Liaison officer, to coordinate with other agencies, and Public Information Officer to serve as the spokesperson of the hospital. • Social Service section should prepare assistance to victims in coordination with mental health professionals of the hospital if available and the Department of Social Welfare; in addition they should lead in providing information to relatives of victims. • Mortuary section should anticipate dead victims brought to the hospital for proper care and identification.	3. Other requirements: All those mentioned in Code White plus: • Activate the Regional Emergency Incident Command System (REICS). • Operations Center on 24/7 with adequate personnel and logistical support to receive, evaluate, analyze all reports. • Mobilize teams to affected areas for Rapid Health Assessment of provinces, LGUs and evacuation centers/temporary shelters in coordination with the DOH Rep. • Regional Director or his designate to make proper coordination with RDRRMC and other agencies like DSWD, DEPED etc. for networking and other requirements. • Incident Commander should assign needed staff in Operations, Logistics, Planning and Administrative to assist affected LGUs. • Public Information Officer to prepare and have regular media conference or press release. • Continuous IEC campaign through health advisories especially in evacuation centers.	3. Other requirements: Activate the following offices: • Material Management Division ↘ Ensure availability of staff to prepare all medicines and supplies needed. ↘ Ensure that the medicines and supplies be transferred to the affected area via NDRRMC arrangement or other means. ↘ Ensure the presence of the inspection team in coordination with FDA. • Finance Service ↘ All unit heads must be available to facilitate release of funds. ↘ Petty cash must be in place. ↘ Facilitate in the travel arrangements and other requirements in case of local or international teams to be sent. • Administrative Service ↘ Should ensure availability of vehicles with drivers, gasoline/diesel etc. ↘ Should ensure the provision of electricity/ generator in all services responding to the emergency/ disaster at the Central Office. ↘ Should ensure availability of other communication lines specially PABX. ↘ Security Force to institute measures, stricter rules at the DOH Compound. ↘ Assist MMD in the preparation of medicines and supplies and transfer of this to airports, etc. ↘ Facilitate arrangement with the airport for the travel of medical team. • National Epidemiology Center ↘ Ready surveillance and outbreak investigation team and experts to be deployed as needed.

CODE ALERT LEVEL: CODE BLUE

HEMB CENTRAL OFFICE	HOSPITAL	REGIONALOFFICES	DOH CENTRAL OFFICES
• Initiate the conduct of coordinative meeting of the national clusters: Health, Nutrition, WASH and Psychosocial.	• The security team, in anticipation of possible influx or patients, relatives, responders, police, press, etc., should ensure smooth flow of traffic inside the compound, especially for the ambulances. • Should report regularly to HEMB OpCen and as much as possible have a regular press release or briefing.	• May need to activate also a Field EOC as needed to coordinate health activities. • Provide technical support in the Management of Mass Dead together with the Health unit of the LGU concerned. • Lead in coordinative meetings of the different clusters under the DOH: Health, Nutrition and WASH. • Provide technical support to LGU's. • Mobilize other requirements as needed such as psychosocial team, etc. • Regularly coordinate with DOH-HEMB OPCEN OpCen for reports and other needs.	• Procurement Division ↘ Should ensure the availability of list of qualified and responsible pharmaceutical companies and other suppliers for emergency procurement of drugs, medicines medical equipment, etc. ↘ Should facilitate procurement of emergency drugs/ supplies as needed. • Health Promotion and Communication Services (HPCS) and Media ↘ Should ensure their availability to assist and provide technical assistance to HEMB and regional offices in the reproduction of behavioral messages and IEC materials. ↘ Should assist regional offices in the conduct of health education activities. ↘ Assist in documentation of events. • Media Relations Unit (MRU) ↘ Anticipate any untoward media reports and recommend necessary response. ↘ Prepare press releases and/or press statement. ↘ Recommend and organize press conferences and other media blitz like radio and television appearances. ↘ Coordinate with HEMB for technical inputs. • Disease Prevention and Control Bureau (DPCB) ↘ All Program Managers with concerns to disaster should be available for their technical support, such as on communicable disease, environmental, nutrition, sanitation, psychosocial, etc. ↘ Provide treatment protocol and guidelines as necessary. ↘ Standby experts to be mobilized to affected area.

CODE ALERT LEVEL: CODE BLUE

HEMB CENTRAL OFFICE	HOSPITAL	REGIONALOFFICES	DOH CENTRAL OFFICES
			• Health Facility and Development Bureau ↘ Technical support for hospitals should be readily available especially for infrastructure concerns. ↘ There should be protocols in the mobilization of blood requirements for emergencies especially for Mass Casualty Incidents. Blood intended for elective cases can be realigned for the use of victims. ↘ Provide technical support and experts, especially for hospital management. • Food and Drug Administration ↘ Ensure the presence of the inspection team to issue certificate of clearance for drugs and medicines. ↘ Facilitate requirements and certification for donated medicines, etc. • Bureau of Quarantine and International Health Surveillance ↘ Will only be activated in the presence of cases of re-emerging diseases, such as SARS and avian flu, which need international surveillance in all ports of entry, and other emergencies related to incoming and outgoing transportations. • Bureau of International Health Cooperation ↘ Provide support in terms of international concerns/international donations and Foreign Medical Team. • Knowledge Management Information Technology Service (KMITS) ↘ Provide support in relation to information technology. • Bureau of Local Health Development ↘ Assist in coordination with the local government units. • Have regular coordination with DOH- HEMB

CODE ALERT LEVEL: CODE RED

HEMB CENTRAL OFFICE	HOSPITAL	REGIONALOFFICES	DOH CENTRAL OFFICES
1. Conditions for Adopting Code Red Any natural, manmade, technological or societal disaster, where all of the following are present: • Declaration of disaster in the affected area, the magnitude of which is beyond the capacity of the region to support the operations • 100 or more casualties in one area • Health personnel in the region not capable to handle entire operation; need for external support to initially manage the situation • Mobilization of the health sector needed • Mobilization of key offices in DOH needed	1. Conditions for Adopting Code Red Any of the following is present: • When more than 50 (red tag) casualties are suddenly brought to the hospital. • An emergency wherein the services of the hospital are paralyzed because 50% of the manpower are themselves victims of the disaster. • Hospital is structurally damaged requiring evacuation and/or transfer of patients.	1. Conditions for adopting Code Red Any of the following is present: • Conditions resulting in mass deaths • Disaster declared in two or more provinces/LGUs in the region or 30% of the cities in Metro Manila. • Major receiving hospitals in area are not able to provide optimal services due to damages or 50% of staff are affected. • Mobilization of entire regional resources not enough (as more than 50% of staff are victims) and thus require external support. • Uncontrolled epidemic/ outbreak	1. Conditions for adopting Code Red Any natural, manmade, technological or societal disaster where all of the following are present: • Declaration of disaster to the affected area, the magnitude of which is beyond the capacity of the region to support the operations • 100 or more casualty in one area • Health personnel in the region not capable to handle entire operation; need of external support to initially manage the situation • Mobilization of health sector needed • Mobilization of key offices of Department of Health

CODE ALERT LEVEL: CODE RED

HEMB CENTRAL OFFICE	HOSPITAL	REGIONALOFFICES	DOH CENTRAL OFFICES
2. Human Resource requirements for responding to the Code: The HEMB office personnel and staff augmentation from other offices shall be divided into 3 teams to go on a 24-hour duty rotation every 3 days. The team is composed of the following: • Team Leader • 2 Data Collectors/Encoders • Logistics • Communication • Administrative Officer • Support Staff/ Clerk • Driver • At least 1 staff to be assigned at OCD OpCen on 24 hours duty Provide staff to the OCD during the code acting as liaison for concerns related to the DOH. All HEMB staff should be mobilized and all activities suspended.	2. Human Resource requirements for responding to the Code: • All personnel enumerated under Code Blue • All medical interns and clinical clerks • All nurses • All nursing attendants • All institutional workers • All administrative staff All staff of the hospital from admin to technical should be mobilized.	2. Human Resource requirements for responding to the Code: • Mobilize all regional staff and make schedule on a rotation basis but ensuring that all areas will be covered from the operation center to the field. • All DOHREP teams in unaffected areas should report to the Regional Health Office and provide support to affected LGUs. • Provide staff at the Command Center of the Region/Province/City to serve as liaison and serve as representative of the RO. • Suspend all activities (training, workshops, conferences, monitoring etc.) of the Region to ensure that there will be enough staff to support the operation. All staff of the regional office, from administrative to technical, should be mobilized.	2. Human Resource requirements for responding to the Code: • All services should ensure the availability of staff for 24 hours to address all requests for technical as well as other logistical support. • A representative from each office with concerns in the operation should be available at the Command Center to attend meetings, submit reports and answer concerns and issues raised to the Department of Health. This will be decided by the IC based on the type of emergency/disaster and the magnitude of the event. • All Central Office bureaus and offices should augment staff to the Operations Center during the code red alert. • Expert teams should be available for deployment as needed by the affected Regions All activities of the Central Office should be suspended temporarily.

CODE ALERT LEVEL: CODE RED

HEMB CENTRAL OFFICE	HOSPITAL	REGIONALOFFICES	DOH CENTRAL OFFICES
3. Other requirements • ICS activation mandatory Coordination Activities: • Coordinate with the: ↘ Regional offices, hospitals and partners to get and update information ↘ NDRRMC and other agencies and address concerns brought to the Department of Health ↘ NNC, Disease Prevention and Control Bureau (DPCB) and NCMH coordinates, with international partners in the Health, Nutrition, WASH and Psychosocial Clusters and call coordinating meetings as necessary (tri or quad cluster) ↘ With all members of the health sectors ↘ With international partners for donations and other support together with BIHC ↘ With local partners for local donations Monitoring and Reporting: • Continuous monitoring and generation of reports from all sources: DOH family, NDRRMC family, all health sector partners etc. • Prepare regular updated reports/ presentations for use of Secretary, EXECOM, NDRRMC, and other partners • Document all activities and a Final Report Support Services: • HEMB-OPCEN to provide support to the DOH Command Center. • Ensure that all actions, resources and logistics are mobilized, monitored and documented • Continuous support to the OCD. • Assist in the preparation of the rehabilitation and recovery plan together with the Health Policy and Development Planning Bureau (HPDPB), NEDA, Regional Offices	3. Other requirements All those mentioned in Code Blue plus: • ICS activation mandatory • The Chief of Hospital/ Medical Center Chiefs can cancel all types of leaves and can order all personnel to report to the hospital • The Chiefs of Hospital/ Medical Center Chiefs can temporarily stop all elective admissions and surgeries; send home and discharge patients no longer needing hospital care • The Chiefs of Hospitals/ Medical Centers should anticipate requests of additional staff due to the number of patients. He is further authorized to request help from neighboring Regional Offices or accept volunteers and other professionals to augment its manpower resources rather than transferring patients.. • Network with other hospitals for augmentation of resources and transfer of patients in special cases • Answer all queries of the media pertaining to patients in the hospital • Anticipate evacuation and/ or use of field hospital; closure and/ or quarantine of the hospital • The Chief of Hospital/ Medical Center Chief to specifically be concerned with safety and security, not only of the patients but the personnel as well. All activities is to decrease mortality and morbidity of the patients but considering also the safety and welfare of the hospital personnel	3. Other requirements All those mentioned in Code Blue plus: • ICS activation mandatory • The RO Director can cancel all types of leaves and can order all personnel to report to the RO. • The RO Director should stop all operations not related to the disaster. • The RO Director should anticipate request of additional manpower and specialists not available in his RO. He should request help for support from neighboring Regional Offices and to accept volunteers and other professionals to augment its manpower • Continuous networking with PDRRMC/CDRRMC and all clusters assigned to the DOH (Health, Nutrition, WASH, Psychosocial). • Do active and massive public Information campaign especially in evacuation centers • Ensure regular briefing of media. Anticipate issue and concerns from media. • Provide regular updated report to HEMB Central OpCen.	3. Other requirements • ICS activation mandatory • Each Office to deploy one personnel to augment HEMB Central Operation Center and NDRRMC/OCD Operation Center • Attend regular command conference meetings and address all issues pertaining to their Office. Implement what is discussed and approved • All Directors or Designates (mentioned above) to report 24/7 to Operation until Code Red is deactivated or lifted • Provide logistical as well as technical support if necessary

CODE ALERT LEVEL: CODE ORANGE

HEMB CENTRAL OFFICE	HOSPITAL	REGIONALOFFICES	DOH CENTRAL OFFICES
1. Conditions for Adopting Code ORANGE: (for Mega Disasters as Ty Yolanda, Catastrophic Events, Pandemic, terroristic activities)	1. Conditions for Adopting Code ORANGE: (for Mega Disasters as Ty Yolanda, Catastrophic Events, Pandemic, terroristic activities)	1. Conditions for Adopting Code ORANGE: (for Mega Disasters as Ty Yolanda, Catastrophic Events, Pandemic, or nationwide terroristic activities)	1. Conditions for Adopting Code ORANGE: (for Mega Disasters as Ty Yolanda, Catastrophic Events, Pandemic, nationwide terroristic activities)
Any natural, biological, technological or societal disaster, where all or any three of the following are present: • All lifelines down (communications, transportation, power, water, food supply) • More than 5000 deaths/injured • More than 50% of staff unable to report for work, especially those delivering critical functions • More than 50% of health facilities are damaged and non-functional or main hospital compromised and unable to render health services • No information within 24 hours post disaster or very limited info in the next 3 days • Breakdown in chain of command; Chaos, civil unrest, looting and safety security compromised • Isolation of the affected areas	Any natural, biological, technological or societal disaster, where all or any three of the following are present: • All lifelines down (communications, transportation, power, water, food supply) • When more than 100 (red tag) casualties are suddenly brought to the hospital; hundreds of yellow and green tagged patients • More than 50% of staff unable to report for work, especially those delivering critical functions • Hospital is structurally damaged; equipment destroyed requiring evacuation and/or transfer of patients • Breakdown in chain of command • Isolation of the affected areas • Internal disaster in the hospital and inability in the delivery of critical services	Any natural, biological, technological or societal disaster, where all or any three of the following are present: • All lifelines down (communications, transportation, power, water, food supply) • More than 5000 dead in the region and resulting to mass dead and missing • More than 50% of health facilities are damaged and non-functional or main hospital compromised and unable to render health services . • More than 50% of staff unable to report for work, especially those delivering critical functions • Chaos, civil unrest, looting and safety security compromised • Mobilization of entire regional health resources (including affected LGU Health) resources not enough and thus require external support	Any natural, biological, technological or societal disaster, where all or any three of the following are present: • All lifelines down (communications, transportation, power, water, food supply) • More than 5000 deaths/injured • More than 50% of staff unable to report for work, especially those delivering critical functions • More than 50% of health facilities are damaged and non-functional or main hospital compromised and unable to render health services • No information within 24 hours post disaster or very limited info in the next 3 days • Breakdown in chain of command; chaos, civil unrest, looting and safety security compromised • Isolation of the affected areas • Uncontrolled human to human transmission of SARS/ avian flu

CODE ALERT LEVEL: CODE ORANGE

HEMB CENTRAL OFFICE	HOSPITAL	REGIONALOFFICES	DOH CENTRAL OFFICES
2. Human Resource requirements for responding to the Code: All HEMB office personnel and staff augmentation from other offices shall be divided into 3 teams to go on a 24 hour duty rotation every 3 days. The team shall be composed of the following: • Team Leader/Assistant. Team Leader • 2-3 Data Collector/ Encoder • 2-3 Logistics members • 2-3 Communications • 2 Administrative Personnel • Support Staff/ Clerk • 2-3 drivers • Additional staff from other offices mandatory Provide staff to the OCD during the code acting as liaison for concerns related to the DOH; may open alternate OpCen nearest to site. Mobilize all HEMB staff and suspend all other activities.	2. Human Resource requirements for responding to the Code: • All personnel enumerated under Code Red • All medical interns and clinical clerks • All nurses • All nursing attendants • All institutional workers • All administrative staff Mobilize all staff of the hospital, from administrative to technical staff. Request for augmentation of hospital personnel should be addressed right away. Automatically support from outside resources (may be prearranged, pre-agreed)	2. Human Resource requirements for responding to the Code: • Mobilize all regional staff and make schedule on a rotation basis but ensuring that all areas will be covered from the operation center to the field. • All DOHREP teams in unaffected areas should report to the Regional Health Office and provide support to affected LGUs. • Provide staff at the Command Center of the Region/Province/City to serve as liaison and serve as representative of the RO. • All activities of the Region should be suspended (training, workshops, conferences, monitoring etc.) to ensure that there will be enough staff to support the operation. Mobilize all staff of the regional office from administrative to technical. Request for augmentation of RO personnel should be addressed right away.	2. Human Resource requirements for responding to the Code: • Mobilize all central office staff and make schedules to support critical services. • All CO Directors should be available at the Command Center to attend meetings, submit reports and answer concerns and issues. • All Offices provide and augment staff to the Operations Center, Command Center, warehouse and other areas needing administrative support. • Expert teams should be available for deployment as needed by the affected Regions and be involved in planning. Mobilize all staff of the central office from administrative to technical. Identify right away needed support from partners and international organizations for both technical and administrative needs.

CODE ALERT LEVEL: CODE ORANGE

HEMB CENTRAL OFFICE	HOSPITAL	REGIONALOFFICES	DOH CENTRAL OFFICES
3. Other requirements • ICS activation mandatory Coordination Activities: • Coordinate with: ↘ Regional offices, hospitals and partners to get and update information ↘ NDRRMC and other agencies and address concerns brought to the Department of Health ↘ All Central Offices; with international partners in the Health, Nutrition, WASH and Psychosocial Clusters, and conduct coordinating meetings as necessary (tri or quad cluster) ↘ All members of the health sectors ↘ With international partners for donations and other support together with BIHC ↘ With local partners for local donations Monitoring and Reporting: • Continuous monitoring and generation of reports from all sources: DOH family, NDRRMC family, all health sector partners etc. • Prepare regular updated reports/ presentations for use of Secretary, EXECOM, NDRRMC, and other partners • Document all activities and a Final Report Support Services: • HEMB-OPCEN to provide support to the DOH Command Center. • Ensure that all actions, resources and logistics are mobilized, monitored and documented • Continuous support to the OCD. • Assist in the preparation of the rehabilitation and recovery plan together with the Health Policy and Development Planning Bureau, NEDA, Regional Offices	3. Other requirements All those mentioned in Code Red plus: • Activation and Implementing the Hospital Incident Command System. For code Orange, the unaffected Hospital Director in the Region should come in for support • The Chief of Hospital/Medical Center Chiefs/ designate make decisions on the critical or essential services that will be provided; to put up temporary hospital at the hospital grounds (for structural or non-structural problems); to isolate or lock down (for pandemic or other reemerging uncontrolled epidemics) • The IC/Chief of Hospital/Medical Center Chiefs should tap other sources of manpower (from local areas, based on arrangements or agreements) and inform Central Office. (This decision should be ASAP.) • Networking with other hospitals for augmentation of resources and transfer of patients in special cases • Answers all queries of the media pertaining to patients in the hospital • Continuous reporting to SOH, superiors and HEMB Central OpCen • The IC/Chief of Hospital/ Medical Center Chief/designate to specifically be concerned with safety and security, not only of the patients but the personnel as well. All activities is to decrease mortality and morbidity of the patients but considering also the safety and welfare of the hospital personnel	3. Other requirements All those mentioned in Code Red plus: • Prearranged buddy RO together with his/her team to come in as IC. • The IC/Designate Director make decisions on the critical or essential services that will be provided; to ensure RHA done right away for prioritization of services. • The IC/Designate Director should decide right away to ask for support (manpower and logistics) after rapid assessment. This should include not only technical but admin support • Continuous networking and representing the DOH to RDRRMC/PDRRMC/CDRRMC and all clusters assigned to the DOH (Health, Nutrition, WASH, Psychosocial). • Do active and massive public Information campaign especially in evacuation centers • Ensure regular briefing of media. Anticipate issues and concerns from media. • Continuous reporting to DOH, superiors, HEMB Central OPCEN.	3. Other requirements • All Offices anticipate and prepare technical needs of the incident. Any Office can be given other responsibilities outside of their mandates to support the operations • Attend regular command conference meetings and address all issues pertaining to their Office. Implement what is discussed and approved • All Offices have standby teams and experts ready for deployment at short notices • Ready to augment other logistical needs available in each Office

CODE ALERT LEVEL: CODE ORANGE

HEMB CENTRAL OFFICE	HOSPITAL	REGIONALOFFICES	DOH CENTRAL OFFICES
Guidelines in implementing the Code Alert • The HEMB Code Alert shall be declared by the HEMB Director as recommended by any of the Division Chiefs. • Announcements should be made through telephone brigade. EOD 1 during the time of announcement should ensure that all staff are informed through all means. • Administrative Officer/EOD 1 to prepare Office Order/Department Personnel Order and be responsible for ensuring that transportation and drivers are available. • The code is upgraded, downgraded or lifted by the HEMB Director upon recommendation by any of the Division Chiefs or the Supervisor of OpCen. • Administrative Officer/EOD 1 to prepare Office Order on the changes or lifting of the Code.	Guidelines in implementing the Code Alert • The Hospital Code Alert shall be declared by the: ↘ Secretary of Health or by the Director of HEMB for emergencies with national concerns ↘ Medical Center Chiefs; Chiefs of Hospital; HHEMS Coordinator; Head of the Disaster Committee of the Hospital emergencies within their catchment area, whether internal or an external one • Chiefs of Hospital/Medical Center Chiefs to automatically declare Code White during national events and activities especially with the potential of an MCI; no need for announcement from Central Office. • Each hospital shall prepare its own procedures in declaring and lifting the Code. • The alert level is raised, lowered or suspended by the Secretary of Health or Director of HEMB for emergencies with national implications; the respective Medical Center Chiefs/Chiefs of Hospital or their designates based on their evaluation of the conditions in their catchment area. • Conditions to raise or suspend the alert level depend on the threat, whether it is increased or is no longer present. • Arrival of patients in the hospitals warrant the raising of the alert level; likewise, alert can be suspended when no significant incident is monitored and the hazard or condition (typhoon, election, bombing etc.) is finished and/or contained.	Guidelines in implementing the Code Alert • The Regional Code Alert shall be declared by the: ↘ Secretary of Health or Director of HEMB for emergencies with national implications; ↘ Regional Director and RHEMS Coordinator for regional emergencies • Regional Directors to automatically declare Code White during national events and activities especially with the potential of an MCI; no need for announcement from Central Office. • The alert is raised, lowered or suspended by the Secretary of Health or HEMB Director for emergencies with national implications; by the respective Regional Director or RHEMS Coordinator for regional emergencies. • Each region shall prepare its own procedures in declaring and lifting the Code. • Conditions to raise or suspend the alert level depends on the threat whether it is increased or is no longer present.	Guidelines in implementing the Code Alert • The Central Code Alert shall be declared by the Secretary of Health upon the recommendation and evaluation of the Director of HEMB for natural and manmade emergencies with national implications; for epidemics and reemerging diseases upon recommendation of the Directors of DPCB. • This will be disseminated through a Department Memorandum; HEMB OpCen may call through a telephone brigade all Offices concerned; this will also be followed in lifting the Code

Chapter 3

Management of the Victims

Chapter 3: Management of the Victims

I. Introduction

Proper management of victims is an integral component of a well-organized and effective response to any health emergency or disaster. Saving lives, minimizing disabilities, and preventing the victims' health conditions from worsening are the paramount concerns in any emergency or disaster. It is essential that victims, especially in mass casualty incidents (MCI), are given proper management and care on-site before they are brought to the hospital, while they are being transported to the hospital, and while they are confined in the hospital. The hospitals, therefore, must be able to address the surge capacity of victims resulting from emergencies and disasters of mega proportions. Equally important is for victims who are displaced in temporary shelters/evacuation centers to receive the same care and attention. A must in all these settings is the availability and accessibility of the essential package of health care and services to the victims regardless of where they are located or found.

While the living victims are the focus of victim management, Chapter 3 also provides guidelines on the proper management of the dead in as far as these is also part of the role of the DOH Central Office, the regional offices, and the DOH hospitals.

II. Objectives

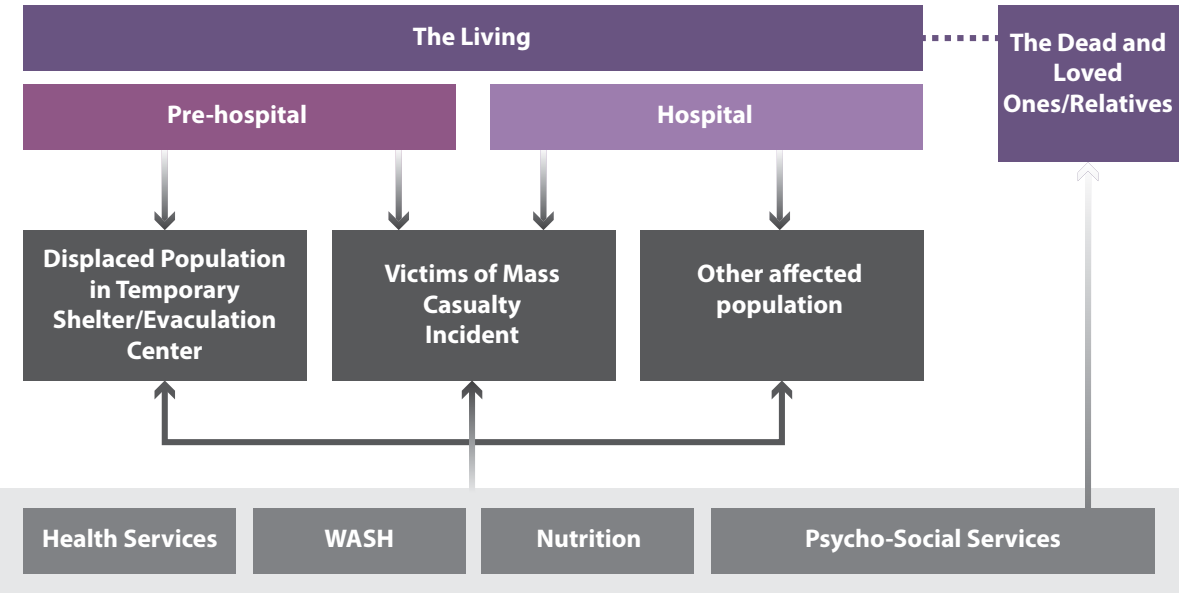
In general, Chapter 3 provides a comprehensive set of guidelines and procedures to help you manage victims of health emergencies and disasters. It is hoped that through this chapter, you will be able to:

a. Install and run a well-coordinated mass casualty incident management system.
b. Enhance the capacities of hospitals to respond to the surge volume of victims during mass casualty incidents resulting from emergencies and disasters of mega proportions.
c. Establish and operate proper management and care for victims in the community and in temporary shelters.
d. Provide victims with the essential emergency package of services in different settings: pre-hospital, hospital, community and temporary shelters.
e. Perform your expected roles and functions in managing the dead in close collaboration with the DILG and other national, regional and local agencies taking the lead in this concern.

III. Key Elements in the Management of the Victims

Management of victims encompasses the key elements illustrated In Figure 14.

Figure 14. Key Elements in the Management of the Victims



Pre-Hospital Care comprises the care and management of victims housed in temporary shelters or evacuation centers and MCI victims before they are brought to the hospital.

Hospital Care consists of care and treatment of MCI victims and the other individuals or populations affected by the emergency or disaster who require a higher level of care and services.

Care in Temporary Shelter/Evacuation Center covers the provision of care and services to populations displaced into temporary shelters (e.g., evacuation centers). It specifies the provisions stipulated in the DSWD's guidelines for managing victims in evacuation centers with focus on Health Services to be provided, including WASH, Nutrition, and Psychosocial services.

Care of Other Affected Populations refers to the management of victims affected during an emergency or disaster (not necessarily victims of MCI) that seek care and treatment in the hospitals.

Management of the Dead and Their Loved Ones and Relatives provides guidelines on the expected roles and functions of the DOH (Central Office, regional health offices, and hospitals) relative to this concern vis-à-vis the responsibilities of other lead agencies and offices at different levels of operations.

The ***Package of Services*** includes Health Services, WASH, Nutrition and Psychosocial services that must be made available to the emergency/disaster victims in different settings.

IV. Policy Statements

Policy Statement 1:

The DOH Central Office, ROs, and DOH hospitals are tasked to establish, operate and run an effective and efficient mass casualty incident management system in response to any health emergency or disaster affecting the whole country or in selected regions or localities.

Policy Statement 2:

To ensure proper management of victims of mass casualty incidents prior to hospital care, the DOH Central Office, ROs, and DOH hospitals must have established all the necessary preparations prior to the onset of the emergency or disaster, have mobilized in time all the required resources, and have properly organized and managed the operations in the field.

Policy Statement 3:

All DOH hospitals are mandated to design, install and operate the necessary systems and processes enhancing their capacities to respond to surge volume of victims brought about by any emergency or disaster of mega proportions.

Policy Statement 4:

The DOH Central Office and ROs are expected to work closely with DSWD and other concerned agencies to provide holistic management and care of victims displaced by any emergency or disaster in temporary shelters/evacuation centers.

Policy Statement 5:

The DOH Central Office, ROs, and DOH hospitals must coordinate with lead government agencies as they provide technical assistance in managing the dead.

Policy Statement 6:

A standard package of essential emergency services, inclusive of but not limited to Health Services, WASH, Nutrition and Psychosocial Services, must be clearly defined for each affected population group in various settings (community, hospital, evacuation center, etc.) and for each type of emergency or disaster, and ensured continuous availability and accessibility.

V. Guidelines

A. Managing the Victims of Mass Casualty Incidents

1. General Guidelines

1.1 ***Mass casualties require different categories of response.*** A mass casualty incident is a result of many types of hazards resulting in emergencies/disasters, and can occur in a variety of ways, all of which have a bearing on the type of response to be mounted. Examples include earthquakes, transport or vehicular accidents, violent crimes, building collapse, hazardous materials incidents, civil disturbances, natural disasters resulting in

flash floods, landslides or storm surges, major fires, and terrorist attacks.

1.2 ***Multi-Sectoral Participation.*** A comprehensive set of interventions are needed in managing victims of a mass casualty incident, necessitating multilevel and multi-sectoral actions from various groups of stakeholders.

1.3 ***Preparation for MCI.*** Adequate preparation is essential in order to effectively and efficiently manage victims in a mass casualty incident. This requires good preplanning, training, tested coordination, establishment of guidelines and procedures, early implementation of Incident Command, maximum use of existing resources, and adequate preparation and response. The first five minutes in managing mass casualties actually determine what will happen in the next five hours of the event.

2. Specific Guidelines

2.1 Field Management in a Mass Casualty Management System

There are eight components needed to respond to mass casualty incidents involving multi-sector groups. Different agencies are involved in implementing these components but the DOH is mainly involved in the following areas: alerting process, identification of the Advance Medical Post (AMP) covering the triage and treatment, evacuation of victims to the hospital, and hospital care management and treatment.

Figure 15. Definition and Components of MCI Field Management

Establishing Mass Casualty Management System Field Management	
Definition: **Encompass procedures used to organize the disaster area in order to facilitate the management of victims**	
Components:	
• **Alerting Process**	• **Search and Rescue**
• **Pre-identification of Field Areas**	• **Field Care**
• **Safety/Security**	• **Evacuation**
• **Command Post**	• **Management Center**

2.1.1 Alerting Process

The organization of the field management begins with the alert process with the following objectives:

Objectives of the Alerting Process

1. Confirm the initial warning.
2. Evaluate the extent of the problem.
3. Ensure that appropriate resources are informed and mobilized.

2.2 OpCen Functions

a. The OpCens established at the DOH-CO, ROs and hospitals play a critical role in the management of casualty incidents as summarized below:

Functions of OpCen for MCI

1. Receive all warning messages via all sources.
2. Serve as dispatch center in times of emergencies.
3. Anticipate scenarios and alerts and guide additional teams going to the site as needed.
4. Alert all receiving hospitals to prepare for influx of patients.
5. Coordinate and monitor logistical requirements/needs at the site.

b. The Operations and Dispatch Center shall observe the following conditions in dispatching the Response Teams:

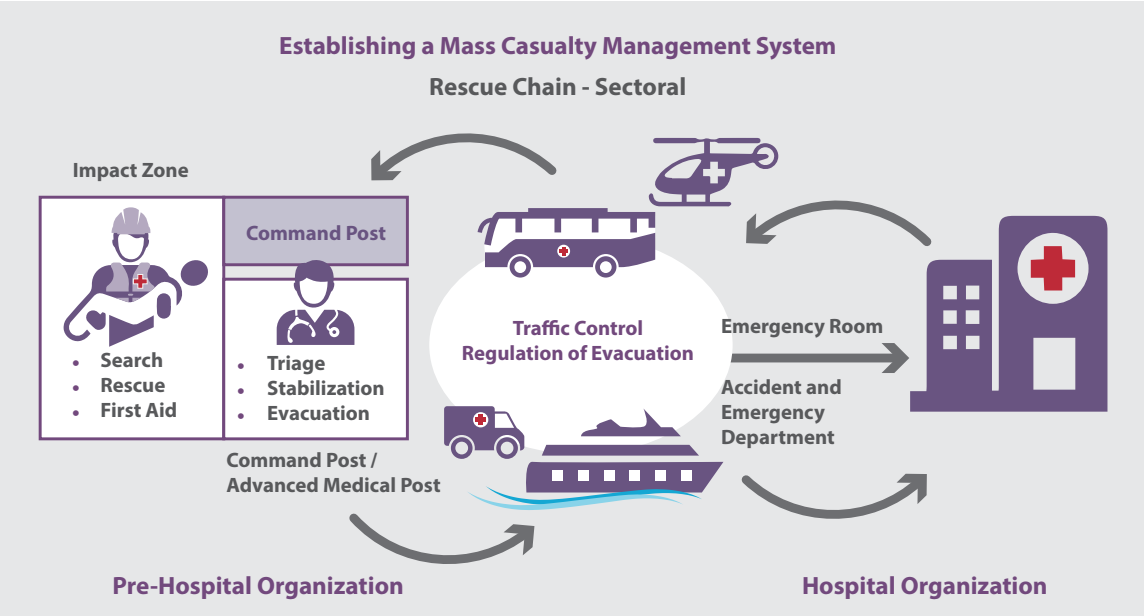
Guidelines in Dispatching Response Teams

1. For confirmed MCI, teams within the catchment area will be the first to be dispatched.
2. Teams outside the catchment area can also be dispatched upon the request of the team on-site or upon instruction of HEMS Central Operations Center.
3. The DOH Central Office Operations Center, upon instruction of the HEMB Director, can dispatch teams from any hospital or RO upon monitoring events that necessitate response from DOH or upon request by government agencies with authority over certain events (NDRRMC, NSC, etc.)
4. While the initial Response Teams have been dispatched, the Operations and Dispatch Center shall anticipate a scenario alert or actively get more information to decide when additional teams might be needed.
5. Nearby hospitals and possible receiving hospitals should anticipate and prepare by reviewing logistics and personnel requirements.

2.3 Organization of Field Management

Field management encompasses the procedures used to organize the disaster area in order to facilitate the management of victims. As shown below, a number of activities and processes have to be properly managed on-site (pre-hospital organization) prior to bringing the victims to the hospitals or referring them to the evacuation shelter. These processes, where the DOH is heavily engaged, include the Advanced Medical Post (AMP) where triaging and stabilization of victims take place, including the transport of victims to the hospital, and at the ER itself.

Figure 16. Field Management Organization



2.3.1 Initial Assessment and Pre-Identification of Field Areas

a. The initially dispatched Response Team shall undertake initial assessment of the actual situation in the field.

Table 16. Objectives and Data Requirements for Initial Assessment

Aims of Initial Assessment	Data Requirements for Initial Assessment
1. Identify immediately the extent and potential risk of the problem. 2. Mobilize adequate resources to correctly organize field management. 3. Conduct immediate assessment of the initial incident.	• Precise location of the event • Time of the event • Type of incident • Estimated number of casualties • Added potential risk • Exposed population • Right resources needed (logistics and manpower)

b. Submit the results of the initial assessment immediately to the Operations Center. At this stage, refrain from starting any haphazard or unplanned work to avoid delay in the mobilization of resources.

c. Pre-identify field areas for various purposes prior to dispatch and operations to allow the various incoming resources to reach their places rapidly and efficiently. This stage is actually the first part of deployment. The identification of the field areas should consider the factors listed in Table 17.

Table 17. Pre-Identification of Field Areas

Considerations in the Identification of Field Areas	Field Areas
1. Topography of the area 2. Wind direction 3. Access roads 4. Potential risks to victims; include population and boundaries	1. Impact Zone 2. Command Post Area 3. Advance Medical Post Area 4. Evacuation Area 5. Staging Area 6. VIP and Press Area

2.3.2 Search and Rescue

Note that the Search and Rescue operation is led by the Department of National Defense (DND) and the DOH is just one of the other concerned agencies tasked to perform this task. The particular role of DOH in Search and Rescue includes the following:

a. Locate the victims.
b. Move the victims from unsafe locations into the collecting area.
c. Assess the victims' status or do an on-site triage.
d. Provide first aid, if necessary (no CPR on-site in MC event)
e. Transfer victims to AMP through entry triage (medical triage) under the supervision of the CP/IC or Commander/Coordinator.
f. Require trained medical personnel to stabilize/resuscitate/amputate trapped victim before extrication in special situation.

2.3.3 Pre-Hospital Care

a. The Triage Process

Triage comes from the French word that means "to sort." It is utilized to identify treatment priorities by deciding which victim receives treatment and which does not. It is performed on the basis of the urgency relative to: (i) the victim's status; (ii) victim's survival (chance or likelihood); and (iii) availability and capability of care resource. The triage identifies victims for immediate stabilization, life-saving measures, or surgery.

i. There are four basic priority categories for treatment and transport:
ii. Highest Priority
- Patients require immediate care and transport.
- Patients receive treatment at the scene for life-threatening injuries.
- First to be sent to available medical facilities.

Intermediate Priority
- Patient treatment and transport can be delayed.

Delayed or Low Priority
- Referred to as "walking wounded".
- Injuries require medical care at some point.

- Treatment and transport can be delayed.
- Patients to be monitored and reassessed.

Lowest Priority

- Patients have either died or are near death.
- Alive victims but have suffered severe or serious injuries with little chance of survival.
- When resources are limited, patients must be ignored.

iii. Triaging can be done at three levels:

- On-site or where the victims lie: The victims are classified into two categories – acute or non-acute.
- At the Advance Medical Post: Victims are classified into four categories and color-tagged as: Red, Yellow, Green or Black.
- During evacuation or transport of victims: Victims are also classified into four categories and color-tagged as in the AMP.

iv. The Initial Triage Officer shall:

- Size up the situation.
- Ensure safe approach and scene survey.
- Activate additional resources based on:
  - Number of victims
  - Size of the incident
- Better to requesting more equipment and personnel than not enough

v. Simple Triage and Rapid Transport System

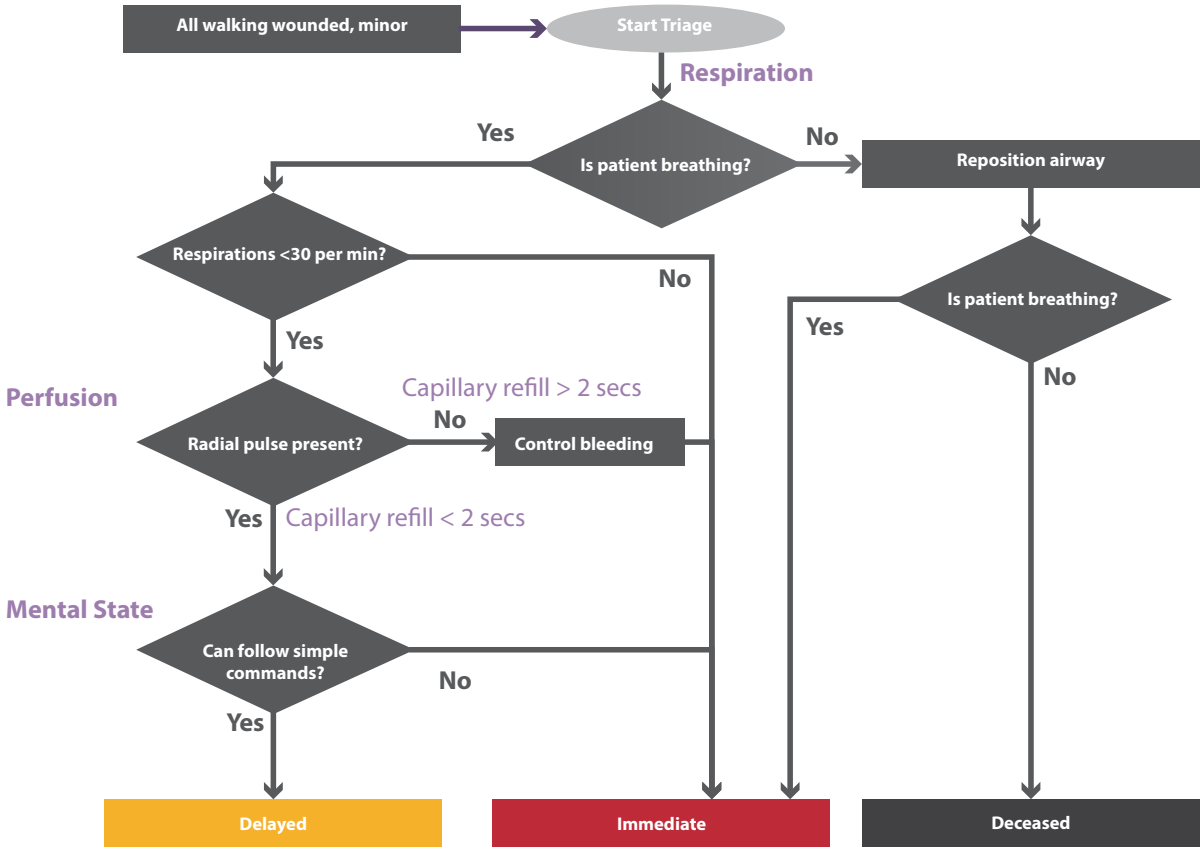
The system requires first responders to have tags, ribbons or tapes in four colors:

- Priority One (Highest Priority)
  - **Red**: Requires immediate care (e.g., life-threatening injuries)
- Priority Two (Intermediate Priority)
  - **Yellow**: Requires urgent care but can delay treatment and transport up to one hour
- Priority Three (Delayed or Low Priority)
  - **Green**: Walking wounded but can delay treatment and transport up to three hours
- Priority Four (Lowest Priority)
  - **Black:** No care required: patient is dead or near death
  - Hardest priority to deal with emotionally
  - Necessary for others to survive

vi. Steps in triaging victims

- First step
  - Announce to all people able to get up and walk to go to a specific area.
  - Allow responder to focus on the injured.
  - Place green tag to people who can successfully move
  - Tell people to look out for each other and notify responders of any significant changes.
- Second step
  - Conduct an orderly survey of remaining victims.
  - Decide how to move through area.
  - Perform quick assessment on each person and label or tag accordingly; no more than 10 seconds per patient.

Figure 17. Triage Process and Steps



b. Advanced Medical Post

A recent progress in pre-hospital emergency/disaster medicine is the establishment of an Advanced Medical Post (AMP) which requires good triaging, specially skilled or trained "disaster field medical teams", and good communication (radio) between the field scene and the medical facility.

i. The AMP is intended to manage victims pre-hospital and to prevent transferring the chaos in the scene or field to the hospital. The purpose of the AMP is to reduce loss of life and limb, and to save as many victims as possible in the context of existing and available resources/ situation. This is on the basis of the victim's status, chance of survival, and available resources.

ii. The AMP abides by the 3-T Principle of Tag-Treat-Transfer of the victim.

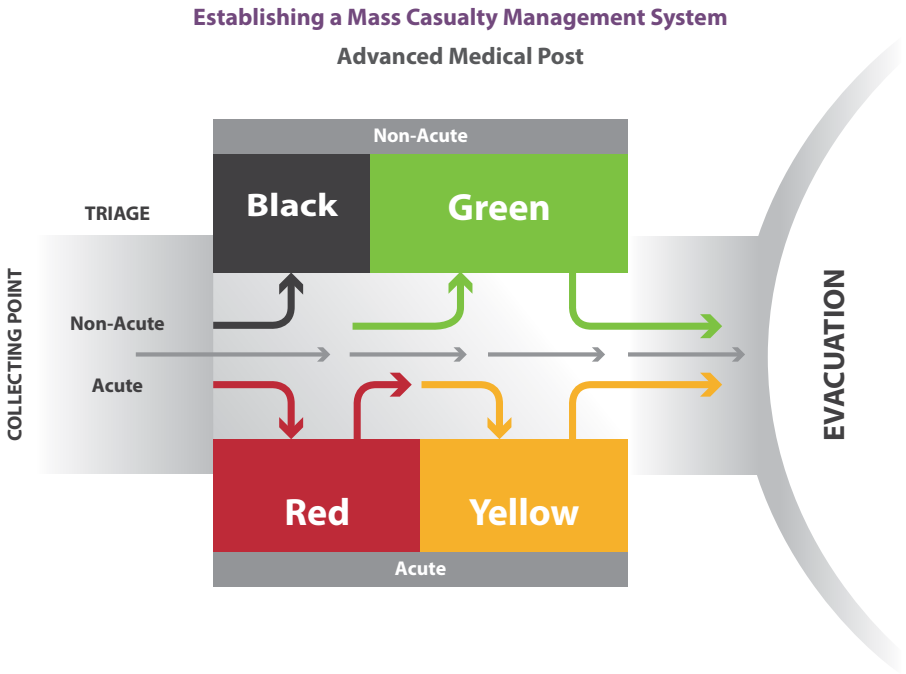
iii. The AMP is located about 50-100 meters from Impact Zone (walking distance) with direct access to the Evacuation Road/Command Post, in clear radio-communization zone, and is safe (upwind).

iv. The AMP can be a tent, building or a mobile field hospital.

v. The roles of the AMP are the following:
   - Provide "entry" to medical triage.
   - Stabilize effectively the victims in an MCI situation.
   - Perform intubation, tracheostomy, chest drainage, shock management, analgesia, fracture immobilization, fasciotomy, control of external bleeding, and dressing.
   - Convert Red to Yellow category as may be possible.
   - Organize patient transfer to designated care facilities.

vi. AMP requires the presence or availability of the following personnel:
   - Emergency room personnel (Accident and Emergency Department), physicians/nurses (trained and skilled)
   - Support personnel: anesthetists/surgeons/EMTs/nurses/aiders, etc.

Figure 18. Advance Medical Post for MCI



c. Evacuation/Transfer Organization

This process ensures that victims of MCI are safely, quickly, and efficiently transferred by appropriate vehicles to the appropriate prepared facility.

i. In preparing for evacuation, determine if the receiving facility is a single or multiple reception facility. You must also establish the type of vehicle, the type of escort required, and the specific destination.

ii. In preparing for transport, the Evacuation Officer reporting to the ATM should:
- Assess the patient's status: vital signs, ventilation/hemostasis.
- Check security of equipment and accessories.
- Ensure efficiency of immobilization measures.
- Ensure that triage tags are secure and clearly visible.

iii. Evacuation procedures
- The evacuation of victims is guided by two basic principles:
  - "Not to overwhelm the care facility."
  - "Avoid spontaneous evacuation of unstable patients."
- Evacuation of victims must be done only if the following conditions are met:
  - Victim is in most possible stable condition.
  - Victim is adequately equipped for transfer.

- Receiving facility is correctly informed and ready.
- The best possible vehicle and escort are available.

B. Hospitals Responding to Surge Capacity

The network of hospitals constitutes the major component of the national health care delivery system. They provide a more comprehensive level of health care and services requiring more sophisticated procedures which the primary health care facilities cannot provide. The importance of hospitals becomes more critical during emergencies and disasters when they are expected to manage and treat victims suffering from different forms of injuries, traumas, life-threatening conditions, and different forms of diseases. When the impact of disasters is felt, the importance of uninterrupted hospital services becomes even more appreciable. Hospitals should be able to handle not only internal emergencies but external emergencies as well. With the expectation that hospitals must be able to buffer and manage the sudden surge of patients coming in for medical care, the corresponding mechanisms to manage logistical, material, and human resources as humanitarian aid for health should be in place.

1. General Guidelines

1.1 All efforts must be exerted to ensure the continuous/uninterrupted operations of the hospitals and other health care facilities to address the challenges of emergencies and disasters. Hospitals and other health care facilities must be prepared to withstand and remain functional during these situations.

1.2 All hospitals must have the surge capacity to address the sudden increase in number and prolonged demand of emergency and disaster victims coming in for management and treatment.

1.3 Enhancing the surge capacity of hospitals includes providing for increased number of potential patient beds, wider space where patients may be triaged, managed, vaccinated, decontaminated, or simply located, increased available personnel of all types, and continuous availability of necessary medications, supplies and equipment, as well as the legal capacity to deliver health care under situations which exceed authorized capacity.

1.4 Hospitals and other health care facilities shall utilize, build and strengthen partnerships and networks, and develop corresponding mechanisms in times of emergencies and disasters.

2. Specific Guidelines

2.1 Hospitals must be able to introduce and undertake innovative measures along the 4Ss – space, staff, stuff, and special services – of the hospital organization and operations in order to respond to surge capacity.

2.2 The hospital should be the last facility standing in a disaster and must continue functioning even after the disaster. In the event that there is failure in operations due to structural damage, destroyed equipment, or hospital staff being also disaster victims, the following minimum hospital services should be in place:

Table 18. Strategies/Mechanisms in Handling Surge Capacity

Space	Staff	Stuff	Special Services
• Use pre-identified spaces to accommodate additional patients and provide additional beds. • Create extra spaces; use lobby, meeting/training rooms, gyms, tents or mobile hospitals. • Discharge stable patients and facilitate fast discharges of patients. • Increase capacity for operations by increasing number of operating tables/rooms. • Make arrangements with other non-admitting hospitals to receive transfer of some patients. • Prioritize admissions only of patients from disaster sites. • Stop elective admissions and surgeries.	• Observe the code alert, thereby observing the organizational shift to an emergency mode. • Reassign hospital staff to direct provision of care and management. • Extend number of hours for hospital staff. • Cancel all leaves, vacations and training. • Receive volunteers, local staff and experts from other members of the network (usually predetermined and prearranged). • Hire contractual personnel during this period.	• Do emergency procurement for logistics not available in the hospital and/or network. • Activate MOA with pharmaceutical companies for special arrangements, delivery of essential drugs, supplies and/or equipment. • Encourage inter-hospital, interagency and inter-regional sharing of resources, especially from non-affected hospitals. • Increase stockpiling especially of emergency essential drugs, medicines and supplies in anticipation of disasters. • Tap and encourage donations from local or international partners. • Improve logistics management. • Establish warehouses nearby or around emergency sites or strategic points.	• Establish fast lanes for diagnosis, management and treatment (e.g., dengue fast lanes); set up a one-stop shop for administrative requirements (e.g., payment, processing of PhilHealth requirements). • Facilitate payments for emergency procurement. • Mobilize PhilHealth support for covering conditions and services resulting from the emergency or disaster. • Establish arrangements for needed higher-level hospital care, especially for special cases (neurosurgical or spinal cases, etc.) • Provide psychosocial services, especially for victims needing special care and attention. • Provide for other concerns, like nutritional and other public health needs.

Table 19. Essential Services to Be Provided by Hospitals During Emergency/Disaster

Secondary/Tertiary Hospitals (District and Provincial Hospitals/Level 1 and 2)	Regional Hospitals and Medical Centers (Level 3)
• First aid (e.g., wound care, etc.) • Emergency room care • RH services including NSD • Care for simple orthopaedic cases like splinting/ packaging of patient • Simple surgical procedures including appendectomy	• First aid (e.g., wound care, etc.) • Emergency room care • RH services including Caesarian section • More complex orthopaedic and neuro-surgical cases • Cardio-thoracic surgery • Acute abdominal surgery • Blood transfusion

C. Management of Victims in Evacuation Centers

The LGUs have the overall responsibility for setting up and managing evacuation centers (EC) for displaced populations during an emergency or disaster. The DOH and other concerned national agencies are called upon to assist in managing and running these centers if the need goes beyond what the local governments can handle. The major involvement of the DOH (CO, ROs and hospitals) is in managing the victims during emergency or disaster, as described below.

1. General Guidelines

1.1 All established evacuation centers should be able to provide the four essential packages of health services: Health Care, WASH, Nutrition and Psychosocial.

1.2 The EC should have areas for medical station/clinic, isolation and quarantine facilities, breastfeeding corners.

1.3 The EC must be able to provide evacuees with access to safe water, sanitary toilet, and waste disposal area.

1.4 Essential drugs/medicines and medical supplies must always be available in the EC once activated.

1.5 The EC should be equipped with communication and transportation facilities to be able to refer and transfer evacuees needing higher level of health care.

1.6 Health point persons assigned in managing evacuees must actively participate in the overall management of the evacuation center.

2. Specific Guidelines

2.1 Ensure that the following essential services are available in the evacuation centers:

Table 20. Essential Services in Evacuation Centers

Health	WASH	Nutrition	Psychosocial Services
• Medical station/clinic • Isolation and quarantine facilities for communicable diseases • Basic medicines and medical supplies – CAMPOLAS Plus kit • Medical teams available 24/7 especially for high-risk EC/temporary shelters • Consultation and treatment, immunization, chemoprophylaxis • Reproductive health services; child care Services • Provision of services for TB and other non-communicable diseases (HPN, diabetes, etc.), including continuous provision of medicines • Provision of transport to other/higher level health facilities Note: • ECs within 500 meters of nearest public health facility shall utilize that facility. • ECs more than 500 meters from nearest public health facility should be manned by health staff 8 hours on a daily basis for the first 2 weeks.	• Toilet and bathing areas; well lit, can be locked from inside; with adequate ventilation; separate for men and women; 4 female toilets to 3 male toilets; 1 toilet for disabled • Installation/ construction of toilet facilities: toilets for short-term displacement – 1 per 50 persons; for long-term displacement – 1 per 20 persons • Provision of potable drinking water (bottled water, water rationing/trucking); water analysis and treatment • Continuous water quality monitoring (water analysis and treatment) • Provision of water kits • Provision of hygiene kits; • Promotion activities • Vermin control program such as spraying, fumigation, misting if necessary • Provision of garbage bins or labeled waste receptacles • Repair/restoration of water facilities	• Establishment of breastfeeding areas/corners with privacy, security and supportive care • MUAC screening • Food and inspection and monitoring of milk code violations • Outpatient feeding for moderately and severely acute malnourished (MAM/ SAM) children (high-risk group) • Referral of severely acute malnourished children with complications • IYCF assessment and counselling • Provision of access to breast milk supply (milk banks and wet nurses) • Blanket Supplementary Feeding for children 6-59 months • Provision of vitamin A capsules (VAC), Multiple Micronutrient Powders (MNP); iron with folic acid; • Zinc supplementation for all diarrheal cases • Inclusion of fortified foods in family packs	• Rapid MHPSS assessment • Level 1: psychosocial services for acute needs: psychological first aid, provision of basic needs • Level 2: addressed to vulnerable groups - community and family support • Level 3: focused services at managing high-risk cases to prevent and reduce risks of mental health cases and their consequences psychosocial processing (PSP) or debriefing, counseling, etc. • Level 4: specialized services for cases: treatment by specialists, management in mental health facilities • Provision of psychotropic drugs • Consultation and treatment; • Provision of transport to higher-level health facilities

2.2 Each respective Point Person of the cluster in charge of the service packages shall carry out the tasks listed below. In providing these services, there are international standards known as SPHERE that can be used as reference. (Refer to Table 22)

Table 21a. Tasks of the Health Cluster Point Person

Pre-Impact (A day or days before)	During Impact (0 hour to 48 hours)	Post-Impact (After 48 hours and onwards)
• Ensure collection and dissemination of information to partners by HEMB Operations Center. • Identify high-risk areas based on pre-event data to determine areas to be prioritized in logistics and human resource mobilization. • Check inventory of resources and prepare logistical needs: ↘ CAMPOLAS Plus kits ↘ First aid kits ↘ Family kits ↘ Hygiene kits ↘ WASH supplies ↘ Cot beds ↘ Tents ↘ Cadaver bags • Check coverage of health programs in the areas to be affected. • Have standby medical teams and public health teams. • Conduct pre-deployment orientation to teams. • Map out partners (4Ws: Who, What, When, Where)	• Coordinate with partners and call for a cluster meeting for planning health response. • Activate Health Cluster Response Plan. • Ensure deployment of rapid health assessment teams and regular submission of reports which will be used in planning response actions. • Ensure assessment of established evacuation centers/ temporary shelters. • Ensure assessment of all affected health facilities. • Deploy medical teams and public health teams depending on needs of the assessed areas. • Decide activation of SPEED in all health facilities. • Augment logistics such as medicines, medical supplies, WASH supplies, cadaver bags, etc. to affected areas. • Ensure submission of reports to Operations Head and HEMB Operations Center. • Continuously disseminate reports to partners • Conduct Health Cluster meetings; initiate quad or tri-cluster meetings	• Ensure adequate and timely provision of different health services in areas affected: ↘ Medical consultation and treatment ↘ Measles immunization ↘ Tetanus vaccination ↘ Chemoprophylaxis ↘ Reproductive health ↘ Health education • Activate SPEED. • Provide CAMPOLAS Plus kits and other logistics. • Provide technical assistance. • Augment medical and public health teams based on the assessments done and surge of patients. • Ensure assessment of all damaged health facilities. • Map out Health Cluster Response using 4Ws (Who, What, When, Where). • Conduct regular cluster meetings. • Ensure proper documentation of all health responses provided, lessons learned and recommendations for the improvement of future response. • Ensure submission of reports to Operations Head and dissemination of reports to partners. • Prepare Recovery and Rehabilitation Plan.

Table 21b. Tasks of the Nutrition Cluster Point Person at Various Stages of the Response

Pre-Impact (A day or days before)	During Impact (0 hour to 48 hours)	Post-Impact (After 48 hours and onwards)
• Monitor through the Operations Center or through quad media. • Update resource inventory/ mapping of logistics: ↘ Vitamin A capsules ↘ Multiple micronutrient powders ↘ Ferrous sulfate or iron with folic acid ↘ IECs for nutrition ↘ MUAC tapes ↘ Weighing scale ↘ Weight for height reference table ↘ Height board ↘ RUTF ↘ RUSF ↘ Human milk banks (inform them ahead for proper coordination) • Obtain pre-event data and get nutrition status of areas that have great risk of the incoming emergency/disaster. • Coordinate with partners in relation to their availability, location, and resources available. • Activate Standby Teams depending on the magnitude expected or projected: ↘ Joint Rapid Nutrition Assessment Teams ↘ Infant feeding/ Breastfeeding Support Groups	• Obtain health assessment reports, and real-time updates from the Operations Center or other sources. • Establish contacts and gather critical information (baseline) to identify immediate priorities where situation may worsen. • Identify areas for assessment, prepare team, request for augmentation if necessary, and facilitate deployment; conduct pre-deployment orientation • Assist in the conduct of gap-analysis and in the prioritization and planning/ scheduling of nutrition interventions. • Disseminate daily situation report to DOH HEMB and partners. • Alert notification to health facilities with capacities for severe acute malnutrition (SAM) or “severe wasting” management in the area.	• Provide technical assistance on the following: ↘ Implementation of nutrition interventions ↘ Information management ↘ Monitoring and evaluation ↘ Resource augmentation and generation ↘ Policy monitoring of EO51 (MILK Code) • Lead/facilitate cluster coordination initiatives. • Lead in the preparation of Recovery and Rehabilitation Plan. • Continuously review and update action plan. • Report daily to HEMB OpCen on accomplishments and interventions done. • Regularly report to quad or tri-cluster meetings. • Accomplish documentation including Post-Incident Evaluation.

Table 21c. Tasks of the WASH Cluster Point Person

Pre-Impact (A day or days before)	During Impact (0 hour to 48 hours)	Post-Impact (After 48 hours and onwards)
• Monitor event through the Operations Center or through quad media. • Gather data and information regarding status and assessment of evacuation center/temporary shelters. • Coordinate with partners in relation to their availability, location, and resources available. • Conduct inventory of WASH logistics. • Map and check status of partners. • Start communication and coordination with partners. • Prepare WASH teams on standby. • Initiate action planning for MHPSS response. Note: a. WASH assessment in pre-Identified ECs c/o LGU b. Prepositioning water (bottled water) c/o LGU and partners c. Prepositioning of hygiene kits c/o LGU or RO	• Obtain health assessment reports and real-time updates from the Operations Center or other sources. • Establish contacts and gather critical information (baseline) to identify immediate priorities where situation may worsen. • Activate WASH cluster; activate WASH response plan. • Identify areas for assessment, prepare WASH assessment teams with logistic provision, facilitate deployment; conduct pre-deployment orientation. • Organize WASH services in the evacuation centers, communities and hospitals. • Disseminate daily situation report to DOH HEMB and partners. • Deploy Regional WASH Team if needed. Note: a. Provision of potable water (bottled water, water rationing/ trucking, water treatment) c/o LGU, partners and RO b. Provision of water kits and hygiene kits c/o LGU or RO c. Provision of labeled waste receptacles c/o LGU and partners	• Provide technical assistance on the following: ↘ Implementation of WASH interventions ↘ Repair/restoration of water facilities c/o LGU, water providers and partners ↘ Monitoring and evaluation • Conduct WASH damage needs and assessment. • Continuously augment water kits/water disinfectants, hygiene kits, water testing reagents, IEC. • Continuously and massively promote hygiene. • Identify response gaps and resource requirements; arrange for resource augmentation and generation. • Map out MHPSS response using 4Ws (Who, What, When, Where). • Continuously review and update action plan. • Lead/facilitate cluster coordination initiatives; attend quad cluster meetings. • Lead in the preparation of Recovery and Rehabilitation Plan. • Report daily to HEMB OpCen on accomplishments and interventions done. • Document response including Post-Incident Evaluation.

Table 21d. Tasks of the PSS Cluster Point Person

Pre-Impact (A day or days before)	During Impact (0 hour to 48 hours)	Post-Impact (After 48 hours and onwards)
• Monitor event through the Operations Center or through quad media. • Conduct pre-disaster MHPSS risk assessment. • Coordinate with partners in relation to their availability, location, and resources available. • Review resource map and check inventory of resources (health facilities, psychiatric facilities, rehab and treatment centers, trained MHPSS providers, experts, drugs and medicines, MHPSS kits, IEC materials, etc.) • Map and check status of partners. • Start communication and coordination with partners. • Prepare MHPSS teams on standby. • Review stockpile of logistical needs. • Initiate action planning for MHPSS response.	• Obtain health assessment reports and real-time updates from the Operations Center or other sources. • Establish contacts and gather critical information (baseline) to identify immediate priorities where situation may worsen. • Activate MHPSS cluster; activate MHPSS response plan. • Identify areas for assessment, prepare MHPSS assessment teams with logistic provision, facilitate deployment; conduct pre-deployment orientation. • Organize MHPSS services in the evacuation centers, communities and hospitals. • Disseminate daily situation report to DOH HEMB and partners.	• Provide technical assistance on the following: ↘ Implementation of MHPSS interventions ↘ Screening and referral to higher levels for high risk cases ↘ Monitoring and evaluation • Conduct MHPSS orientations as necessary. • Disseminate IEC materials. • Identify response gaps and resource requirements; arrange for resource augmentation and generation. • Map out MHPSS response using 4Ws (Who, What, When, Where). • Continuously review and update action plan. • Lead/facilitate cluster coordination initiatives; attend quad cluster meetings. • Lead in the preparation of Recovery and Rehabilitation Plan. • Report daily to HEMB OpCen on accomplishments and interventions done. • Accomplish documentation including Post-Incident Evaluation.

2.3 Observe the following SPHERE Standards for the requirements in the provision of Health, WASH, Nutrition and Psychosocial Services:

Table 22. SPHERE Standards for the Provision of Health, WASH, Nutrition and Psychosocial Services

HEALTH

HEALTH SERVICE DELIVERY

1 basic health unit	10,000 population
1 health center	50,000 people
1 district/rural hospitals	250,000 people
>10 inpatient and maternity beds	10,000 people

HUMAN RESOURCES

1 medical doctor	50,000 population
1 nurse	10,000 population
1 midwife	10,000 population
1 community health worker	1,000 population
Clinicians	50 patients per day

EMERGENCY SHELTER GUIDELINES

Accommodation

Minimum floor area	3.5 m^2/person
Minimum Air space	10 m^3/person
Minimum Air Circulation	30m^3/person/hr
Minimum distance between beds	75 cms

Washing

1 hand basin	10 persons
1 wash bench	(4-5m)/100 persons

Laundry platform (3 m double-sided)

Two/100 persons

SEXUAL AND REPRODUCTIVE HEALTH

- Pregnant women in their 3rd trimester should receive clean delivery kits.
- At least 4 health facilities with BEmONC and newborn care/500,000 population
- At least 1 health facility with CEmONC and newborn care/500,000 population
- Proportion of deliveries by Caesarian section is not less than 5% or more than 15%

NUTRITION

NUTRITIONAL ASSESSMENT AND MEASURING TARGETS

Age Groups	Ave. % in Population
Infants < 6 mos	1.35
6-11 mos	1.35
12-59 mos	10.8
5-9 years	11.7
10-14 years	10.5
15-19 years	9.5
20-59 years	48.6
*Pregnant Women	3.5
*Lactating Women	3.0

CLASSIFICATION OF MALNUTRITION IN CHILDREN

Nutrition Indicator	Well-nourished	MAM	SAM
Weight for height	+2 to 1 SD (90-120%)	WFH- 3- <-2 Z score (70-79%)	WFH <-3 Z score (<70%)
MUAC	>13.5 cm	MUAC 11.5-<12.5cm	MUAC <11.5 cm
Edema	Absent	Absent	Absent

ESTIMATING ENERGY REQUIREMENTS

- Average daily energy requirement is 2,100 kcal/person/day broken into:
  - 10% of total energy provided by protein (53g)
  - 17% of total energy provided by fat (40g)
  - Adequate micronutrient intake
- Special needs of pregnant women
  - Needs additional 300 kcal/day
  - If malnourished, need another 500 kcal/day
  - Should receive iron and folate supplements
- Special needs of lactating women
  - Needs an additional 500 kcal/day
  - If malnourished, need another 500 kcal/day
  - Should receive sufficient fluids, taking into account activity.

BREAST FEEDING

Up to 6 mos	• Breastfeed as often as child wants, at least 8x in 24 hours
6 mos to 12 mos	• Breastfeed as often as the child wants. In addition, give adequate servings of complementary food 3x a day
12 mosto 2yrs	• Breastfeed as often as child wants. Give adequate servings of complementary food at least 5 times a day
> 2 yrs	• Give three meals of family food per day. Also give nutritious food 2x a day

MICRONUTRIENT SUPPLEMENTATION DURING EMERGENCIES/DISASTERS SITUATION

Give additional Vit A	Ave. % in Population
6-11 mos infants	100,000 IU
12-59 mos children and postpartum women (unless they have not received similar dose in past 4 wks.)	200,000 IU

Micronutrient Powder (MNP) supplement

6-23 mos children; expand provision of MNP to 24-59 yo as well as pregnant and lactating women

Measles vaccine

Should be available targeting all infants and children 6-59 mos (may be expanded up to 15 yrs with substantial crowding)

Give Elemental Iron	
2-6 mos (low birth weight)	0.3ml of 15 mg /0.6ml
10-49 yrs lactating women/nonpregnant women	1 tab 60 mg iron with 2.8 mg folic acid weekly
180 days starting from determination of pregnancy	1 tab 60 mg Fe with 400mcg folic acid daily
Anemic patients less than 10 yrs	Therapeutic dose
Anemic 10-49 yrs	1 tab of 60mg Fe with 400 mcg folic acid daily until Hgb normalizes

WATER, SANITATION AND HYGIENE (WASH)

WATER REQUIREMENTS FOR SURVIVAL (PER PERSON)

Type of need	Quantity (liters per day)
Survival (drinking and food)	2.5-3 lpd
Basic hygiene practices	2-6 lpd
Basic cooking needs	3-6 lpd
TOTAL	**7.5- 15 lpd**

MAXIMUM NUMBER OF PEOPLE PER WATER SOURCE

250 people per tap	Based on a flow of 7.5 liters/min
500 people per hand pump	Based on a flow of 17 liter/min
500 people per single use open well	Based on a flow of 12.5 liter/min

MINIMUM WATER QUANTITIES FOR INSTITUTIONS AND OTHER USES

Use	Guideline quantity
Health centers and hospitals	• 5 liters/outpatient; 40-60 liters/in-patient/day(additional for laundry equipment, flushing toilets)
Cholera centers	• 60 liters/patient/day; 15 liters/carer/day
Therapeutic feeding centers	• 30 liters/in patient/day; 15 liters/carer/day
Reception/transit centers	• 15 liters/ person/day if stay is more than one day
Schools	• 3 liters/pupil/day for drinking and hand washing (use for toilets not included)
Mosques	• 2-5 liters/person/day for washing and drinking
All flushing toilets	• 20-40 liters/user/day for conventional flushing toilets connected to a sewer; 3-5 liters/user/day for pour flush toilets
Anal washing	• 1-2 liters/person/day
Livestock/day	• cattle, horses, mules: 20-30 liters/head; goats, sheep, pigs: 10-20 liters/head; chickens: 10-20 liters per 100

SUGGESTED QUANTITIES OF WATER AND DISTANCES OF WATER POINTS FROM SHELTERS AT DIFFERENT STAGES OF EMERGENCY RESPONSE

Time	Qty	Distance
2wks-1mo	5 lpd	1 km
1-3 mos	10 lpd	1 km
3-6 mos	15 (+) lpd	0.5 km

Minimum provision of domestic water containers:
Two vessels 10-20 L for collecting water plus one 20 L vessel for water storage, (narrow necks and covers) per 5 person HH

Maximum distance from any HH	500 meters
Maximum waiting time to collect water	15 minutes
Disposal of wastes through communal pit	1.2x1.2x1.8 meters in size for every 500 persons

WATER TREATMENT OPTIONS AND HOUSEHOLD DRINKING WATER

Item	Amount
Drinking Water Disinfectant (tablet), sodium dicholoro-isocyanourate	• 3.5 mg tab (free available chlorine 2mg) for 1 liter water • 67 mg tab (free available chlorine 40 mg) for twenty liters water
Water Disinfectant (granular), calcium hypochlorite (65-70% available chlorine)	• Stock Solution: Mix 1 tsp/5 grams of calcium hypochlorite in 1 liter water • From Stock Solution: Mix 2 tsp in 20 liters of water and let it stand for at least 30 min

LIST OF BASIC HYGIENE ITEMS

Item	Amount
10-20 liter capacity water container for transportation	1/household
10-20 liter capacity water container for storage	1/household
250 g bathing soap	1/person/month
250 g laundry soap	1/person/month
Acceptable material for menstrual hygiene	1/person

WATER, SANITATION AND HYGIENE (WASH) (...continued)

BASIC SURVIVAL WATER NEEDS

Use	Minimum demand	Remarks
Survival needs: water intake (drinking and food)	2.5-3 L	Depends on the climate and individual physiology
Basic hygiene practices	2-6 L	Depends on social and cultural norms
Basic cooking needs	3-6 L	Depends on food type and social and cultural norms
TOTAL	7.5-15 L	

MINIMUM WATER DEMAND PER DAY (PROLONGED PERIOD)

Use	Minimum demand
Drinking	2 liters/person/day
Food preparation and cooking	10 liters/person/day
Bathing	15 liters/person/day
Laundry	15 liters/person/day
Sanitation and hygiene	10 liters/person/day
TOTAL	**52 liters/person/day**

PSYCHOSOCIAL SERVICES

ESSENTIAL HEALTH SERVICES - MENTAL HEALTH: KEY ACTIONS

- Ensure interventions are developed on the basis of identified needs and resources.
- Ensure that there is at least one staff member at every health facility who manages diverse, severe mental health problems in adults and children.
- Enable community members including marginalized people to strengthen community self-help and social support.
- Address the safety, basic needs and rights of people with mental health problems in institutions.
- Ensure that community workers, including volunteers and staff at health services, offer psychological first aid to people in acute distress after exposure to extreme stressors.
- Minimize harm related to alcohol and drugs.
- As part of early recovery, initiate plans to develop a sustainable community mental health system.

D. Management of the Dead

In emergency or disaster management, most efforts are concentrated on the living victims, while the very least considerations are given to the dead. This section provides the guidelines on the management of the dead, with the DOH providing technical assistance to the agencies in-charge, such as the DILG. For better appreciation, the general guidelines are presented in whole although these are beyond the domain of the DOH. The specific guidelines, however, are confined to the roles of the DOH Central Office, ROs, and DOH hospitals in the retrieval, storage, identification, transfer and final disposal of the dead, including what the local health offices are expected to carry out under the technical oversight of DOH.

1. General Guidelines

1.1 Every dead person has the right to be found, identified, and buried according to their culturally acceptable norm.

1.2 The rights to privacy of the dead shall be observed at all times.

1.3 All efforts shall be exerted for the proper retrieval, identification and disposition of the remains in a respectable and dignified manner to prevent if not minimize the negative psychosocial impact on the bereaved and the community including the responders.

1.4 The handling of the dead body, from retrieval, identification and disposition, must be carried out in a sanitary manner so as not to pose infection to the responders and contaminate the environment.

1.5 Protection and safety of responders and volunteers must always be observed in the retrieval, handling, transport and disposition of body parts and dead bodies. This shall be the primary consideration of sending agencies and properly coordinated with other concerned agencies.

1.6 Proper information should be disseminated that dead bodies due to natural disasters do not pose a risk for epidemic.

1.7 Unidentified dead bodies shall never be buried in common graves. Instead, they should be placed in individual niches, trenches or any culturally acceptable burial place.

1.8 Mass cremation of bodies should be discouraged.

1.9 Final disposition of dead bodies due to infectious diseases and chemical, biological, radiological, nuclear and explosive (CBRNE) shall be done in accordance with the DOH recommended guidelines and procedures.

1.10 Bereaved families must be provided with psychosocial services.

2. Specific Guidelines

2.1 The DILG is the lead agency in the management of the dead. It has the prime responsibility in the planning, monitoring and evaluation of the Management of the Dead and coordinates with the LGUs in the Search, Rescue and Retrieval (SRR) operations, identification and disposal of the dead, management of missing persons, and management of bereaved families.

2.2 The DOH, on the other hand, is expected to undertake the following in support of the management of the dead:

a. Formulate standards/specifications of cadaver bags and personal protective equipments (PPEs) to be used in the search, rescue and retrieval of the dead.
b. Include in the licensing requirements of morticians the training on Management of the Dead.
c. Develop the protocols to prevent contamination of the environment while disposing of the dead.
d. Provide technical inputs in establishing temporary morgue and burial sites.

2.3 The DOH shall provide technical oversight to the local health office (LHO) as they participate in the management of the dead:

a. LHO shall coordinate all processes related to the management of corpses, including the retrieval, handling, transport and disposition of body parts and dead bodies.
b. LHO shall retrieve ante-mortem information/records from hospitals/PhilHealth.
c. LHO shall issue a Death Certificate based on the Certificate of Identification issued by the NBI/PNP.
d. LHO shall authorize the release of the identified dead body to the family or claimant upon verification of the legitimacy of the claimant.
e. LHO shall be witness to the exhumation of unidentified remains for proper disinfection of the interment area.

D.2.4 Together with the other agencies, the DOH shall:

a. Provide psychosocial services to the responders and bereaved families of the dead and missing persons together with DSWD, PRC and DILG.
b. Provide a minimum package of services to the responders, particularly medical services, through the DOH hospitals.

2.5 The DOH hospitals should submit the report on the number of dead bodies to the ROs. In turn, the DOH-CHDs shall integrate the reports from the hospitals and submit these to DOH Central Office. The DOH-CO then shall submit the report to the NDRRMMC.

Chapter 4

Management of Service Providers

Chapter 4: Management of Service Providers

I. Introduction

The timely mobilization and deployment of appropriate response teams are crucial in saving lives and in reducing the impact of the emergency or disaster. Failure in this component surely jeopardizes the effectiveness and efficiency of the overall response. There are basic elements that need to be established to ensure the efficient and effective mobilization of the response teams. These include the proper organization of the teams which entails: identifying the right category of teams to be deployed, clarifying their expected roles and functions, and setting and applying the criteria to be used in selecting their respective members. This must be followed by their proper and timely deployment, monitoring their movements and assistance until post-disaster phase, and proper documentation upon pull out from the sites. Equally important as the mobilization and deployment of response teams is the establishment of a systematic and rational scheme in managing volunteers, both local and foreign.

II. Objectives

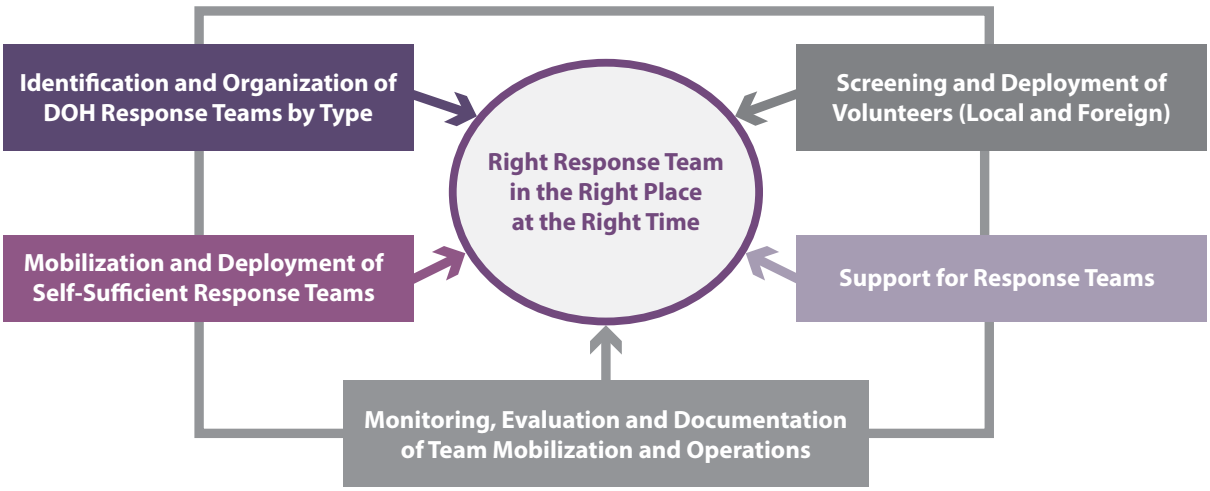
Chapter 4 provides you with guidelines on the organization, mobilization, deployment and management of the response teams during a health emergency and disaster. This chapter will guide you on how to:

a. Identify and organize the appropriate response teams to be mobilized and deployed in the context of emergencies and disasters of mega proportions.
b. Mobilize, deploy and manage the response teams in strategic areas affected by the emergency or disaster.
c. Manage the deployment and operations of volunteer response teams, both local and foreign, and maximize their contributions in responding to the emergency or disaster.
d. Properly monitor, evaluate and document the mobilization of teams.

III. Key Elements in the Management of Service Providers

The effective mobilization of response teams relies on key elements that must be in place to ensure that appropriate services and responses are made available at the right time and in the right place during an emergency or disaster. These elements are shown in Figure 19.

Figure 19. Key Elements in the Proper Management of Response Teams



IV. Policy Statements

Policy Statement 1:

The DOH-CO, and all ROs and DOH hospitals shall organize, according to their mandate and expertise, Emergency Response Teams that can be mobilized anytime.

Policy Statement 2:

The organization, deployment and assignment of volunteer response teams, both local and foreign, can be coordinated at various levels of operations (DOH-CO, RO and hospitals) as long as they follow the recommended protocols and standards.

Policy Statement 3:

All mobilized response teams must be self-sufficient when responding to emergencies and disasters.

Policy Statement 4:

The safety and security of the response teams shall be of primary consideration while in operation. Emergency pullout/evacuation and/or repatriation procedures shall be in place for any untoward incident that may compromise the health, safety and security of the team.

Policy Statement 5:

The mobilization/deployment of response teams shall follow the existing protocols on coordination and collaboration with the host or recipient of assistance.

Policy Statement 6:

All mobilized DOH response teams shall be entitled to allowable compensation or benefits, which include but are not limited to overtime pay, per diem, insurance coverage for the duration of deployment and post-exposure health consequences, rest days, and recognition and reward. Support shall also be extended to their families.

Policy Statement 7:

The deployment and operations of the response teams shall be monitored and documented throughout the Response Phase.

Policy Statement 8:

All response teams are expected to prepare and submit reports and updates to concerned DOH offices on a regular basis. Likewise, a final report including observations and recommendations is required.

V. Guidelines

The mobilization of response teams is triggered by three categories of situations:

a. Planned events;
b. Emergency incidents or events
c. Emergency or disaster affecting other countries

Under each scenario, appropriate response teams must be organized with members to be selected based on a certain set of criteria, and must be mobilized following certain procedures, as detailed below.

A. Mobilization and Deployment of Response Teams for Planned Events

1. Trigger

Events organized by the DOH or other national government agencies, where the DOH has been requested to mobilize teams for emergency response services:

- National and local holidays
- Events of national importance (e.g., elections, State of the Nation Address, etc.)
- Events involving figures/personalities of national importance (e.g., the President, ambassador, etc.)
- Events with security implications
- International events hosted by the Philippine government

2. Mobilization of Medical Teams for Special Events

a. Consider the composition recommended for each type of teams to be organized.

Table 23. Criteria in Screening Medical Team Members for Special Events

Composition	Number	Screening Criteria	Functions
Medical doctor	2	• Employee of the DOH Central Office, RO, DOH hospitals or DOH-attached agency with plantilla position or job order • Possess any of the expertise needed for the mission • A team player • Willing to assume multi-tasking role • Understand the concept of Incident Command System	• Medical consultations • Referral to hospitals • Mass casualty management
Nurse	1 (or 2 if no EMT-B)		
Basic Emergency Medical Technician (EMT-B)	1		
Ambulance driver	1		

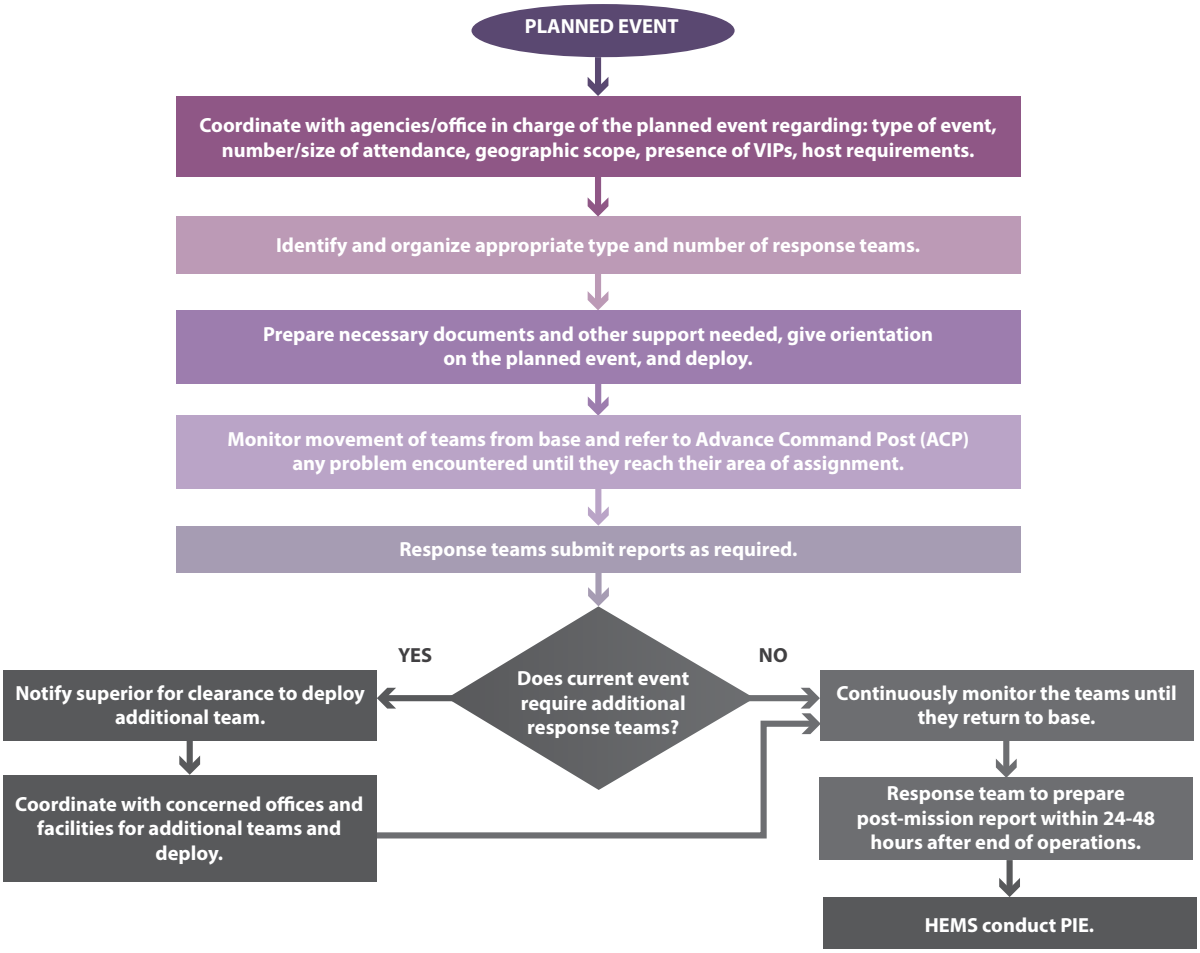
b. Screen members of the Medical Team based on the recommended criteria.

c. Determine the number of teams to be organized depending on the severity of the event and the scope or magnitude of areas and population that are affected.

d. Mobilize and deploy teams.

The flow of the mobilization and deployment process for planned events is illustrated in Figure 20.

Figure 20. Flow in the Deployment of Response Teams for Planned Event



3. Areas of Concern in Managing Big International Events Held Locally

When holding big international events locally, attention must be focused on the certain major areas of concern (Table 24) in order to prevent mortalities and minimize morbidities among all delegates and participants to the event.

Table 24. Tasks in Managing Major Areas of Concern During Special Events

Areas of Concerns	Tasks to Be Carried Out
Airport	• Ensure the availability of medical personnel 24/7 at the airport to address all health concerns there. • Document all consultations and referrals and submit daily report to OpCen. • Make available transport to nearest appropriate health facility with prearranged agreements.
Venue	• Ensure the availability of medical teams strategically located at the venue throughout the period of meetings/conferences. • The number and type of teams would depend on the number of participants, the vastness of the facility; fixed clinics and available first aiders and runners are recommended. • The medical team in the venue works in close coordination with the security unit, especially in cases of emergencies (fires, earthquake), mass casualty incidents (bombings). • Document all consultations and referrals and submit daily report to OpCen. • Make available transport to nearest appropriate health facility with prearranged agreements.
Hotel	• Ensure the availability of medical teams 24/7 in all hotels identified, especially those where large number of participants are billeted. • Document all consultations and referrals and submit daily report to OpCen. • Make available transport to nearest appropriate health facility with prearranged agreements.
Hospital	• Identify all hospitals strategically located in the area and make arrangements for referral of patients if necessary. This arrangement shall include, but not be limited to, the following: identification of a point person in the hospital; procedure for walk-in and referred patients; coverage and payment; and reporting. • Document all consultations and admissions and submit daily report to OpCen.
Public Health	• Establish surveillance system in all areas for early detection of diseases with epidemic potential; do an environmental assessment and make necessary interventions for diseases like dengue, etc. • Provide IEC or advisory materials to all delegates. • Document all activities for submission daily to OpCen.
Special Concerns/ Contingency	• One area of special concern focuses on the provision of close-in doctors in the event that heads of state are part of the participants. One doctor per head of state is the requirement in close coordination with the PSG. • Provision of a medical team with ambulance is also a requirement whenever wives of VIPs go out for trips outside or inside the city. • This committee also prepares medical team with ambulance as a contingency for emergencies. • Document all activities, consultations and referrals, and submit daily to OpCen.

B. Mobilization and Deployment of Response Teams for Emergency Incidents/ Events

1. Trigger

1. The event is a major emergency (e.g., transportation accidents, fire, etc.)
2. A state of calamity has been declared (e.g., typhoon, landslide, flooding, tsunami, volcanic eruption, etc.)
3. The event has a potential for international implication (e.g., hostage taking of foreigners)
4. There is instruction from higher authorities (NDRRMC, OSEC, Malacañang, etc.)
5. The LGU and/or RO has requested for assistance.

2. Mobilization and Deployment of Response Teams

Table 25. Response Teams to Be Mobilized for Emergency and Disaster with Corresponding Functions

Type of Team	Composition	Functions	Level Needed
Rapid Health Assessment Team (RHA Team)	Any 3 of the following including a driver: • DOH Rep • Surveillance Officer • HEMS Coordinator/ Assistant Coordinator • Nurse • Midwife • Or any personnel with training or orientation on how to do a Rapid Health Assessment	• Validate and monitor situation in the first 24 hours. • Assess magnitude of the event: population affected, evacuation centers, lifelines destroyed, etc. • Assess health situation: casualties, health facilities damaged, health personnel reporting for work, availability of drugs/medicines/ supplies, response capacity of community. • Determine health capability to cope with the situation. • Prepare report, including observations, recommendations and support needed. (See RHA Template.)	CO RO Hospital
Medical Team especially for evacuation centers and the community	Minimum members include at least 3-5 from the following fields • Doctors • Nurses/EMT • Logistics/admin persons • Driver	• Provide the following services: - Medical consultations and treatment - Reproductive health services - Child care services - Immunization/chemoprophylaxis - Monitoring and provision of continuous treatment for tuberculosis, diabetes, hypertension, etc… - Treatment and care of wounds/ injuries	RO Hospital

Public Health Team (or Composite Team); an expanded team compared with above to provide more comprehensive public health services; they work together as a team	A team composed of experts to provide public health services, to include at least 5 members as follows: • Health Emergency Manager • Surveillance Officer • Program Managers (doctors) especially for communicable diseases, RH services, child care services • Sanitary Engineer/ Nutritionist • Logistics person • Driver	• Provide the following services at evacuation centers and the community as a team: - First aid , treatment of wounds - Medical consultations and treatment; reproductive health care - Child care services - Vaccination • Assessment of WASH and Nutrition needs • Establishment of surveillance system	CO RO
SPEED (Surveillance) Team	Composed of 2-3 members from the following: • SPEED Point Person in the region • RESU Point Person • Epidemiologist Assistant/Nurse • Driver	• Provide technical assistance to the LGUs in activating and deactivating SPEED in evacuation centers, RHU, and hospitals. • Orient/train other field reporters in the event that local health people are themselves victims. • Provide all necessary logistical requirements to ensure implementation of SPEED. • Recommend need of START Teams to be deployed. • Monitor and evaluate SPEED reports and make necessary recommendation to superiors for the appropriate interventions.	CO RO
START Team	Composed of at least 5 members who are: • HEMS Coordinator/ HEMS Assistant. Coordinator • ESU Coordinator • ESU Asst. Coordinator • SPEED Focal Person • Any SPEED-trained staff at the national, regional and provincial levels.	• Provide leadership in SPEED implementation in terms of technical skills and logistics. • Ensure proper coordination and networking. • Provide crash courses to identified SPEED data managers and reporters. • Ensure proper transition before disengagement. Note: START Team to be activated only from other regions/areas when the SPEED Team of the affected areas are victims themselves and cannot meet the demands to activate SPEED.	CO RO

WASH Teams	Composed of at least 3-5 members from among the following: • Regional Sanitary Engineer • Provincial/Rural Sanitary Inspectors • Environmental Point	• Lead in WASH Rapid Assessment. • Recommend priority areas for WASH. • Provide technical guidelines and assistance related to WASH. • Ensure the following in coordination with the LGU concerned: - Collection and disposal of wastes - Acquisition and distribution of potable water supply - Construction of additional toilet facilities - Supervision of sanitary conditions of the community - Hygiene promotion, vector control, etc.	CO RO
Trauma Team	Composed of at least 5 members including a driver with ambulance: • 2 Doctors (surgeon, anaesthesiologist, internal medicine) • 2 Nurses preferably with EMT training • Nursing aid with EMT training	• Manage cases especially in relation to trauma or in mass casualty incidents. • Work with the Incident Commander in MCI and handle the Advanced Medical Post in providing triage, treatment and proper transport of patients to the nearest appropriate facilities. • Lead in the setting up of temporary health facilities or field hospital.	Hospital
Nutrition Team	Composed of at least 3-5 members coming from the following: • Regional Nutritionist • Provincial/LGU Nutritionist • Staff from the Regional NNC • Barangay Nutrition Scholars	• Lead in the conduct of a Rapid Nutritional Assessment. • Prioritize services to vulnerable population. • Identify appropriate nutritional intervention in the area; assist in supplemental feeding. • Monitor Milk Code/ BF areas. • Coordinate with higher level facilities for referral of severely malnourished children. • Lead in advocacy and IEC in Nutrition.	CO RO
Psychosocial Support Team	At least 3-5 members coming from any of the following: • Doctors • Nurses • Psychologists Note: Recommended special training in MHPSS for disaster	• Lead in the conduct of rapid MHPSS assessment. • Prioritize services to vulnerable population based on the assessment including relatives of mass dead. • Identify appropriate psychosocial support care to victims and responders, military and leaders. • Implement preventive measures with proper coordination with higher level facilities. • Provide necessary psychotropic drugs at various levels.	CO RO Hospital

Operations Center Team	At least 3 members with experience in Operations Centers, especially in monitoring the event and preparing reports	• Assist in the activation, and management of OpCen. • Provide technical guidance in the timely collection of data, validation, evaluation and translation into reports that serve as inputs to decision-making and appropriate intervention. • Assist in the preparation of presentations and reports for presentation.	CO RO Hospital
Support Teams	This refers to support teams such as: 1. Financial Teams: Group of personnel coming from the financial section 2. Administrative Teams: may compose of drivers, janitors, packers, logistic aides, utility workers, carpenters, cooks	• Assist and support in the finance service, especially during Code Orange Alert . • Depending on the need due to the impact of the disaster, provide support to meet administrative needs of responders and victims (e.g., cooking meals, packing of commodities, cleaning/washing, mobility/ transport, etc.) that are lacking in the affected areas, especially during Code Orange Alert.	CO RO Hospital
Other Expert Teams	Depending on the situation and need, other special teams can be requested to support in the following fields:		
	1. Health Infrastructure: architects, engineers experts 2. Technology experts or equipment experts 3. Toxicology experts: toxicologists or chemical experts	• Evaluate damages in hospitals including estimated costing and works needed for repair and rehabilitation. • Determine damage to equipment such as x-rays, CT scan, MRI, etc. • Assess/diagnose poisoning cases, oil spill inhalation, and other chemical accidents.	CO CO CO Hospital

3. Steps in Mobilizing Response Teams

Figure 21. Flow in the Mobilization of Response Teams for Emergency Events

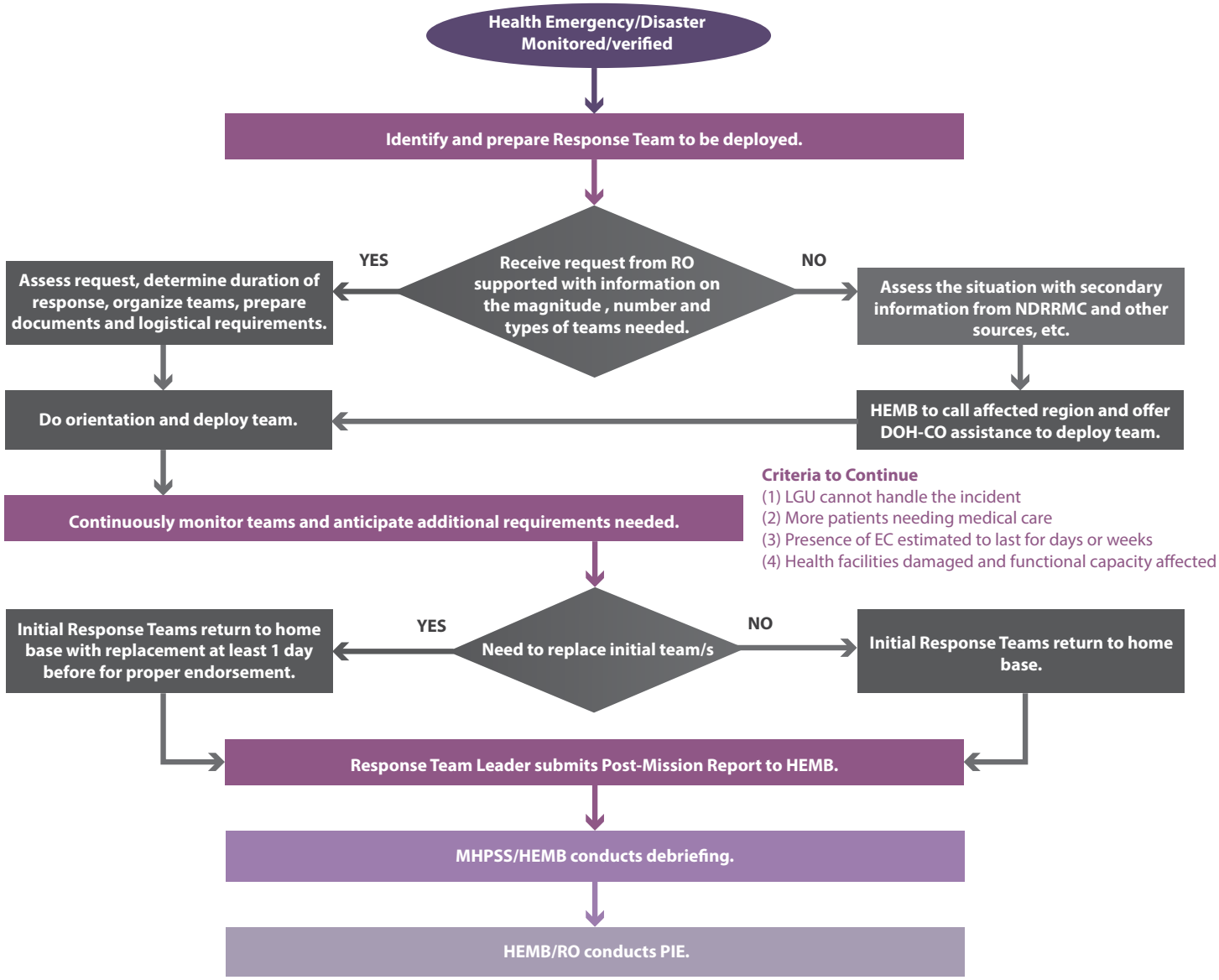


Table 26. Roles and Responsibilities During Local Team Deployment

Response Phase	HEMB-CO	Requesting RO/Hospital	Sources of Teams from RO/Hospitals; Team Leader/Members	Receiving RO/Hospital
Pre-Deployment	• Continuously monitor the emergency/ disaster. • Assess the situation based on reports from all sources. • Coordinate with affected RO or hospitals if there is need to augment teams. • Once request is received, identify the number and types of teams needed. • If no request is received, continue evaluation and/or offer the support. • If it is Code Alert Orange, automatically prepare the teams. • Start identifying where to get the teams through the HEMB database.	• Perform continuous evaluation and assessment of the emergency or disaster in your area. • Through your RHA, identify the number of teams needed and match with available teams in your area. • Decide right away if you need augmentation. • Identify how many teams are needed, types of teams, and duration you want to be augmented. • Immediately request HEMB OpCen. • While waiting for the teams' arrival, identify areas where to deploy the teams and make initial arrangements.	• Monitor the emergency/disaster. • Start organizing and preparing your teams. • Check availability of logistical requirements based on your type of team. • Inform HEMB that your team is ready and available for deployment if needed; make sure your superior knows. • Wait for instructions if you will be deployed. • Team Leaders/HEMS Coordinator to ensure composition of his team members. • Team members to prepare their individual needs and also those of their family.	
	• Based on the request including the duration of deployment, make a plan on the identification and scheduling of the teams. The following should be considered: types and number of teams, with teams coming within the catchment area or nearest the affected areas to be prioritized; logistical needs • Make a schedule and inform right away the first batch while notifying the subsequent batches to go on standby. • Inform superiors of the initial action done and get additional instructions and authority to proceed to inform the RD/Chief of Hospital where teams will be going and to process necessary documents.	• Continuously coordinate with HEMB OpCen regarding the deployment, dates of arrival, etc. • Identify logistics needed for the emergency and coordinate or request the bringing of these by the incoming teams. • While waiting, prepare for the orientation of the incoming teams, to include the situation in the area, the health problems identified, etc. • Although teams should be self-sufficient, identify where they can be accommodated.	• Once teams to be deployed are identified. check the situation in the area or request orientation from HEMB. • Prepare everything that is needed by ensuring that the teams are self-sufficient (personal needs, food, drugs, medicines, supplies, equipment, etc.) • All preparations should be good for 2 weeks. • RD/Chief of Hospital to give approval of team movement and ensure they are properly equipped with everything they need including financial needs.	

	• HEMB Admin to prepare the following administrative requirements only if needed: Department Personnel Order; per diem; arrangement with airlines or military planes if going as a group; procurement of tickets and other needs in relation to travel. For land travel each team should be responsible for their vehicle, fuel, etc. • HEMB Response Division to conduct team orientation. • Prepare all necessary documents and templates needed for reporting and documentation. • Inform RO/hospitals of the arrival date of teams.	• Prepare vehicles to fetch teams at the port of entry (airport or seaport). • For land travel, ensure that they know where to go, either directly to their deployment area or through the regional office. • Provide to HEMB OpCen different routes to use in case of problems in transportation, especially if airports are destroyed or roads are impassable.	• Attend the pre-deployment orientation at HEMB. • Ensure that the necessary logistical requirements needed for the mission are properly packed and labeled. Listings of all logistics should be documented. Prepare documents so utilization of logistics will be documented. In the event that some logistics will be left in the affected area, prepare documents for donations. • Prioritize and number all baggages, especially the food and the medical needs. Ensure that each member has a 3-day supply of food that is hand-carried.	

Response Phase	HEMB-CO	Requesting RO/ Hospital	Sources of Teams from RO/Hospitals; Team Leader/Members	Receiving RO/Hospital
During Deployment	• OpCen to monitor the activities of the team from arrival and everyday thereafter. • HEMB Director or Response Division Chief to do regular calls. • Ensure the safety and security of teams. Attend to accommodations, issues and problems.		• Upon arrival, the team leader to do courtesy call and receive orientation briefings from Regional Office, Hospital Director, or HEMS Coordinators. • Receive mission order and give assignments to all the team members; make schedules especially for hospital deployment. • Team leaders to coordinate regularly with all key officials (RD, Chief of Hospital, LCE, etc.) • Team leader to ensure accommodation and safety of the team.	• Receive the arriving teams and conduct an orientation briefing; answer all concerns of the teams; ensure their security and safety. • In prioritization of deployment, incoming teams will be given nearby and secured areas; teams from the affected area shall be the ones deployed to farthest area as they are more familiar with the geography, culture and language of the people. • Give their mission, location and assignments. • Coordinate regularly with the team leader for any issues and problems.

	• Daily reporting is mandatory following the HEMB template; OpCen staff should ensure that reports are received every night to be incorporated to the next day's HEARS Report. • Refer to superiors for any report needing immediate action. • Continuously monitor the movement of the teams, the logistics distributed, and requests from the area. • HEMB Response Division Chief to monitor changes in the response to the disaster and, based on the recommendation of the teams deployed, make adjustments or deactivate sending of teams.		• Team Leader to ensure that daily reports following HEMB template are submitted to RD/Chief of Hospital and to HEMB OpCen every night throughout the duration of stay. • Team Leader to ensure that all issues and problems are acted upon immediately and conduct an evaluation and debriefing every night. • Internal problems should be solved at their level; coordinate if necessary with HEMB. • Monitor the response to the emergency and recommend continuation of the sending of teams, type and expertise needed. • Follow the ICS if activated. • Ensure that endorsement be done for the next team. • Document everything.	• Have continuous coordination with the team through the Team Leader. • Ensure that the team is integrated in their setup and not a separate entity.. • Discuss with the team their observations and listen to their recommendations. • Have the Team Leader attend meetings.
	• Reports from teams should be analyzed to ensure proper and continuous flow of team mobilization. Ensure that the appropriate teams are mobilized and the needs of the teams are properly addressed. • Continuous reporting to higher officials. • Develop database and mapping of the teams deployed on real time. • May need to coordinate also with families or superiors of the team		• The whole team should analyze daily reports; it shall not focus only on patients seen and attended but also on issues of management of the event and the victims. • Attend meetings as necessary with the RO/ Chiefs of Hospital or the LGU assigned; in some instances with the Evacuation Center management. • Start preparing your final report.	• Reports of the team should also be included in the report of the region or the hospital.
	• Be aware of the final arrangement for the arrival of the team. • Inform their superiors • Make arrangements for their debriefing after their arrival.		• Inform HEMB-CO for their final arrangement in returning back to their area. • Prepare all necessary activities for proper endorsement, donation of remaining drugs, medicines, etc. • Do exit interview with the RD/Chief of Hospital.	• Ensure proper transfer of endorsement to succeeding team. • Accept and document turnover of all remaining drugs, medicines, supplies or equipment. • Conduct exit interview.

Response Phase	HEMB-CO	Requesting RO/Hospital	Sources of Teams from RO/ Hospitals; Team Leader/ Members	Receiving RO/Hospital
Post-Deployment	• Administrative Unit to process liquidation and payment of reimbursement, if any.	• Ensure that all their staff submit their liquidation papers within 1-3 days upon arrival. • Ensure the submission of the Post-Mission Report/Final Report within 10 days upon arrival at the HEMB Central Office	• If there is an excess in cash advance, return immediately to the proper authority with complete liquidation papers, such as official receipts, Reimbursement Expense Report (RER), etc.	• Accomplish itinerary of travel, Appendix A and B with supporting documents.
	Response Division to initiate the conduct of the following: • Post-Incident Evaluation to be scheduled immediately or at most 3 days upon arrival • Psychosocial debriefing in coordination with the DOH Mental Health Program to be scheduled immediately • Document output of the PIE and other lessons learned for future reference and to identify gaps and lessons for improvement of the systems, policies and procedures • Preparation and submission of the official report to supervisors • Preparation of communication addressed to director of hospitals/regions to express thanks for the support extended. • Submission and completion of Post-Mission/Final Report within 10 days upon arrival.	• Approve the attendance to a Post-Incident Evaluation and/or psychosocial debriefing	• Upon return, submit to HEMB the deed of donation papers and other pertinent documents, if applicable. - Contingency fund - Official receipt - Reimbursement Expense Report (RER) - Justification for expenses made	• Submit to HEMB the following travel documents for liquidation purposes if applicable: - Plane ticket/e-ticket - Boarding passes - Certificate of Appearance Note: The one in charge of admin should ensure that all documents mentioned above of every member of the team be kept in one folder and retrieved from each member after every travel.
	• Schedule for the citation/awarding of the teams.	Provide respite period: • For 2 weeks deployment, a minimum of 3 days respite to allow physical and mental recovery of each member of the team • Provide commendation/citation for the team's involvement in the mission in CHD/hospital	• Incorporate the report of all members in drafting the Final Report. • Ensure the submission of Post-Mission/Final Report to HEMB within 10 days upon arrival.	• Participate and give inputs in the drafting of the Final Report of the team.

C. Mobilization and Deployment of Response Teams for Emergency/Disaster Affecting Foreign Countries

1. Trigger

1. Instruction from the Office of the President of the Philippines.
2. In response to bilateral and unilateral agreements between the Philippines and other countries, based on ASEAN agreement and other arrangements entered into by the Philippines with other countries

2. Mobilization and Deployment of Response Team

2.1 Team Composition

a. The composition and number of the team depends largely on the timing of the deployment (e.g., trauma teams are usually needed during the early phase of the event while public health teams would be much more needed after the first week from onset.)

b. A mix of hospital/trauma and public health teams may be ideal to send after the first week.

Table 27. Number by Potential Category of Team Members and Selection Criteria

List of Potential Team Members	No.	Selection Criteria
General surgeon	2	• Employee of the DOH Central Office, RO, DOH hospital or DOH-attached agency with plantilla position • Has 1-2 years of practical field experience in managing emergency situations and/or disasters. • Has relevant training in Health Emergency Management • Possesses any of the expertise enumerated in the list of experts needed to compose the team • Can be recalled and deployed within 6 hours from time the order for deployment is given • Has available valid travel documents • A team player • Willing to assume multi-tasking role • Willing to be separated from the family for at least 2 weeks to 1 month. • Mentally/psychologically and physically fit • Knowledge/understanding of the local dialect/language is an advantage.
Orthopedic surgeon	2	
Obstetrician/ gynecologist	1	
Pediatrician	2	
Nurses - EMT-trained	8	
Internal medicine doctor	2	
Sanitary engineer	2	
Psychosocial service provider	2	
Epidemiologist	2	

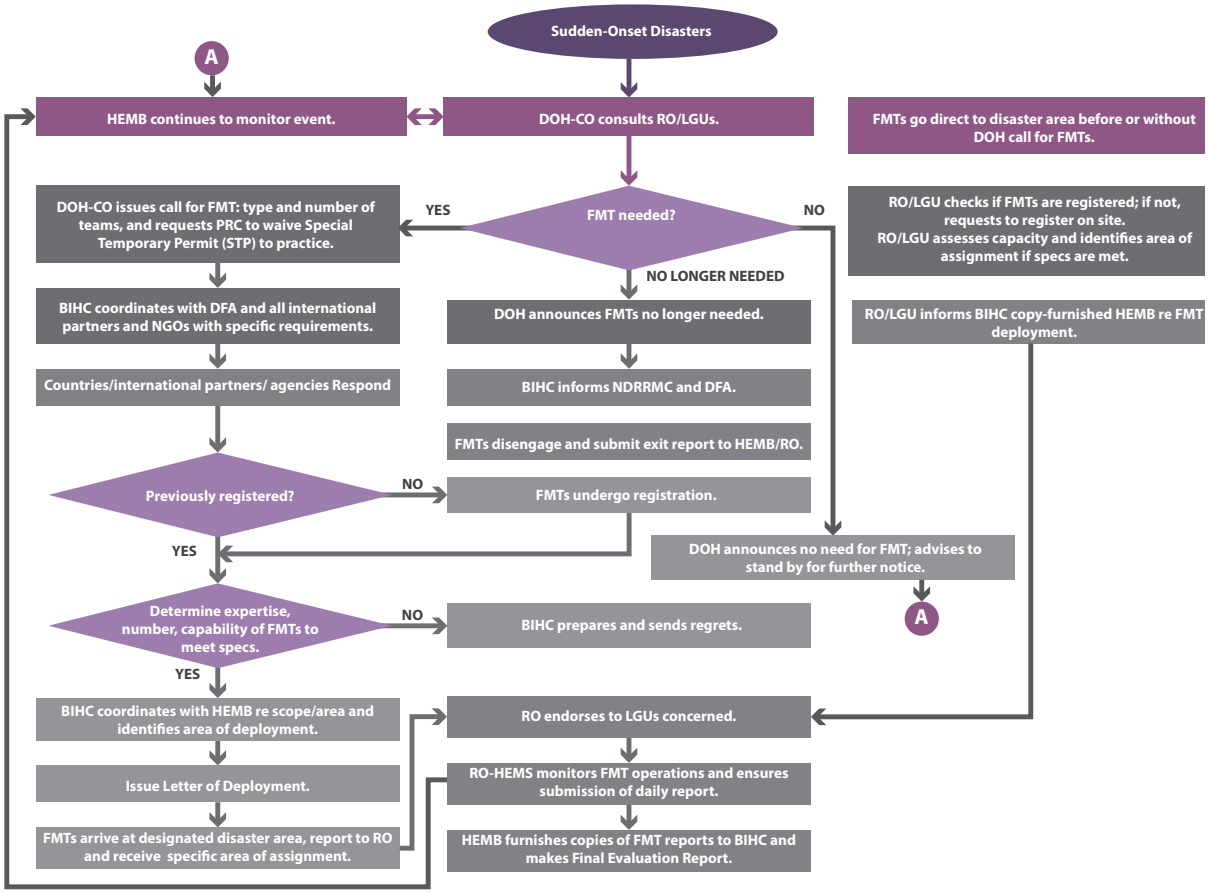
2.2 Tasking of Team Members

Table 28 Summary of Key Positions and Tasks of the Team

Key Position	Number	Functions/Tasks
Team Leader	1	• Assume the role of Overall Commander (command, control, coordination) of the mission. • Lead in the conduct of team building activities for the entire team prior to deployment. • Oversee and ensure security of the team. • Provide focus to the group on the mission. • Act as the official representative/spokesperson of the response team during meetings and interviews. • Approve all communications, reports and other transactions. • Oversee the implementation of the team's work plan and schedule. • Supervise the development and writing of the mission report. • Designate other required tasks to Assistant Team Leaders or members as necessary.
Assistant Team Leaders - Public Health - Hospital	2 (1) (1)	• Act as Team Leader in the absence of the Team Leader. • Assist the Team Leader in the management of the team. • Ensure that all activities are properly documented. • Lead the Operations Team. • Assume all tasks and responsibilities assigned by the Team Leader as necessary.
Documentation Officer/Secretary	1	• Assist the Team Leader in recording and documenting minutes of meetings of the team. • Prepare team report for approval of the Team Leader. • Prepare all outgoing official communication to be submitted by the team.
Administrative/ Finance Officer	1	• Manage the utilization and dispensing of the logistics of the team. • Ensure the completeness of liquidation requirements/financial transactions. • Oversee the safekeeping of all travel and financial documents. • Secure Certificate of Appearance for all team members. • Turn over relevant documents needed for liquidation to HEMB.

3. Team Mobilization Process

Figure 22. Team Mobilization Process



4. Requirements of Teams for International Team Deployment

The following must be checked prior to the departure of the team:

Table 29. List of Documents and Requirements for International Deployment

	Documents	Needs
Personal	• Passport (not expiring within 6 months from the time of arrival to destination; type of passport will be determined according to the country of deployment) • Visa, if required • Department Personnel Order • Travel Authority • Travel Tax Exemption Certificate • Plane ticket/e-ticket with attached code number • Airport tax receipt/terminal fee (paid at the airport) • Insurance papers • At least two valid identification cards with pictures • Extra ID pictures Financial: • Daily subsistence allowance • Pre-departure allowance	• Two luggages, one for check-in and one for hand carry, preferably back pack • One attire for official functions • Wash and wear clothes • Light clothing, good for a minimum of two weeks mission • Jacket or sweat shirt (depends on the weather condition)/rain gear/blanket • Cap, sunglasses • Official uniform • Personal medicines • Toiletries • Cellular phone with roaming SIM with charger and spare battery • Flashlight with spare batteries • Whistle • Mirror • Extra money • Ball pen, pocket notebook
Group	• Reporting forms needed as prescribed by HEMB: - Patient Consultation Form - Post-Mission Report Form - Logistics Utilization Form - Others • Acceptance letter/letter of introduction to the host country • Inventory of logistics (hard and soft copy) • Deed of donation papers needed when leaving goods to affected country	• Tarpaulin that will identify the team at least two: 1 pc (5x7); 1 pc (3x5) • Two laptops with portable printer • Drugs/medicines and medical supplies • Satellite phones (at least one unit) or roaming cellular phones • Digital camera with video capability • Bottled drinking water • Food provisions, preferably canned goods, biscuits • Contingency fund in addition to individual subsistence to be handled by team leader, approximately USD10,000; take note that limit per person to carry including your personal money is also USD10,000 so this could be distributed to other members of the team. • Personal Protective Equipment (PPE)

4.1 Monitoring the Teams

a. Monitor, through the team leaders by phone/radio, the movement of the teams including:
   - Arrival
   - Areas and assigned activities
   - Condition of teams
   - Needs/problems

- Schedule of departure
- Extension of stay

b. Refer problems encountered by the team to concerned offices for immediate action/ decision.
c. Based on reports/feedbacks received, implement the appropriate actions:
    i. Augment teams (type/quality), if needed.
    ii. Scale down response teams.
    iii. Terminate operations.
d. Report and monitor activities while on mission.
    i. The Operations Center of the respective sending agencies shall monitor the activities/ movement of the team throughout the entire duration of the mission.
    ii. All teams deployed shall report to the sending agency daily, or as often as necessary.
    iii. The Post-Mission Report shall be submitted within 24 hours after termination of operations for locally deployed teams and 10 days after arrival for internationally deployed teams.
e. Conduct Post- Mission Evaluation.
    i. A Post-Mission/Post-Incident Evaluation shall be conducted within 5 days from termination of operations (within the country) or upon arrival in the country (international).
    ii. The report shall be submitted to HEMB and/or concerned ROs.
f. Return to normal duty. All team members shall report back for duty on the days designated according to the type of event:
    i. Planned events: Next reporting/working day
    ii. Emergency events within catchment area: After 1 day
    iii. Mission lasting more than one week: After 3 days of respite
    iv. International emergency events: After 5 days of respite

4.2 Roles and Responsibilities During International Deployment

Table 30 lists down the respective roles and responsibilities of HEMS, the ROs and DOH hospital, and the team leader and members before, during, and after international deployment.

Table 30. Roles and Responsibilities During International Deployment

Phase	HEMB	RO/Hospital	Team Leader	Team Member
Before	1. Define the humanitarian mission and its requirements. 2. Get instructions from superiors and request authority to proceed in organizing the team and to process travel documents and other requirements. 3. Identify medical teams to be deployed and their composition based on the requirements, the members to be selected from the existing HEMB database and through consultations: a. Trauma Team - General surgeon - Orthopedic surgeon - Obstetrician-gynecologist - Internal medicine specialist - Family medicine doctor - OR technicians - Pediatrician - Nurse/paramedic b. Public Health Team - Public health physician - Epidemiologist/surveillance - Sanitary engineers - Public health nurse - Nutritionist c. Psychosocial Team - Psychiatrist with public health perspective - Psychologist - Mental health social worker - Mental health nurse 4. Prepare and send communications to head of office requesting permission for the identified personnel. 5. Coordinate with the following : a. NDRRMC as needed b. DFA for passport processing and coordination with host countries	1. Prepare letter allowing the participation of the RO/ hospital personnel to be part of the team. 2. RO Director/Chief of Hospital to allow the identified person to prepare his/her needed documents, attend meetings and be relieved from regular duty schedule/ assignment. 3. Provide the following: a. Transport vehicle to and from the airport/pier b. Medicines/medical supplies, equipment/ peculiar to their hospital which can be reimbursed c. Travel expenses for personnel outside Metro Manila	1. Organize the team and assign clear tasks to each team member in addition to their usual assignment. Team members preferably include but are not limited to the following: - Assistant Team Leader - Operations Officer - Planning Officer - Documentation/Reporting Officer - Logistics Officer - Administrative Officer 2. Assign a partner for the buddy system that will be followed throughout the mission. 3. Ensure that the necessary logistical requirements needed for the mission are available (minimum logistical weight of 20 kilos per bag/ box). 4. Ensure availability of reporting forms (in soft and hard copy) such as: - Post-Mission Forms - Consultation Forms - Daily Reporting Forms - Logistics Utilization Form 5. Ensure that the contingency fund is available and be knowledgeable in using it. 6. Ensure the attendance of the team members to briefing/orientation in relation to travel. 7. Ensure leveling of expectations of the team members.	1. Endorse/turn over work to the identified reliever. 2. Ensure that the pre-deployment requirements as defined in the checklist are complied with. 3. Receive assignment from the Team Leader and understand the specific roles and responsibilities of each member. 4. Observe protocol in media handling. 5. Always be on standby for emergency dispatch schedule. 6. Attend and receive briefing by the Central Office and other concerned agencies.

c. Embassy for visa requirements/ approval
d. Airport authorities/management
   - Send-off area for the team
   - Special assistance as needed
e. Airline authorities for exemption in case of excess baggage/cargo limit

6. HEMB Admin Unit to facilitate the following:
   - Canvass of plane fare/travel reservation
   - Purchase of plane ticket
   - Purchase of insurance
   - Per diem and other travelling expenses

7. Coordinate with the following offices in DOH:
a. BIHC for travel documents (DPO, Travel Authority, etc.)
b. BOQ for pre-departure health requirement of team (vaccination/ prophylaxis for endemic diseases)
c. Finance Service to facilitate the processing of funds
d. MMD for the following:
   - Packaging and labeling of logistics in the warehouse
   - Ensuring that weight requirements are followed (20 kg per bag/box)
   - Provision of transportation for delivery to airport
e. Admin Service to provide:
   - Additional vehicle needed to transport medical teams
   - Manpower to carry the logistics from warehouse to airport
f. MRU for special coverage and documentation of the preparation and departure and arrival of the team
g. Personnel Division for Service Record (at least 2 years of service) and other documents
h. Legal Service for Certificate of No Pending Case
i. NCHP for the tarpaulin needed by the team
j. OSEC for updates on the ongoing activities and additional budgetary requirements as needed

	8. HEMS to do the following: a. Brief/orient the team on: - Latest situation status of the disaster - Roles and responsibilities - Visa and immunization requirements - Travel arrangements - Date of departure b. Organize the team and define tasks in consultation with TL. c. Provide the following: - Briefing kit on background/ situation update - Directory of team and other pertinent persons - DPO - Reporting forms - Team duties and responsibilities - Map (if any) - Tarpaulin/streamer to identify the Philippine Medical Team - Identification cards (IDs) - Official uniform (vest or jacket) - Other necessary equipment (e.g., satellite phones, laptop and portable printer, etc.) d. Lead in identifying needed medicines/medical supplies and equipment in consultation with TL.			
During	1. OpCen to monitor the activity of the team. HEMB Director or Response Division Chief to coordinate regularly. 2. Get daily updates following the HEMB template, prepare and submit reports. 3. Provide update reports to: a. Higher authorities (NDRRMC, Malacañang, DFA, OSEC, USEC, ASEC, etc. b. Family members 4. All issues and concerns should be referred to the Director or Response Division Chief		1. Upon arrival, coordinate with the following: - Embassy officials - Health official at the country - Other cluster head/members 2. Act as the official spokesperson in all the communication and coordination among the local officials, media and agencies. 3. Attend meetings as needed with embassy officials, health. officials and other important persons	1. Observe the buddy system. 2. Always ask permission before leaving your post. 3. Submit accomplishment report to the Team Leader regularly. 4. Perform roles and functions assigned by the Team Leader.

			4. Ensure security and safety of team members. 5. Conduct daily planning meetings and debriefing sessions among all members to discuss problems encountered and possible solutions/ recommendations. 6. Send daily reports to HEMB-OpCen on: • Current situation and area of assignment • Work progress • Problems encountered • Planned actions • Effectiveness of response • Condition and performance of all members • Schedule of return trip and any change in schedule 7. Coordinate with the following: - Philippine Embassy before departure date from area of assignment - HEMB-OpCen for itinerary of travel 8. Conduct exit conference/briefing with host country before departure. 9. Turn over goods for donations to the host country. 10. Supervise the development and writing of the mission report.	5. Inform the Team Leader of any problems encountered during the tour of duty. 6.Participate in the daily briefing and planning meetings. 7. Be a team player. 8 .Observe proper conduct and decorum at all times, being a representative of the Philippine government.

After	1. Administrative Unit to process liquidation and payment of reimbursement (if any) 2. Response Division to: a. Initiate conduct of the following: - Post-Incident Evaluation to be scheduled immediately or at least 3 days upon arrival - Psychosocial debriefing in coordination with DOH Mental Health Program to be scheduled immediately b. Document PIE outputs and other lessons learned for future reference and identify gaps and lessons to improve policies, systems and procedures. c. Prepare and submit official report to supervisors, NDRRMC, DFA, BIHC d. Prepare communication addressed to Director of hospitals/regions to acknowledge support extended e. Ensure submission and completion of Post-Mission/ Final Report within 10 days upon arrival. 3. Schedule the citation/awarding of the teams.	1. Provide a minimum of 3 days respite period for 2 weeks deployment to allow physical and mental recovery of each member of the team. 2. Provide commendation/ citation for the team's involvement in the mission in RO/hospital	1. If there is an excess in cash advance, return immediately to the proper authority with complete liquidation papers such as official receipts, Reimbursement Expense Report (RER), etc. 2. Upon return, submit to HEMB the deed of donation papers and other pertinent documents, if applicable. - Contingency fund - Official receipt - Reimbursement Expense Report (RER) - Justification for expenses made 3. Incorporate the report of all members in drafting the Final Report. 4. Ensure submission of Post-Mission Report to HEMB and BIHC within 10 days upon arrival.	1. Accomplish itinerary of travel, Appendix A and B with supporting documents. 2. Submit to HEMB the following travel documents for liquidation purposes: - Plane ticket/e-ticket - Boarding passes - Airport tax receipt per country - Certificate of Appearance Note: The one in charge of admin should ensure that all documents mentioned above of every members of the team be kept in one folder and retrieved from each member after every travel, such as boarding pass, etc. 3. Provide inputs in drafting the Final Report of the team.

D. Mobilization and Deployment of Volunteers

The contributions of volunteers in the response to health emergencies and disasters are invaluable, especially during sudden-onset disasters (SODs) which usually occur with little or no warning. SODs are known to result in excessive injuries and casualties surpassing the capacities of the national government to manage and handle, thus prompting its leaders to seek assistance from international and local volunteer groups. In fact, during highly massive catastrophic events, volunteer workers spontaneously come to assist and help even without the official call of the affected country/area. The arrival and assistance of these volunteers, both local and foreign, however, also pose several concerns to the host country/area. Some issues that revolve around volunteer workers include: the mismatch of expertise and actual need; limited capacity to provide the needed services; lack of proper coordination with the host country/area; noncompliance to host country's service standards and protocols; inability to be self-sufficient; inability to stay for at least two weeks; inability to make proper reporting to concerned agencies/officials; and others.

This section has two parts: Part 1 is focused on the mobilization and deployment of foreign volunteer groups – Foreign Medical Teams (FMT); and Part 2 deals with the guidelines in managing local health professionals as volunteers. Each part discusses the trigger or criteria for mobilizing and deploying teams, the process of mobilizing and deploying them, the forms to be used to facilitate their on-site registration, the assessment of their capacities, and evaluation of their performance as part of the response.

D.1 Mobilization and Deployment of Foreign Medical Teams

1. Trigger

The need to mobilize and deploy foreign medical teams (FMTs) is triggered by the following set of criteria:

- if the organic staff of the health sector are not enough to carry out the response.
- If the magnitude of the impact is wide and extensive.
- If there is lack of the needed expertise in the country/affected area.

2. Types of FMTs

There are generally three types of FMTs that can be mobilized during SODs. These are described as follows:

Type 1. Outpatient Emergency Care – Outpatient initial emergency care of injuries and other significant health care needs

Type 2. Inpatient Surgical Emergency Care – Inpatient acute care, general and obstetric surgery for trauma and other major conditions

Type 3. In-patient Referral Care – Complex inpatient referral surgical care including intensive care capacity

A more detailed description of each type of FMT is presented in the following table: the services they can provide, the minimum benchmark capacities, and characteristics based on the Global Health Cluster and WHO Classification and Minimum Standards for Foreign Medical Teams in Sudden-Onset Disasters.

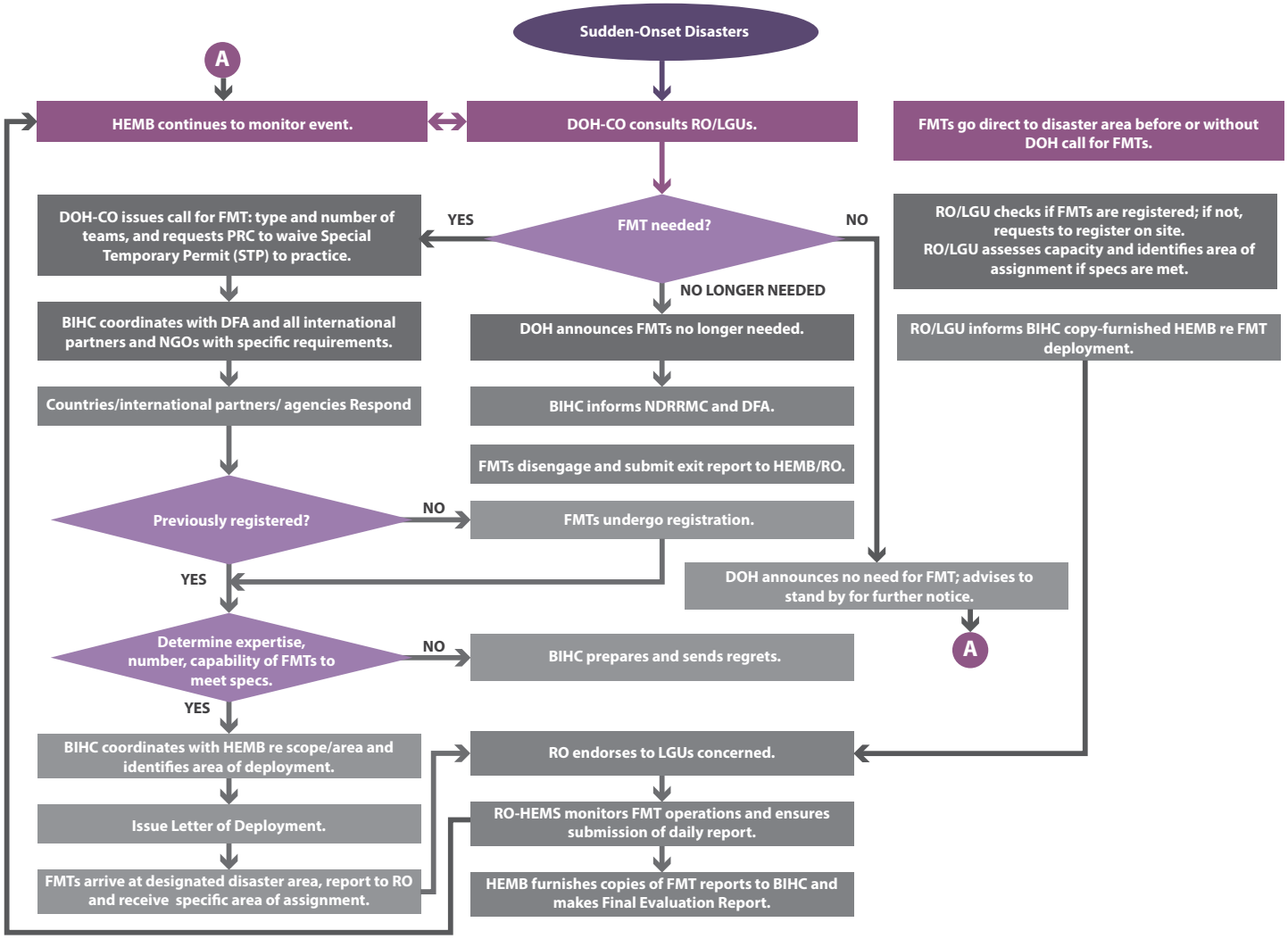
Table 31. Services and Key Characteristics by Type of FMT

FMT Type	Services	Key Characteristics	Minimal Benchmark Indicators	Opening Hours
Outpatient Emergency Care	• Triage • Assessment, first aid • Stabilization + referral of severe trauma and non-trauma emergencies • Definitive care for minor trauma and non-trauma emergencies	• Light, potable and adaptable • Care adapted to context and scale • Staffed and equipped for emergency care for all ages	• 100 patients per day	Day and night services
Inpatient Surgical Emergency Care	• Surgical triage, assessment and advanced life support • Definitive wound and basic fracture management • Damage control surgery • Emergency general and obstetric surgery • Inpatient care for non-trauma emergencies • Basic anaesthesia, X-ray, blood transfusion, lab and rehab services • Acceptance and referral services	• Uses existing or deployable facility structures • Clean operating theatre environment • Care appropriate to context and changing burden of disease • Multidisciplinary team experienced to work in resource-scarce settings	• 1 operating theatre with 1 operating room: 20 inpatient beds • 7 major or 15 minor operations per day	Day and night services
	• Capacity to provide Type 2 services • Complex reconstructive wound and orthopedic care • Enhanced X-ray, blood transfusion, lab and rehab services • High-level pediatric and adult anaesthesia • Intensive care beds with 24-hr monitoring and ability to ventilate • Acceptance and referral services	• Uses existing or deployable facility structures • Sterile operating theatre environment • Enhanced multi-disciplinary teams	• 1 operating theatre with 2 operating rooms: 40 inpatient beds • 15 major or 30 minor operations per day • 4-6 intensive care beds	Day and night services
Additional Specialized Care FMT	• Context-specific specialist care supplementary to Type 2 + 3 FMT services or local hospital • Specialized services may include: Burn care, dialysis and care for crush syndrome, maxillo-facial surgery, orthoplastic surgery, Intensive rehabilitation, maternal health*, neonatal and pediatric transport and retrieval* • Units that may be self-contained not embedded	• Responds to an expressed need for specialized services • Embedded in and operates from FMT 2 or 3, national hospital or health system • May for some services be self-contained	• Depending on capacity	• On request

3. Steps in the Mobilization and Deployment of FMTs

The following chart outlines the process in the mobilization and deployment of the foreign medial teams in times of sudden-onset disasters.

Figure 23. Process in the Mobilization and Deployment of FMTs During Sudden-Onset Disasters



4. Tasking of DOH In the Management and Coordination of FMTs

Table 32. Tasks of DOH Offices in Managing the FMTs Pre/During/Post-Impact

Phase	BIHC	HEMB	RO	FMTs
Pre-Impact				
During Impact (0-48 hours)	• Ready FMT registry • Coordinate with HEMB on the following: - Magnitude of impact - Need for FMT mobilization and deployment - Identification of type, number of FMTs needed - Identification of specific disaster areas for FMT deployment • Endorse to DOH Secretary re FMT mobilization and deployment, if needed. • Coordinate with DFA re needed FMTs. • Issue letter of acceptance and deployment. • Provide IDs to FMTs prior to deployment. • Coordinate with international development partners for FMT assistance. • Write letter to PRC to lift the STP. • Coordinate with Bureau of Immigration to facilitate documents and entry of FMTs. • Register new FMTs. • Assess capacity of FMTs. • Orient /brief FMTs re deployment and other necessary protocols. • Monitor arrival of FMTS at the designated disaster area. • Coordinate with the HEMB/ROs re direct arrival of other FMTs to the site and monitor registration and capacity assessment.	• Coordinate with RO/LGUs re magnitude of impact , determine if FMTs are needed and identify type, number needed and disaster area for deployment . • Recommend to BIHC the identified FMT requirements (type, number and area for deployment). • Inform NDRRMC re FMT requirements. • Continue to monitor situation and advise BIHC for additional FMTs as needed. • Assist BIHC through Regional/ LGU HEMS Coordinators re monitoring and coordination of FMTs who directly arrived on-site for proper registration, capacity assessment and deployment .	• Conduct needs assessment (Rapid Health Assessment). • Advise HEMB re need for FMT (type, number and specific area for deployment). • Ensure that all FMTs who arrived directly on-site are registered and capacity-assessed. • Monitor/track operations and performance by FMTs. • Brief/orient FMTs re deployment. • Endorse FMTs to the concerned LGU/s.	• Register with BIHC (even prior to SODs). • Submit intent to provide assistance. • Undergo assessment by BHIC. • Ensure self-sufficiency and sustainability of operations for at least 2 weeks. • Make sure to attend briefing/ orientation by BIHC/RO re deployment. • Wear FMT identification/ pass. • Provide the assistance/ services to victims according to DOH standards and protocols.

Post- Impact (> 48 hours)	• Facilitate entry of FMTs' medical equipment and supplies . • Continue to monitor operations and performance of the deployed FMTs. • Continue to assess situation in coordination with HEMB and determine continuous/ additional FMT deployment. • Monitor FMT submission of daily reports and Exit Report. • Conduct evaluation of FMT mobilization and deployment and come up with final report . • Monitor turnover of donations by FMTs. • Update and maintain FMT registry. • Coordinate with DFA, NDRRMC, ROs re disengagement of FMTs.	• Continue to monitor situation and advise additional/ continuous FMT deployment or disengagement/ demobilization. • Advise BIHC re additional/ continuous FMT deployment or demobilization/ disengagement. • Furnish BIHC copies of daily reports from FMTs and the Exit Report prior to dis-engagement. • Assist BIHC through the Regional/ Provincial HEMS Coordinator re monitoring/ tracking and documentation of donations by FMTs. • Participate in the final evaluation of the FMT deployment and performance.	• Convene Health Cluster meetings with partners/ FMTs. • Continue monitoring situation and advise HEMB for continuous/ additional deployment of FMTs or demobilization. • Maintain and update database on FMT and submit registry to BIHC. • Facilitate and monitor submission by FMTs of daily report and Exit Report and submit to HEMB. • Facilitate and ensure proper documentation of the turnover of donations by FMTs and submit report to BIHC.	• Attend health cluster coordination and consultation meetings. • Submit daily report to LGU/RO. • Update ROs/ LGUs re status and other needs during operations. • Communicate with BIHC/RO re plan to extend stay. • Prepare Exit Report including recommendations. • Coordinate with LGU/ RO re turnover of donations.

D.2 Mobilization and Deployment of Local Volunteers

The effectiveness of local volunteers during an emergency or disaster is largely dependent on how well they were organized, trained and equipped during the Preparedness Phase. As a general policy, volunteerism is encouraged and welcomed but requires great responsibility both on the part of the volunteers and of those managing them. Volunteers include not only medical teams but also those who provide support in other aspects of operations, such as maintenance, engineering, administrative and financial needs, service utilities and logistics management. In Code Alert Orange (e.g., Typhoon Yolanda), volunteers will be accepted, giving priority to those who are more experienced, better-trained, and self-sufficient (will not a burden to the affected area). Volunteers belonging to a group or association (e.g., PMA, NGOs) are preferred over individual volunteers as they are easier to manage and deploy.

1. Trigger or Criteria

The need to mobilize local volunteers is triggered by the following criteria:

- If the organic staff of the health sector are not enough to carry out the response.
- If the magnitude of the impact is wide and extensive.
- If there is lack of expertise in the affected area.

2. Areas Where Local Volunteers Can Be of Assistance

1. Support to hospital services (wards, ER, laboratory, X-ray, etc.)
2. Provision of public health services in the community and evacuation centers
3. Support to operations, such as in the area of engineering, management of transportation/ motor pool, preparation of food, janitorial services and other utilities, management of storage, transport, pickup and distribution of drugs/medicines and other medical supplies

3. Roles and Responsibilities of the Local Volunteers

1. Coordinate directly with the assigned DOH offices at the national/regional levels or directly with the local health offices as to the type and number of volunteers required in the affected areas.
2. Prepare proper documentation and be willing to be properly matched with the actual need/requirements of the affected areas.
3. Prepare necessary professional and personal items to be self-sufficient, and familiarize themselves with the procedures and protocols to be followed.
4. Proceed to areas designated by the local host and work within the system.
5. Provide quality services and follow proper recording and reporting.
6. Prepare and submit daily reports and post-mission report within 48 hours after the completion of the mission or transferring to another area.

4. Process in Mobilizing and Deploying Local Volunteer Health Workers

It is assumed that local volunteers have undergone proper registration with the DOH at the national and regional levels following the DOH recommended process and criteria. Local volunteers are also allowed to register directly with the local health offices (PHO/CHO) according to the requirements set by the LGUs concerned. The process in mobilizing and deploying local volunteers follows that of foreign medical teams. Instead of the BIHC though as the overall coordinator of FMTs at the national level, the HEMB will take the lead in coordinating the deployment of local volunteers.

5. Post-Deployment

1. All volunteers must undergo exit interview with the host and submit final report to the LGU, copy-furnished the regional and national DOH.
2. Concerned local and regional health offices shall submit the updated list of local volunteers in their respective area to HEMB, which is the overall repository of reports and data related to the emergency/disaster.
3. Major equipment should be donated to the DOH national or regional health offices for better maintenance and maximum use. Drugs/medicines and medical supplies given to the local host must be included in the Final Report, including their estimated cost.
4. Participate in the debriefing sessions and Post-Incident Evaluation to be organized at the different levels of administration for further enhancement of future responses.
5. HEMB shall take charge of the final documentation and organize the recognition program/activity.

Chapter 5

Management of Information System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Chapter 5: Management of Information System

I. Introduction

Relevant, accurate and timely information is vital in the overall management of a well-organized and effective response to any emergency or disaster. Information about the event, victims, responders and the overall situation is necessary to guide the operations throughout the Response Phase. The information management system comprises the collection, validation, consolidation and analysis of data and the immediate utilization of information for decision-making, design and selection of appropriate response interventions, prioritization of resources, and enhancement of policies and guidelines in managing response to subsequent emergencies or disasters. It is also necessary that information be shared, disseminated and communicated to concerned DOH offices, other government agencies, and partners, including the general public, for their own use and reference.

II. Objectives

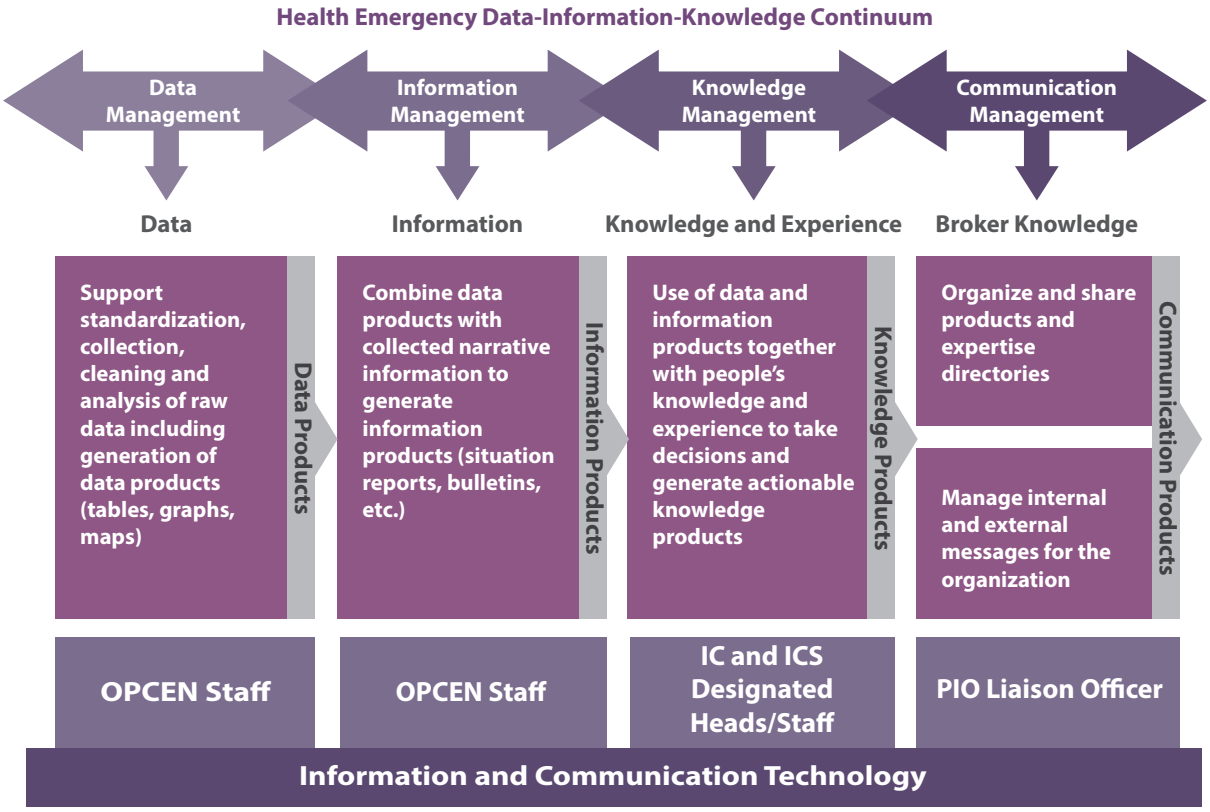
This chapter will provide you with guidelines on how to manage information and maximize its use to further benefit the design, management and implementation of emergency response. Specifically, this chapter will help you to:

a. Apply the steps and processes in managing health emergency data and information.
b. Appreciate the principles of knowledge management and maximize the utilization of information for decision-making and other actions necessary during the Response Phase.
c. Adopt the risk communication approach in sharing and disseminating the knowledge learned during the response.
d. Assess/evaluate and document the overall process and result of the response.

III. Key Elements in the Information Management System

The data-information-knowledge-communication continuum shown in Figure 24 contains the essential elements in managing information during a health emergency response – from collection of data to their translation into information useful to concerned DOH offices in the ICS chain of command, and their use in making decisions and taking actions during the Response Phase. The continuum goes on to include the management of communication, or the sharing and disseminating of the knowledge drawn and learned in the process, as well as assessing and documenting the overall Response Phase.

Figure 24. Health Emergency Data-Information-Knowledge-Communication Management System



Data Management. The effective and efficient management of the response is highly anchored on relevant, timely and accurate information drawn from data collected, validated and consolidated from predetermined sources throughout the Response Phase. Data management requires that data requirements and their sources are clearly identified, the data collection tools are standardized, data are cleaned and validated, and they are translated into graphs, tables and other forms for easier interpretation and use. Data management also demands that databases are established and continuously updated.

Information Management. Information management is the process of translating the collected and consolidated data sets into useful information by analyzing and interpreting the data at hand, supplemented with pertinent narrative information about the particular data sets. It also requires that significant findings or data are identified and highlighted from all the other data collected.

Knowledge Management. This is the process of acquiring, managing and utilizing disaster information, including one's experiences, instincts, ideas and rules in order to come up with appropriate decisions and draw up key actions as part of the health emergency response.

Communication Management. This entails the use of risk communication in sharing and disseminating information and knowledge to specific target groups (e.g., those affected, other stakeholders such as responders, decision-makers, etc.) in order to generate the desired decisions, actions and behaviors in response to the health emergency. It also covers the proper management of the media in order to maximize their support.

Documentation and the conduct of ***Post-Incident Evaluation*** (PIE) are also emphasized as subsets of the information management system, coming in at the end of the data-information-knowledge-communication management continuum. Both of these processes are undertaken during the post-impact stage of the Response Phase. During these processes, the lessons learned, experiences, and results of the health emergency response are documented, assessed/evaluated and shared/disseminated with corresponding recommendations to enhance management of response for future health emergencies or disasters.

IV. Policy Statements

Policy Statement 1:

All efforts must be exerted to collect timely, accurate and relevant data, which must be managed appropriately to generate information as basis for decision-making by the concerned DOH officials and staff in the ICS chain of command pre- during- post impact.

Policy Statement 2:

Risk communication shall be the approach adopted in disseminating and communicating pertinent information and knowledge to target audiences throughout the Response Phase.

Policy Statement 3:

The media must be properly managed to maximize their inputs and contributions for the benefit of the victims and their loved ones, the responders and all the stakeholders involved in the response.

Policy Statement 4:

Response to all major emergencies and disasters shall be assessed and documented by the ROs, hospitals and CO within their respective jurisdiction for the purpose of developing and amending policies and guidelines, and enhancing response interventions for future health emergencies or disasters.

Policy Statement 5:

Post-incident evaluation (PIE) shall be undertaken at the end of each major emergency and disaster, and integrated into the overall documentation report of the response.

V. Guidelines

A. Data-Information-Knowledge Management

In any emergency or disaster, timely, accurate and sufficient health information is critical in mounting the appropriate response. Information is needed to facilitate decision-making on the Code Alert level to be set, the type of interventions to be carried out, the volume/size of resources (both human and nonhuman) to be mobilized, and the affected areas to be prioritized for assistance. It is therefore important that quality (relevant, accurate, timely) data are collected and processed into information in the form of reports. These reports are then submitted and disseminated to all concerned authorities

for their reference and use in carrying out appropriate interventions and actions. This process consists of the following steps:

- Routine/daily collection of data
- Analyzing the data gathered and identifying those of significance
- Classifying the events being monitored
- Translating the data into appropriate reportable information format
- Ensuring the timely dissemination of reports to concerned authorities
- Making use of the information for decision-making and carrying out appropriate response actions

1. General Guidelines

The DOH-CO-HEMB is the overall repository of information in relation to health emergencies and disasters. Hence, it is expected that all information related to emergencies and disasters are submitted to HEMB.

1.1 The HEM staff/units established in each regional office and in the DOH hospitals also serve as the repository of information in their respective regions/hospitals.

1.2 Data collection, processing, reporting and dissemination for health emergencies and disasters shall follow the standard templates officially released by DOH-HEMB. As such, HEMB shall regularly review and amend existing forms and guides, or develop new ones as needed, and ensure that these documents are appropriately disseminated to all potential users and concerned agencies.

1.3 All reporting units at all levels shall devise mechanisms to obtain, review, analyze and use the information gathered to determine the best possible actions and interventions for their level at any given time.

1.4 All reporting field units shall develop strategies and mechanisms to ensure that the needed information are obtained accurately and on time. These include but are not limited to network expansion, designation of focal persons, and others.

1.5 Reporting units shall utilize any of the available forms of information and communication technology (ICT) to ensure the timeliness of reports.

1.6 All means must be explored to confirm the validity of data collected and evaluate if the content of the incident complies with the requirements for reporting.

1.7 When information is urgently needed and vital to operations, and required by rapidly evolving conditions secondary to an emergency or disaster of a significant magnitude, reports may be obtained or relayed directly across any level (national, regional, local) outside of the normal protocols.

2. Specific Guidelines

2.1 Data Requirements for Information Needed in Making Decisions and Taking Actions in Response to Health Emergencies or Disasters

The following summarizes the data sets to be collected and processed to generate the information needed by the concerned DOH officials/staff in the ICS chain of command as they make decisions and take appropriate response actions.

Table 33. Continuum of Data-Information-Knowledge Requirements During Response Phase, with Corresponding Sources

Key Decisions/ Response Actions	Information Needed	Sources of Information	Data Sets	Sources of Data
1. Decide to activate OpCen, determine Code Alert and level of alert. 2. Determine if need to elevate, downgrade or lift the alert level. 3. Determine offices to be activated as part of the ICS chain of command. 4. Determine concerned agencies to coordinate with. 5. Determine logistical requirements and identify specific sources.	1.1. Type/ nature of event, location and extent of geographic area affected 1.2. Magnitude of the event 1.3. Extent of response expected	HEARS PLUS Report	For new/delayed/ongoing events: • Nature of emergency/incident • What and where the incident occurred • Exact location/map of area affected	• PAGASA, PHIVOLCS, etc. • Regional Health Office • Local Health Office • Hospitals • N/R/LDRRMC • Quad-Media (radio, TV, news, social media)
		Field Reports	• Nature of hazard • Date, time, place of occurrence	
		FLASH Report	• Type of event/emergency/disaster • Exact location and date of occurrence	
		Rapid Health Assessment	• Type of hazard • Date, time and place of occurrence	
		Health Situation Update	• Level of Code Alert: when activated, when deactivated	
	a. Number of casualties (mortality, morbidity, missing)	HEARS Plus Report	For new and delayed events reported • Health consequences: number of deaths`, injured For ongoing events • Number of casualties (deaths, injured)	• Regional/ Local Health Offices • Hospitals • N/R/LDRRMC • For mortalities from natural disasters, coordinate with NBI • For mortalities from man-made disasters, coordinate with PNP-SOCO- (Forensic)
		Field Reports	• Casualties: number of dead and injured	
		FLASH Report	• Number of casualties (deaths, ill, injured, missing, and special vulnerable groups affected (children, elderly, women) • Chief complaints • Current status of victims	
		Rapid Health Assessment Report	• Casualties (deaths, injured (pre-hospital, hospital-OPD/ admitted	
		Health Situation Update	• Affected population: families, individuals • Dead: identified, unidentified • Injured: pre-hospital, hospital (OPD, admitted)	

	b. Extent of displaced population	HEARS Plus Report	• No. of displaced populations (no. of ECs, families, individuals)	• Regional Offices/ Local Health Office • Hospitals • N/R/LDRRMC • D/LSWD
		Rapid Health Assessment Report	• Impact of event on the community: total number of EC, total number of families inside EC; total number of individuals inside EC	
		Health Situation Update	• Displaced population: total number of EC, total number of families inside EC; total number of individuals inside EC	
	c. Extent of health facilities affected	HEARS Plus Report	• Status of damaged facilities: no. of HF existing, assessed, extent of damage (partially, completely), status of operations (functional, not functional), estimated cost of damage	• Regional Health Offices • Local Health Offices • Hospitals • HFDB
		Rapid Health Assessment Report	• Impact on health facilities: no. of existing, damaged, functional and nonfunctional by type of health facility	
		Health Situation Update	• Extent of damaged health facilities secondary to the event, including estimated cost	
	d. Extent of health personnel affected	Rapid Health Assessment Report	• Impact on health personnel: % of health personnel reporting by type of health facility	• Regional/Local Health Offices • Hospitals • HFDB
	e. Status of lifelines in the affected areas	Rapid Health Assessment Report	• Availability of communication services: landline, cell phones, internet • Status of electrical services (available or unavailable) • Status of main roads/bridges (passable or impassable) • Status of airports and seaports (functional or nonfunctional)	• N/R/LDRRMC family • Regional/Local Health Offices • Hospitals • Partner agencies
		Health Situation Update	• Status of lifelines by location: communication (landline, cell phone, internet), electricity, water services, main road and bridges, airport and seaport	
6. Determine type, quantity/ volume of logistics to mobilize, allocate and distribute. 7. Decide to do emzergency procurement if necessary.	• Type, quantity/ volume of logistics to be provided, procured, allocated to identified affected areas	HEARS Plus Report	For new events: • Status of distribution of logistics according to kind, source and recipient, status (in-transit, received)	• Regional/ Local Health Offices • Hospitals
		Rapid Health Assessment	• Adequacy of essential drugs/ medicines in the RO, hospitals, LGUs	
		Health Situation Update Report	• Current stock levels in RO, hospitals and LGUs, and augmentation to the affected areas	

8. Determine type, number of responders (DOH, local and foreign volunteers) to mobilize and deploy.	• Type and number of teams to be deployed, areas where to deploy them, need to add or pull out	HEARS Plus Report	• Summary of manpower deployed: no. of doctors, nurses, other health personnel per DOH team deployed, other local health volunteers and foreign teams	• Regional/ Local Health Offices • Hospitals • HEMS Coordinators
		Health Situation Update	• Summary of health human resources: human resource deployed (technical and medical), date, place of deployment, sending agency, name of team, team leader, team composition, total team members, technical assistance, services provided, patients seen and referred (for medical team), top morbidity cases	
9. Identify type of services to be provided in various settings.	a. Type, quantity/ volume of hospital services	HEARS Plus Report	• Location, name of hospital, service providers • Summary of hospital services provided in affected regions: no. of patients served: ER consultations, OPD consultations, admissions, no. of operations done, no. of referrals, no. of discharges, no. of deaths, no. of Home Against Medical Advice	• Hospitals • HEMS Coordinators • Partners
		Health Situation Update	• Number of patients served: ER/ OPD consultations and treatment, medical admissions, surgery admissions and referral	
	b. Type, quantity/ volume of Health services provided	HEARS Plus Report	• Location, name of evacuation, service providers (name of teams, number of teams, duration of deployment) • Summary of Health services provided: no. of population served with first aid, consultation and treatment, immunization (measles, TT, OPV), patient transport, pneumonia treatment, chemoprophylaxis, RH services, health education, CAMPOLAs	• Team Leader • RHEMS/ HHEMS Coordinator • Hospitals • Cluster Point Person • Partners
		Health Situation Update	• No. of population and communities/ areas served with: first aid, consultation and treatment, patients transport, measles immunization, vitamin A, tetanus vaccination, chemoprophylaxis, RH (FP, natal care), health education, referrals, CAMPOLAS Plus	
	c. Type, quantity, volume of WASH services provided	HEARS Plus Report	• Location, name of evacuation, service providers (name of teams, number of teams, duration of deployment) • Summary of WASH services provided: provision of potable water, water testing, distribution of water container, water treatment with disinfectant, provision of water for general/domestic use, construction/installation of toilets/ latrines, hygiene kits provided, jerry cans provided, others (water purifier, mobile water tanks, etc,)	• Regional/ Local Health Offices • Cluster Point Person • Partners
		Health Situation Update	• No. of population and areas/communities served with potable water (bottled water, water rationing, etc.), water container, water testing and treatment, other water- related services, installation/ construction of toilets, hygiene kits, IEC materials for hygiene promotion	• Regional / Local Health Offices • Hospitals • Cluster Point Person • Partners

	d. Type, quantity/ volume of Nutrition services provided	HEARS Plus Report	• Location, name of evacuation, service providers (name of teams, number of teams, duration of deployment) • Summary of Nutrition services provided: no. of population served with nutritional assessment, micronutrient supplementation, IYCF, integrated management of acute malnutrition	• Regional / Local Health Offices • Hospitals • Cluster Point Person • Partners
		Health Situation Update	• No. of population and areas/communities served with: nutrition assessment, micronutrient supplementation, supplementary feeding, integrated management of acute malnutrition, IYCF	
	e. Type, quantity, volume of Psycho-social services provided	HEARS Plus Report	• Location, name of evacuation, service providers (name of teams, number of teams, duration of deployment) • Summary of Psychosocial services provided: no. of population served with PFA, community and family support, counselling, psycho-educational session, psychosocial processing, stress management, referrals, defusing, mental health services	• Regional/Local Health Offices • Hospitals • Cluster Point Person/ members • Partners
		Health Situation Update	• No. population served and communities/areas covered with: psychological first aid, community and family support, counselling, psychosocial processing, stress management and referrals	
	f. Type, quantity/ volume of support services provided	HEARS Plus Report	• Location, name of evacuation, service providers (name of teams, number of teams, duration of deployment) • Summary of support services provided: laboratory services, dental services, fogging, etc. • Type and number of administrative support staff (utilities, engineers, cooks, maintenance, record clerks, accounting clerks, bookkeepers, carpenters, haulers, etc.)	• Regional/Local Health Offices • Hospitals • Cluster Point Person/ members • HEMS Coordinators
	g. Actions taken and recommendations by concerned offices	HEARS Plus Report	• Response and coordination activities	• COs • Regional/ Local Health Offices, • Hospitals
		Field Reports	• Actions taken by the LGU, RO, CO	
		Health Situation Update	• Organization/coordination activities, meetings, on-site visits, case conformation and validation, reporting of updates, logistics monitoring, promotion/advocacy	

2.2 Criteria for a Reportable Health and Health-Related Events

2.2.1 By Type of Hazard

There are four types of hazards that can qualify as a reportable event:

a. ***Natural Hazard.*** A physical force that may cause a disaster when it affects a populated area, such as typhoon, flood, landslide, earthquake, and other similar events.

b. ***Biological Hazard.*** A process or phenomenon of organic origin or conveyed by biological vectors, including exposure to pathogenic microorganisms, toxins and bioactive substances.

c. ***Technological Hazard.*** A hazard originating from technological or industrial conditions, including accidents, dangerous procedures, infrastructure failures, or specific human activities.

d. ***Societal Hazard.*** A hazard that arises from the interaction of varying political, social and economic factors which may have a negative impact on a community.

Table 34. Examples of Different Types of Hazards

<table>
<tr><th>Natural</th><th>Biological</th><th>Technological</th><th>Societal</th></tr>
<tr><td rowspan="2">• Weather disturbance (e.g., tornado, storm surges)
• Flood
• Flashflood
• Landslide
• Earthquake
• Tsunami
• Volcanic activity
• El Niño/La Niña
• Drought/famine
• Heat wave
• Mudflow or debris flow (e.g., lahar)
• Lightning
• Other naturally occurring events with effects on the environment</td><td>• Increasing trends of communicable diseases
• Disease outbreaks
• Red tide
• Food poisoning
• Spread of any substance coming from living organisms that threaten the health of humans</td><td>• Fire
• Transportation accidents (land, air, sea)
• Chemical leak/spill/ poisoning
• Industrial accidents
• Radio nuclear incidents
• Damaged infrastructure/ structural failure
• Other actions resulting in major population displacement</td><td>• Blast/explosion (e.g., improvised explosive device)
• Rallies/strikes
• Mass gatherings
• Stampede
• Armed conflict
• War
• Terrorist or terrorist-related events
• Ambush incident
• Hostage-taking
• Coup d’état/ standoff
• Repatriation
• Riots/civil unrest</td></tr>
<tr><td colspan="3">If casualties due to the following events are > 10, these must be reported:</td></tr>
<tr><td>• Food poisoning</td><td>• Land transportation accidents
• Industrial accidents</td><td>• Ambush
• Hostage-taking</td></tr>
</table>

2.2.2 Based on Special Events

Special events are those that cannot be classified under any of the four types of hazards but have the potential of developing into a mass casualty incident. Special events include the following:

a. National and local holidays
b. Events of national importance (e.g., elections, State of the Nation Address, etc.)
c. Events involving figures/personalities of national importance (e.g., President, Ambassador, etc.)
d. Events with security implications
e. International events:
    i. International emergencies/disaster that have a potential public health effect in the Philippines (e.g., Fukushima nuclear radiation, pandemics)
    ii. International events hosted by the Philippines that may pose a threat for MCI and needing DOH participation/intervention
    iii. International disasters warranting humanitarian assistance from other countries

2.3 Classification of Events

Events being monitored are also classified according to their magnitude and the severity of damages incurred. This classification is based on the following criteria:

- More than 10 casualties (deaths or injured).
- Critical infrastructure and lifelines affected, thus hindering delivery of health services.
- Local government units cannot handle the situation alone.
- Intervention by DOH Central Office and other national agencies is needed.
- There is a declaration of a disaster.

Based on these criteria, the events are classified into the following:

a. ***Minor Events.*** These are events that LGUs can handle and DOH intervention is not needed.
b. ***Major Events.*** These are events that meet any of the two criteria listed above where DOH comes in to provide assistance.
c. ***Disasters.*** These are events that fit all the criteria listed above and/or when a disaster is declared.

2.4 Sources of Reports

There are various sources where reports on health and health-related events can be obtained, as listed below:

a. Media
    i. ***Radio.*** Broadcasts can provide real-time information which is aired 24 hours a day to provide the most recent updates to listeners. Stations have the ability

to reach across borders and become a source of information where reliable news is scarce. When access to the Internet is blocked and phone lines are cut, people can still search the airwaves for trustworthy sources.

ii. ***Television.*** The television is a great source of information as it provides real-time information through reports, video coverage, and different TV news programs. With the advances in technology and existence of different news channels, the latest information as the events happen is easy to obtain.

iii. ***Newspapers.*** These are periodical publications containing news regarding current events, informative articles, diverse features, editorials and advertisements.

iv. ***Internet.*** The Internet provides real-time news and information posted by different agencies and organizations which can easily be accessed by HEMB at all levels. E-mail addresses and websites are monitored for any communication or reports received that need immediate feedback and action.

v. ***Social Media.*** This is a form of electronic communication, such as websites for social networking and micro-blogging, through which users create on-line communities to share information, ideas, personal messages and other content. Some examples are Twitter, Facebook, etc.

b. Reports from the different offices of the DOH. These are reports from the central, regional and hospital levels, particularly from the HEMS Coordinators, including those from the LGUs.

c. Reports from NDRRMC family and partners.

2.5 Types of Reports (Information Products)

a. Health Emergency (HEARS) Plus Report. The HEMB at the DOH Central Office prepares this report and submits it to the Secretary of Health twice a day. Inputs to HEARS are obtained from various sources, including the Field Reports from the ROs and the hospitals. This report includes all monitored reportable events within the last 24 hours as well as updates on previously reported major disasters and special events. The HEARS Report may contain the following:

i. ***New Event.*** Event monitored within 24 hours (8 a.m. to 8 a.m. the next day). Includes a brief description of the incident monitored, its health effects, and actions taken.

ii. ***Delayed Event.*** Event that occurred in the past two weeks but monitored and reported only during the past hours. Includes a brief description of the incident monitored, its health effects, and actions taken.

iii. ***Special Event.*** Includes a brief description of the special event monitored, its health effects, health human resource deployed (if any), and actions taken.

iv. ***Ongoing Event.*** Refers to a major emergency or disaster previously reported but still with ongoing operations with DOH intervention. An example is a displaced population that is temporarily sheltered in evacuation centers or victims admitted in hospitals that need to be continuously monitored.

b. Flash Report. This must be prepared for every monitored incident needing immediate attention and intervention. The report contains information that must be brought at once to the attention of the superiors and/or decision-makers not later than 2 hours from the occurrence of the event. The HEMB units/staff from the hospitals, ROs and DOH Central Office submit their reports to their respective chiefs and directors. The report has two parts: the first part shows the chronology of events, magnitude of the emergency or disaster, and the reported damages that it has incurred in the affected area;the second part shows the actions undertaken by the concerned offices.

c. Field Reports. These are reports prepared by the ROs and DOH hospitals on health and health-related events occurring in the catchment area within a 24-hour period (6:00 a.m. to 6:00 a.m.). These must be submitted before 8 a.m. in time for the HEARS Plus Report submission to the Secretary of Health. (Please refer to RO Reporting Template 1 – Field Report.)

d. Rapid Health Assessment Report. This is a report prepared by the ROs and hospitals within 24-48 hours after a major event or disaster. Its purpose is to determine the magnitude and capacity of the affected areas and the ability of the RO/hospital to handle or cope with the situation. (Please refer to HEMS RHA Form 1 – Regional Rapid Health Assessment and HEMS RHA Form 2 – Health Facility Rapid Health Assessment.)

e. Health Situation Update. This report is an update of a previously reported major event that has to be followed up to track the progress of the event and the services rendered. It is submitted on a daily basis for the first week of the event, three times a week (Monday, Wednesday, Friday) on the second and third week, and once a week (Wednesday) thereafter until response has ended. The essential Information to be reported as part of the Health Situation Update include the following (Please refer to RO Reporting Template 2- HSU):

   i. ***Magnitude of the Event.*** Includes the geographic scope of the disaster, the extent of damages to infrastructure and lifelines, affected population, displaced population, and existence of evacuation centers.
   ii. ***List of Casualties.*** Provides the total number of casualties, both mortality and morbidity, related to the disaster. The list includes the name, sex, address, diagnosis and cause of death/injury of the casualties. If confined in the hospital, the report should include the interventions provided.
   iii. ***Summary of Health Human Resources.*** Monitors the movement of human resources to and from the affected sites. It summarizes the human resources (technical and medical) deployed to affected areas after the occurrence of an incident. It contains information on: the date of deployment, sending agency, name of team, team leader, team composition, total team members, place of deployment, technical assistance (for technical team), services provided,

patients seen and referred (for medical team), and top morbidity cases (for medical team). The report helps in ensuring that all affected sites are visited and duplication of efforts is avoided..

iv. ***Health Infrastructure Status.*** Information on damaged health facilities secondary to the event, including estimated cost. This is for possible provision of financial assistance in the rehabilitation of the facility.

v. ***Summary of Logistical Assistance.*** Shows the logistical assistance given to a locale after the occurrence of an incident. It includes the source of assistance, recipient of assistance, items provided, and amount.

vi. ***Cluster Services Provided.*** Information on all the actions taken by respective Cluster Partners, identified needs, and other details of the response operations.

- Health Services. Include but not limited to the following services: first aid, consultation and treatment, patient transport, prevention and control of diseases (not limited to measles immunization, tetanus vaccination, and vitamin A supplementation), chemoprophylaxis, reproductive health (not limited to family planning and natal care), health education, referrals, and provision of CAMPOLAS. It also includes the number of population served and areas covered for each service rendered, including hospital services.
- Water, Sanitation and Hygiene (WASH). Include but not limited to the following services: provision of potable water, distribution of water container, water testing, water treatment, installation and construction of toilets, provision of hygiene kits, and dissemination of IEC materials for hygiene promotion. It also includes the number of population served and areas covered for each service rendered.
- Nutrition. Include but not limited to the following services: nutrition assessment, micronutrient supplementation, supplementary feeding, integrated management of acute malnutrition, and infant and young child feeding. It also includes the number of population served and number of areas covered for each service rendered.
- Psychosocial Services. Include but not limited to the following services: psychological first aid, community and family support, counselling, psychosocial processing, stress management, and referral of cases. It also includes the number of population served and number of areas covered for each service rendered.

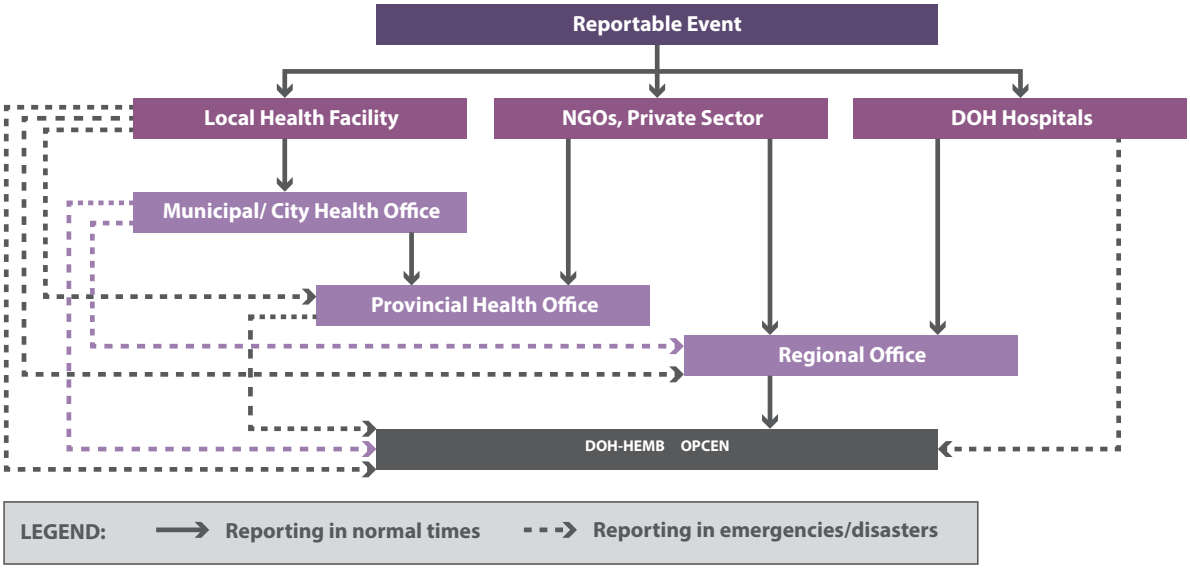
vii. ***Mass Dead.*** Gives the number of mass deaths (identified and unidentified), number of unidentified bodies that have undergone disaster victim identification, number of bodies buried, etc.

(Note: Templates of all these reports are available in the OpCen Manual.)

2.6 Flow of Reports During Emergencies and Disasters

Figure 25 illustrates the generic flow of reports during normal times and during any health emergency or disaster. The flow covers reports coming from: the LGUs (from the local health facility up to the municipal/city health office to the provincial health office); the private sector; and the DOH hospitals. All reports go through the respective ROs and ultimately to HEMB at the DOH Central Office, which is the repository of all reports.

Figure 25. Flow of Reporting Health Information During Emergencies and Disasters



2.7 Frequency of Reporting

Frequency of reporting does not follow a definite schedule. It varies according to the type of report to be submitted. The table below shows the frequency of reporting per type of report and the corresponding recipients of each report.

Table 35. Source, Frequency and Recipients by Type of Report

Type	Source	Frequency	Recipient
Flash Report	Regional offices, DOH hospitals and HEMB	• Done within 2 hours from the occurrence of the event/incident • Subsequent updates are reflected in the HEARS Plus Report.	• Secretary of Health • Cluster Lead • HEMB • RO Directors concerned • Chiefs of Hospitals
HEARS Plus Report	HEMB-OpCen	• Prepared and released twice a day: • (i) HEARS Plus Report released at 8:00 a.m., covers monitored events from 8:00 a.m. to 8:00 a.m. the following day (24-hr monitoring) • (ii) HEARS Plus Report at 4:00 p.m., covers monitored events from 8:00 a.m. to 4:00 p.m. of the same day.	• Secretary of Health • CC: • - EXECOM members • - RO Directors • - Regional HEMS Coordinators • Chiefs of DOH hospitals • NDRRMC • Partners and others
Field Report	ROs and DOH hospitals	Submitted on a daily basis covering a 24-hour period (between 6:00 a.m. to 6:00 a.m.) and must be submitted before 8 a.m. in time for the HEARS Plus Report submission to the Secretary of Health	• DOH-CO HEMB • RO Directors • Chiefs of Hospitals
Rapid Health Assessment	ROs and DOH hospitals	• Once, within 24-48 hours after the event	• DOH-CO HEMB • RO Directors • Chiefs of Hospitals
Health Situation Update	ROs and DOH hospitals	• Daily submission during the first week, twice a week during the second week, and once a week thereafter; will stop reporting if the local government can already handle the situation.	

2.8 Verifying the Report

Verification is an independent procedure that is done to check the veracity of data collected from monitoring. It evaluates if the content of the incident complies with the requirements for reporting. It is often an internal process in which the emergency staff on duty calls the concerned office/staff handling and managing the event or incident. Verification aims to: (i) make sure the data are closest to the truth or what really happened

during the event; (ii) see patterns – in persons, places and time – giving meaning to the data until they become meaningful information; and (iii) integrate the gathered information with other information and evaluate it in terms of the issues confronting the health sector until it becomes evidence. Following are the steps in verifying reports:

a. Any health or health-related event, once monitored, is submitted for verification.
b. The EOD verifies the event with the Regional Coordinator or with the appropriate agency handling and managing the event.
c. The Regional Coordinator or the agency concerned will then verify it with the responding unit at the site.
d. If the event is determined true by a reliable source, the EOD may finalize the information gathered until it becomes reflected in the HEARS Plus Report.

2.9 Notifying the Superiors

The HEMS Coordinators at DOH-CO, RO and DOH hospital are expected to notify their respective immediate supervisors regarding the event and seek clearance for the submission of reports to higher levels without jeopardizing the speed of reporting. Updating superiors does not follow a regular interval. It must be done as often as valid information is conveyed to the OpCen. After the event/incident is brought to the attention of the superiors, either by a call or a Flash report, updates/situation reports should be provided containing the following information.

Table 36. Examples of How to Notify Superiors During an Emergency/Disaster

Information	Example
Situation Update Number	Situation Update #1O
Time of Reporting	as of 10:00 a.m.
Name of Event including the place of incident and time incident took place and or started	Bombing Incident in front of Joubert's Resto, Sta. Ines St., Brgy. Azelav, Quezon City at 8:00 a.m. 07/13/13
	DOH-CO HEMB RO Directors Chiefs of Hospitals
Current condition on the area of incident	retrieval and management of casualties at site still on-going; security managed
Casualties: total number of casualties total deaths and injured, status of injured- (how many are severely injured, their status, and to what hospital they have been brought)	total of casualties 20 out of which are 10 fatalities. Out of the 10 injured, only 1 is in critical condition and is being managed at EAMC, 9 other injured suffered minor injuries are admitted in ARMMC.
Actions Taken – Actions taken by The DOH, or if none, actions taken by other agencies pertaining to health	Retrieval and management of casualties handled by PNP and PRC

Note:
- Constant information after updating should not be included to the next update report. (e.g. the total number casualties remained constant, this information should not appear on the next update)
- SMS Incident Update sending should be terminated after the approval of the Head of Office/designate and that the incident monitored does not need any health-related intervention, all victims are retrieved and managed in a hospital, and such incident was already restrained.

3. Steps/Tasks in Reporting at Pre-Impact, During Impact and Post-Impact

Table 37. Reporting Tasks/Steps by Phase

Pre-Impact (A day or days before)	During Impact (0 hour to 48 hours)	Post-Impact (After 48 hours and onwards)
• Do active monitoring from all sources. • Validate reports or data from reliable agencies. • Analyze data gathered and identify what need to be reported. • Classify events monitored. • Identify appropriate type of reports needed using templates (See OpCen Manual for all types of reports including their templates). • Ensure timely reporting as agreed: ex. Flash Reports within 2 hours of event;,daily HEARS Report every 8:00 a.m. to Secretary of Health; RO and hospitals to submit before 8 a.m. to be included; regions should be able to get from their catchment area enough time to consolidate and submit to Central Office no later than 6 a.m. • Pre-impact reports should include preparedness activities such as, but not limited to, the following: ↘ Activation of OpCen with number of staff ↘ Code Alert level ↘ Standby teams available ↘ Prepositioned logistics with costs ↘ Availability of other logistics in the warehouse or any DOH facility in their area ↘ Meetings conducted ↘ Coordination done with respective LGUS and the Disaster Office concerned (OCD, RDRRMC, etc.)	• Continue monitoring and validation. • Continue analysis of data/ information and identify what to be included in the reports. Rapid Health Assessment should be reported by this time. • The following are information needed in reporting during impact or immediately after (24-48 hrs) ↘ Magnitude of the emergency includes: population affected (individuals or families) including displaced population and number of evacuation centers ↘ Mortalities/morbidities including possible causes; missing; mass dead ↘ Health facilities affected classified according to types of facilities ↘ Initial response provided: teams deployed, logistics provided per province, city or municipality; services provided ↘ Coordination or meetings attended or conducted • The following are information needed in reporting during impact or immediately after (24-48 hrs) ↘ Magnitude of the emergency includes: population affected (individuals or families) including displaced population and number of evacuation centers ↘ Mortalities/morbidities including possible causes; missing; mass dead ↘ Health facilities affected classified according to types of facilities	• Continue monitoring and validation. • Continue analysis of data/ information. • Data collected at this point should be more detailed, specific if possible by municipality or by province/city. • Include in the report on the magnitude of the emergency the following: population displacement, evacuation centers by municipality. • Complete Rapid Health Assessment of ECs to give more details and prioritization of response. • Ensure that report on EC includes: population (families or individuals), availability of water source, availability and number of latrines/ toilets; identified areas for pregnant and lactating mothers; availability of medical personnel and time spent in ECs; availability of drugs, medicines supplies, vaccines, etc.. • Get statistics on consultations, types and actions taken. • Coordinate with hospitals on statistics of patients transferred, etc. • Record health facilities affected. • Obtain more detailed data not only on types of facilities but on area per municipality, including ownership; should also include initial damages (partial or complete) and estimated costs of buildings and equipment; may also include if still functioning and what services are provided. • Team deployment should include number of teams, origin of teams, composition, area assignment, duration of stay and accomplishment; names of team leaders and contact numbers for purposes of coordination.

- Ensure timely reporting as agreed: ex. Flash Reports within 2 hours of event;,daily HEARS Report every 8:00 a.m. to Secretary of Health; so CHD and hospitals to submit before 8 a.m. to be included; regions should be able to get from their catchment area enough time to consolidate and submit to Central Office no later than 6 a.m.

- ↘ Initial response provided: teams deployed, logistics provided per province, city or municipality; services provided
- ↘ Coordination or meetings attended or conducted
- ↘ Availability of personnel (percentage) at all implementing facilities including LGU personnel
- ↘ Capability to cope or handle the situation: number of staff/medical teams working in relation to the magnitude of the disaster; logistical needs

- Logistics deployment should include total logistics provided according to area such as province/city/ municipality or EC; types of logistics; support accepted from other sources and donations; cash accepted or cash utilized used for emergency procurement.
- Services provided should be detailed to include every service provided covering health, nutrition, WASH, psychosocial and hospital services.
- Health services include but are not limited to: consultations, provision of medicines, treatment of wounds, vaccination, chemoprophylaxis, prenatal/postnatal, delivery, transfer to facilities:
- WASH services include but are not limited to: provision of water containers, construction or provision of latrines; provision of hygiene kits.
- Nutrition services include but are not limited to: nutritional assessments, supplementary feeding; provision of micronutrients.
- Psychosocial Services include but are not limited to: psychosocial assessments, debriefing, counselling, referral to hospitals.
- Include technical support in the management of the dead.
- Hospital services include but are not limited to: consultation and treatment, admissions, surgical procedures including type, transfer to higher facilities. rehabilitation and psychiatric care.

B. Communication Management

Information and knowledge obtained relative to the health emergency or disaster are expected to be shared and disseminated to different audiences/users. These could be the concerned offices within the DOH family at the central and regional levels and in the DOH hospitals, the external agencies and partners in the health sector involved in the response, as well as the general public. Risk Communication is the approach to be adopted in managing the dissemination of these information/ knowledge, including proper media management.

B.1. Risk Communication

Risk communication is the purposeful exchange of information about the existence, nature and form, and severity or acceptability of health risks between policymakers, health care providers, and the public/media. It is aimed at changing behavior and inducing action to minimize/reduce risks. It is imperative that the DOH-CO, RO and DOH hospital officials and staff involved in response management, including the local health officials and health workers, develop the habit of communicating health risks before, during and post-disaster.

1. General Guidelines

1.1 Risk communication is essential in informing the public, the DOH family and its partners regarding the response to health emergency and disaster for the following reasons:

a. It is the fundamental right of the population to access information about the risks they face.
b. Organizations are seen to be more legitimate and effective when they are transparent and open with information.
c. The risk is shared by the organization and the population.
d. Risk communication serves as an avenue for information and education to the communities, health personnel and decision-makers. It gives a better chance of explaining risks to the population more effectively.
e. Populations can make better choices when they are better informed.
f. The emergency information can stimulate behavior change.
g. Risk communication prevents misallocation and wasting of resources.
h. It can lower the incidence of illness, injuries and deaths.

1.2 There are seven principles you need to observe in risk communication.

a. Accept and involve the public as a partner. Your goal is to produce an informed public, not to defuse public concerns or replace actions.
b. Plan carefully and evaluate your efforts. Different goals, audiences and media require different actions.
c. Listen to the public's specific concerns. People often care more about trust, credibility, competence, fairness, and empathy than about statistics and details.

d. Be honest, frank and open. Trust and credibility are difficult to obtain; once lost, they are almost impossible to regain.
e. Work with other credible sources. Conflicts and disagreements among organizations make communication with the public much more difficult.
f. Meet the needs of the media. The media are usually more interested in politics than risk, simplicity than complexity, danger than safety.
g. Speak clearly and with compassion. Never let your efforts prevent your acknowledging the tragedy of an illness, injury or death. People can understand risk information, but they may still not agree with you; some people will not be satisfied.

2. Specific Guidelines

2.1 Identification of risks to be addressed

a. Identify risks of the hazard using the risk management process.
b. Determine the knowledge and the behaviors to be learned and adopted to prevent the risks. These will be the basis for the development of the risk communication message.

Example	
Hazard: Risk: Knowledge: Behavior:	• Typhoon • Flooding • Prevention of leptospirosis • Signs and symptoms of leptospirosis • Measures to prevent complications from leptospirosis • Home management of leptospirosis • Bring eligible children for measles immunization and vitamin A supplementation. • Bring children with early signs and symptoms of measles to health workers. • Proper care and management of measles.

2.2 Program implementation. Execute the communication strategies identified in the Risk Communication Plan

2.3 Program evaluation and impact assessment

a. Evaluate the process or assess the strategies/activities that were implemented as against the plan.
b. Assess the impact of the program in terms of the change in the knowledge and behavior of the target group/audience.

3. Risk Communication Tasks Pre- During- Post Impact

There are several tasks that need to be carried out relative to risk communication during the Response Phase from Pre- During- Post impact.

Table 38. Risk Assessment Tasks Pre/During/Post-Impact

Pre-Impact (A day or days before)	During Impact (0 hour to 48 hours)	Post-Impact (After 48 hours and onwards)
1. Activate the Risk Communication Plan. 2. Assess the level of the public's perception of the risk through media reports and other practical and possible means. 3. Review and disseminate risk communication message/s. 4. Reproduce needed IEC materials.	1. Disseminate immediately risk communication messages focused on the SOCO through media briefings and press conferences, and establish when the next update will be. Note that the media updates should be adjusted to the report cutoff time of the team. 2. Post IEC materials at the evacuation centers and other strategic areas. 3. Document (photo and video) team's activities. 4. Start media monitoring.	1. Intensify implementation of Risk Communication Plan. • Continue developing press statements according to assessment and context of the disaster. • Increase frequency of disseminating risk communication messages to reiterate adoption of the desired behavior change or SOCO. 2. Conduct health education classes at the evacuation center. • Organize mother's/parent's class. 3. Continue documentation of implementation of Risk Communication Plan and activities. 4. Evaluate implementation of Risk Communication Plan.

B.2. Media Management

Media plays a very important role in risk communication and handling media is very crucial in health emergency management. Understanding the media is one of the significant tasks of a health emergency manager.

1. General Guidelines

1.1 Always use standard terminology for media management in order to standardize communications between stakeholders.

1.2 Use training courses to keep journalists abreast.

1.3 Consider bringing the media into your organization.

1.4 Always have an identified media spokesperson.

1.5 Be knowledgeable on what the media needs to know. Be transparent.

2. Specific Guidelines

2.1 Familiarize yourself with what media want.

a. Know what kind of information the media want.

b. Consider that media run after information to sell their story and in return merit needed ratings for their newspapers and radio or TV.

2.2 Be prepared for what media will ask

a. Make available for media consumption information on the nature, effect and other vital facts about the risk.

b. Consider that information should be brief and concise so that it will not create misinformation. Below are some of the important data/information that media want:

- Casualties
  - Number killed or injured
  - Number who escaped
  - Nature of the injuries received
  - Care given to the injured
  - Disposition of the dead
  - Prominence of anyone who was killed, injured or escaped
  - How escape was handicapped or cut off
- Property damage
  - Estimated value of loss
  - Description – kind of building, etc.
  - Importance of the property, e.g., business operations, historic value, etc.
  - Other property threatened
  - Insurance protection
  - Previous emergencies in the area
- Causes
  - Testimony of participants
  - Testimony of witnesses
  - Testimony of key responders (e.g., AFD, EHS, UTPD)
  - How emergency was discovered
  - Who sounded the alarm
  - Who summoned aid
  - Previous indications of danger
- Rescue and Relief
  - The number engaged in rescue and relief operations
  - Any prominent persons in the relief crew
  - Equipment used
  - Handicaps to rescue
  - How the emergency was prevented from spreading
  - How property was saved
  - Acts of heroism
- Descriptions of the crisis or disaster
  - Spread of the emergency
  - Blasts and explosions
  - Crimes or violence
  - Attempts at escape or rescue
  - Duration
  - Collapse of structures
  - Extent of spill

- Accompanying Incidents
  - Number of spectators – spectators' attitudes and crowd control
  - Unusual happenings
  - Anxiety, stress of families, survivors, etc.
- Legal actions
  - Inquests, coroner's reports
  - Police follow-up
  - Insurance company actions
  - Professional negligence or inaction
  - Suits stemming from the incident

2.3 Decide when to release information.

a. If people are at risk, do not wait.
b. Inform people concerned of any risk you are investigating and why.
c. If it seems likely that media (or others) may release information, release it yourself.
d. Fill in information gaps for the media.
e. If preliminary results show a problem, release them and explain the tentativeness of the data.
f. If the information will not make sense without other relevant information, wait to release all the related information all at once.
g. Advise community on interim actions while waiting to confirm data.
h. If you don't trust your data, don't release it.
i. Consider the following:
   - Although the agency is vulnerable to criticism, one may be more vulnerable if information is withheld.
   - The alarm caused by early release will be less than the alarm that can be compounded by resentment and hostility if information is withheld.

2.4 Decide when to release information.

a. Press release – Follow the following basic press release structure:
   - Summarize the content: "In a press statement today, the Mayor called on…."
   - Quote the source: "A public health emergency can only be avoided by…," the Secretary said.
   - Link the quote to an important event that is of public knowledge: "The statement was made referring to the recent outbreak of measles where 10 children died…"
   - Acknowledge controversy but show that this is the best course of action: "Despite overwhelming resistance to…,the action is needed because …"
   - Tell the public what to do: "In support of this, the public is asked to…" For more information call…
b. Press statement – It should:
   - Include opening remarks.
   - State the action.

- Link it to an event.
- State other supporters of the action.
- Inform people of their role.

c. Preparing for a press conference

- Before a press conference:
  - Prepare (update) media directory.
  - Select a location which is accessible to media.
  - Make sure there are no other (newsworthy) events happening at the time of your event/press conference.
  - Issue a press conference advisory with the following basic information:
    - ✓ Date
    - ✓ Topic or agenda
    - ✓ Time
    - ✓ Location
    - ✓ Contact information
  - Follow up calls after issuing advisory.
  - In the event of other "breaking" news, try to reschedule your event or reach out to journalists on a one-on-one basis to generate a few stories.
  - Prepare logistics needed. The ideal setup includes a podium (or table) and microphones for the speakers.
    - ✓ For indoor press conferences, leave space for TV cameras at the back of the room.
    - ✓ Provide for sign-in table where media can register their name and contact information.
    - ✓ Prepare a simple signage, e.g., banner behind the speakers. Name plates for speakers may also be necessary.
    - ✓ Prepare a press kit to hand out to media during the press conference. A press kit may contain:
      - Press release containing key information presented at the press conference
      - Fact sheets or background information (including graphs, charts, photos, etc.)
      - Copies of prepared statements
      - Brief background information and photo of speakers
  - Prepare speakers or spokespersons for the event.
  - Decide the order of speakers. Ideally, no more than three speakers should be decked per forum.
  - Develop a brief statement (under 10 minutes is a good rule-of-thumb) or provide spokespersons with talking points and Questions and Answers (Q&As).
  - Include "quotable phrases" or "sound bites" in the prepared statement.
  - Prepare visual aids (must be easily seen from any point in the press areas).
  - Anticipate questions and prepare clear, brief answers.

- Schedule a rehearsal before the press conference.

- During the press conference:
  - Arrive at least an hour before the event to give time to attend to any last-minute matters.
  - Assign staff to greet media guests as they arrive and direct them to the sign-in table.
  - Start on time even if few people are in attendance.
  - Review with the moderator the tasks. The moderator shall have been prepared before the event.
    - ✓ Moderator welcomes the media, briefly explains why the press conference has been called, and acknowledges the speakers and other VIPs present.
    - ✓ Moderator may summarize key messages and open the session to questions. The Q&A portion should last no more than 30 minutes.
    - ✓ Moderator may ask the reporter to identify himself/herself and the name of his/her organization before asking a question.
    - ✓ Moderator designates the appropriate speaker to answer the question (in case there is more than one speaker).
    - ✓ Moderator should not let the press conference drag on or fizzle out.
    - ✓ He/she should step in and formally conclude the proceedings.
  - Consider the following:
    - ✓ In science journalism, off-the-record, not-for-attribution, no-publication news conferences are neither unknown nor totally without merit.
    - ✓ An ideal press conference should last no more than one hour.
    - ✓ TV reporters may still want to get speaker aside for some on-camera comments after the conclusion of the press conference.

- After the press conference
  - Consider sending thank you notes to the VIPs who attended.
  - Distribute press kits to key media who were unable to attend.
  - Monitor the press for coverage.

2.5 Tips in Dealing with the Media During a Crisis

What Not to Do During a Crisis

a. Do not speculate on the causes of the emergency.
b. Do not speculate on the resumption of normal operations.
c. Do not speculate on the outside effects of the emergency.
d. Do not interfere with the legitimate duties of news people.
e. Do not permit unauthorized spokespersons to comment to the media.
f. Do not attempt to cover up or mislead the press.
g. Do not place blame for the emergency.

2.6 Tasks on Media Management Pre- During- Post Impact

Table 39. Media Management Tasks Pre- During- Post Impact

Pre-Impact (A day or days before)	During Impact (0 hour to 48 hours)	Post-Impact (After 48 hours and onwards)
1. Identify spokesperson and media relation/liaison point person. 2. Conduct media analysis. 3. Determine available channels of communication and social media reporters. 4. Identify all possible pool of media/press and not only a few selected media outfits. 5. Prepare holding statement focusing on what the agency is doing in relation to the incident and what the public should do. Always emphasize SOCO.	1. Brief thoroughly the identified spokesperson, reminding him/her to always end statements w/ the SOCO. 2. Prepare media report for the use of the spokesperson. 3. Identify media holding area. 4. Organize press briefing/ conference. 5. Be available and accessible for follow-up questions from media later. 6. Adhere strictly to the established schedule for media updates and no new info should be released after or before the next update. This is done so that there is a semblance of order in information dissemination during this chaotic time. 7. Monitor media mileage.	1. Prepare and disseminate regular press releases/ statements. 2. Organize press briefing/ conference. 3. Use all possible media: Radio, print, TV, social media Note: The dissemination can be done with or without a press conference/ briefing. If regular update schedules have been established, reporters will know to just pick up the updates from a designated press area/ table. The dissemination could also include emailing reporters who cannot come to the area. Emailing could also discourage many reporters from going to the disaster area and just wait for the emailed updates. 4. Monitor media mileage. 5. Document media management activities. 6. Evaluate media management.

C. Post-Incident Evaluation

Post-Incident Evaluation (PIE) is one of the major sources of information that can be used to further enhance the management of the response to health emergencies or disasters. The PIE ensures that all the actions taken during the event are evaluated and lessons learned are documented to be able to come up with appropriate recommendations and suggestions for a better response in future events.

1. General Guidelines

1.1 After every emergency/disaster or special event is monitored and acted upon, a Post-Incident Evaluation shall be conducted.

1.2 It is important to involve the deployed teams in the PIE at the end of the Response Phase.

1.3 The evaluation at the end of the Response Phase is often done in a structured meeting among participants involved in the response.

2. Specific Guidelines

2.1 Make a comprehensive review of the event/incident covering the following:

- Status of HEPRR plans and preparedness prior to the emergency/disaster
- Communications in place
- Early Warning and Alert Response System including origins, transmission and receipt, processing, dissemination, actions taken (by sender and recipient), and functioning of warning systems
- Emergency Operations Center, acquisition, receipt and handling of information, display and assessment of disaster situation, decision-making, and dissemination of decisions and information
- Activation of the Hospital Emergency Incident Command System and Emergency Response Plan
- Mobilization of response facilities/units
- Assignment of tasks to units/departments involved in the response operation
- Operations for internal and external emergencies that carried out search and rescue/search and recovery, casualty handling, initial relief measures, clearance of vital routes/areas, evacuation, restoration of services, and handling the mass dead
- Cluster services: Health, WASH, Nutrition and Psychosocial Support services
- Assessment of Risk Communication in Promotion and Advocacy (e.g., public information, media relations)
- Provision of information for recovery programs
- Human Resource Development concerns (e.g., training, welfare, etc.)
- External assistance arrangements – CO, RO, international donor community
- Any special factors raised by the nature and effects of the particular disaster
- Research requirements revealed by the disaster

2.2 Identify the strengths and weaknesses encountered and process the learning using the following questions:

- What worked well? Why did these work well?
- What did not work well? Why not?
- What are the insights from these experiences in the context of the present event, as well as past events?
- What are the recommendations for future response work?

2.3 Consider other documented sources of insights from actual experiences (e.g., Post-Mission, Final Reports) of the deployed teams in your review.

2.4 Where appropriate, include the briefing from technical experts on future trends and developments to help achieve optimum utilization of post-incident experiences into the Post-Incident Evaluation.

2.5 Come up with a set of lessons learned (either as new lessons or validated ones) based on previous experiences to further enhance the response management.

2.6 Undertake a critical review of the results of the assessment and based on this, come up with recommendations to further enhance the response management.

2.7 Use the results of the PIE as basis for the finalization of the Final Report.

D. Post-Incident Evaluation

1. General Guidelines

1.1 HEMS at the DOH-CO, RO and hospitals, being the repository of information in relation to health emergencies and disasters, shall document the key results and processes of the response as reference for any future events that it may serve.

1.2 HEMS in the DOH-CO, ROs and hospitals shall put into writing all the events monitored, reported, coordinated and responded to, and come up with an analysis that presents facts and findings that may be used to improve preparedness and response of the offices.

1.3 All internal activities that will serve as a guide or reference to staff which will reduce or eliminate operation ambiguity and will improve the office processes continuously shall be recorded, filed and maintained.

1.4 Essential information must be utilized to serve as a basis for future plans, and strategies of the office must be shared and published.

1.5 Essential documents and records are needed to track the progress of the response on a day to day basis.

2. Specific Guidelines

2.1 Documentations on the Event/Incident shall be prepared:

a. HEMS Final Report. This is the last documentation of any major event or disaster which has been previously reflected in HEARS. It is written after all the final reports of the regions affected by the emergency or disaster have been received from the

RHEMS Coordinator and all the response efforts of the DOH have been terminated. It comes in three parts: Part 1 consists of a one-page Executive Summary; Part 2 consists of the Detailed Report; and Part 3 contains the annexes such as tables of raw data, maps, pictures, etc.

Table 40. HEMS Final Report Key Information and Reference

Topic/Subject	Information Needed	Reference Document/Record
Part 1 - Executive Summary		
Description of the Emergency/Disaster	• What, when, where of the emergency	• HEARS Plus Report • NDRRMC reports
Health Impact of the Emergency/Disaster	• Total number of casualties • Casualties from secondary disasters	• Final tally from HEARS Plus Report as reported by ROs • Final Tally from NDRRMC reports
Summary of Response and Coordination Activities	• Summary of actions taken by the different levels of responding agencies	• HEARS Plus Reports • Reports from partner agencies
Cost of Assistance Rendered	• Summary of financial value of assistance provided to local agencies and victims from various sources that were monitored or brought to the attention of the DOH-HEMS	• HEARS Plus Report • Report from the Logistics Officer
Part 2 - Detailed Report		
Background of the Emergency/Disaster	• General information of the event • Chronology of event	• HEARS Plus Report • NDRRMC reports • Partner agencies' reports • Internet
Consequences of the Emergency/ Disaster	• Detailed reports of deaths, injuries and illnesses. References to list of names and other details in the annexes • Health infrastructure damaged and the description of the damage which was validated by the NCHFD • Damages to lifelines (power, water, communication, transportation, major buildings)	• HEARS Plus Reports • HEMS Coordinators' Final Report • NDRRMC reports • NCHFD reports
Response and Coordination Activities Undertaken by HEMS	• Activities undertaken in responding to the event, including coordination and monitoring of dispatch of teams at the local, regional, national and international levels • Mobilized teams by the DOH (total number of mobilized teams, purpose of mobilization and the results of mobilization) • Logistical support which reflects the cost of medicines and supplies, source of medicine and supplies and recipients	• HEARS Plus Reports

Actions Taken By Other Agencies	• Response activities by CHD, LGU, and other agencies	• Partner agencies reports • HEMS Coordinators Final Report • NDRRMC reports
Problems Encountered	• Problems encountered during the monitoring of event, early warning issuance, collection of data, validation of reports, report generation, report dissemination, resource mobilization, incident command system, and other concerns of the group	• Post-Incident Evaluation of HEMS and the cluster
Lessons Learned	• Lesson learned by the staff upon responding to the event	• Post-Incident Evaluation of HEMS
Recommendations	• Recommendation of the writer based on the gathered information from the members of the HEMS team	• Post-Incident Evaluation of HEMS
Part 3 - Annexes		
Annexes	• Tables, graphs, maps, pictures and reports from the field	• Pictures taken by teams mobilized

2.2 Annual List of Emergencies and Disasters by Category (Minor and Major) and by Type

a. Master List of Emergencies and Disasters Monitored by Classification. This document serves as an attachment to the Monthly Accomplishment Report to tabulate all the events monitored in a month. The events recorded in the HEARS Plus Report are listed in this form, including the details of casualties, affected population, and actions taken on the incident. This form is summarized by tallying the number of events per category through the Tally of Monthly Events Form. The data needed in each field are described in Table 41:

Table 41. List of Data Needed in Master-Listing Emergencies and Disasters

Topic/Subject	Information Needed
Date of Incident	Date the incident happened
Date Reported	Date the incident was reported and included in the HEARS Plus Report
Event	Name of the incident monitored. In stating the place where it happened, use only the name of the city and province. Also, always include the following on each instance provided: (i) Food poisoning- include the food eaten/causative agent (e.g., food poisoning due to cassava) (ii) Fire incident - include the type of facility, i.e., whether a residential area, commercial/ business establishment, etc. (e.g., fire incident involving a residential area in Tala, Caloocan City) (iii) Vehicular accident - include the type of vehicles involved in the accident (e.g., vehicular accident involving two passenger buses on EDSA, Quezon City)
Natural/ Biological/ Technological/ Societal/Special	Classification according to nature of event
Region/Site	Exact location where the incident happened.

Number of Casualties	Total number of deaths, injured, missing, number of families and individuals affected. TIP: For emergencies and disasters: (i) Use the maximum/highest number reported figure of families and individuals affected while use the final figures reported for the deaths, injuries/ill and missing .Ill is the equivalent of injured when talking about biological incidents. (ii) In instances that there are no injured people but there are affected individuals such as rescued passengers in a maritime incident, encode the number of passengers in the number of affected individuals column to better indicate that there are no harmed individuals in the said incident.
Actions Taken	Refers to the response provided by HEMS and CHDs. TIP: (i) Make the actions provided brief and concise by summarizing the actions taken for long-lasting events. (ii) Include only the name of the institution and not the name of the person for whom coordination was done.
Criteria for Major Event (check if met)	Check specific cells in the Excel form if any of the items were met by the event monitored: • >10 casualties • Critical infrastructure affected • LGU can't handle alone • DOH Central Office needed
Classification (Minor/ Major/ Special)	Classify according to the severity of the incident reported.

Procedures:

a. The Knowledge Management Officer starts the documentation by gathering all the HEARS Plus Reports in a month as reference for the details that will be tallied.

b. As part of documentation and recording, he/she fills up a separate Excel form pre-encoded with formula which is the databank of the reports made monthly and which automatically produces graphs needed for presentation in the Annual Accomplishment Report and other presentations by HEMS.

c. Copy the tally of the events monitored and paste it to the tab of its respective month and automatically the number of events will be added up to the previous tally.

d. Further segregate the events per region by counting the events reported per region. This will also be recorded.

e. Update this form monthly. This shall also be made available and accessible to all concerned

b. Analysis Report of Events Monitored by HEMS-OpCen. The Analysis Report (Quarterly and Annually) shows the analysis of the events monitored according to its magnitude, nature and classification (natural, biological, technological, societal, and special events). The results are correlated to previous results and analysis is made to determine the progress, effectiveness and changes needed for the operations. This also reflects the analysis of the timeliness of the reports released to partners. Analyses are presented with graphs and tables for visual presentation.

Table 42. Information Needed by Subject Matter

Topic/Subject	Information Needed
Total Number of Events	Indicate total number according to: • Classification according to magnitude of event (minor, major, disaster) • Classification according to nature of event (natural, biological, technological, societal, special)
Major and Disaster Events Monitored	Itemize and indicate the following: • Duration of the incident • Extent of damage in terms of casualties and damaged facilities
Top 5 Events Monitored	Indicate its health consequences and implication.
Distribution of Events per Region	Indicate the frequency of the occurrence of a particular incident Example: • Fire incident in Metro Manila per city per year • Month-to-month variation of typhoons • Regional distribution of natural events
Top Events and Their Corresponding Health Consequences	Example: • Top 10 event subtypes by total number of casualties • Top 5 causes of consultation in evacuation center during emergencies and disasters
Progress of the Reports Received by HEMS-OpCen	• Frequency of the events monitored in comparison to the previous years
Analysis of the Monitoring Activities Done by EODs	• Total number of timely vs. delayed reports • Total number of timely vs. delayed dissemination of report

Once the report is approved and signed by the Head of Office, the analysis is posted on the HEMS website for public consumption. Results are also discussed with the HEMS Operations Center staff through PowerPoint presentation during the EODs' meeting.

Chapter 6

Management of Non-Human Resources


Regular

Chapter 6: Management of Non-Human Resources

I. Introduction

Non-human resources – including logistics (drugs, medicines, supplies, equipment, etc.), lifeline facilities (transportation, communication, energy supply), and finances – are basic elements of a response. Making these resources available and accessible to the teams of responders is critical to the conduct of timely, continuous, and well-organized response actions from pre-impact to post-impact. The acquisition and sharing of these non-human resources across agencies/offices and managing donations (both local and foreign) are expected to facilitate the mobilization and appropriate use of said resources. On the other hand, the availability and timely processing of financial support, the flexibility of use, and the proper accounting of funds post-impact are, as well, core elements of the response.

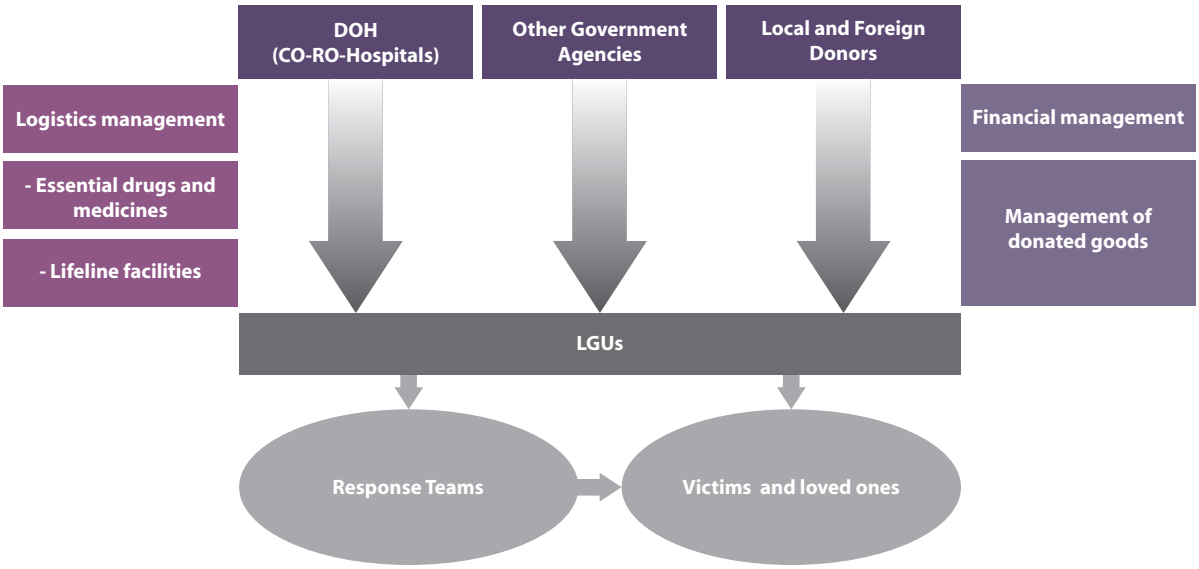
II. Objectives

This chapter provides the policies and guidelines in managing the non-human resources essential in providing emergency response to affected areas and populations. Specifically, it aims to help you:

a. Ensure the availability and accessibility of all necessary logistics during emergency and disaster according to DOH protocols and standards.
b. Mobilize and operate essential facilities for transportation, communication and energy source.
c. Accept, allocate, distribute and document local and foreign-donated commodities and equipment according to DOH recommended protocols.
d. Facilitate the timely release and proper utilization of funds and ensure their proper accounting and documentation.

III. Key Elements in Managing Non-Human Resources for Emergency Response

Figure 26. Elements of Managing Non-Human Resources for Emergency Response



Logistics Management. This element covers the planning, procurement/acquisition, delivery/distribution and utilization of logistics during the Response Phase. Logistics intended for the victims would include drugs, medicines, materials/supplies and equipment, while logistics for the use of the response teams include primarily their personal protection equipment.

Management of Lifeline Facilities. Transportation and communication facilities and energy supply are the lifelines during emergency response. The DOH must ensure that these are adequate and functional throughout the Response Phase with alternative options to source them from. Since other agencies, in addition to DOH, are also expected to provide for these facilities, defining and establishing the systems and procedures on how to coordinate with the concerned offices are major considerations during the response.

Management of Donated Commodities. The outpouring of logistics support from local and foreign sources during emergencies and disasters poses both positive and negative implications to response management. Donated goods are very much welcome as augmentation to what the DOH and LGUs can provide. However, they also pose problems for those involved in the response if they do not conform to DOH-recommended protocols and are not properly managed.

Financial Management. This element refers to the requisitioning, release, utilization and accounting of funds during response. Mechanisms to expedite these processes are very important for the timely mobilization of responders and the timely provision of the needed services and care to the victims and their loved ones. Sourcing of emergency funds (e.g., Quick Release Funds, contingency funds, etc.), including the role of PhilHealth reimbursements, require equal attention.

IV. Policy Statements

Policy Statement 1:

The DOH-CO, ROs and DOH hospitals must establish their respective logistics management systems with the aim of providing the right logistics to victims and affected populations in the right amount with the right price at the right time and right place during health emergencies and disasters.

Policy Statement 2:

The DOH-CO, ROs and DOH hospitals must establish and activate their separate financial management system that will ensure adequate financial support on time, is flexible to use to meet the varying needs of the victims/affected population and response teams, and free from legal impediments.

Policy Statement 3:

The DOH-CO, ROs and DOH hospitals must be self-sufficient in terms of lifeline facilities (transportation, communication, energy source, etc.) and observe redundancy throughout the Response Phase.

Policy Statement 4:

The DOH-CO, ROs and DOH hospitals must establish a mechanism to facilitate sharing of resources with other government agencies, cluster members and partners.

Policy Statement 5:

All donated commodities, equipment and funds, both from local and foreign sources, must be properly receipted, rationally allocated, and delivered on time with appropriate documentation.

V. Guidelines

A. Management of Logistics

1. General Guidelines

1.1 The DOH-CO, ROs and DOH hospitals shall establish mechanisms to ensure immediate availability and accessibility of needed logistics during a health emergency and disaster. These mechanisms may include, but are not limited to: direct sub-allotment, emergency procurement, use of contingency funds and QRF, identification of alternative warehouses, private-public partnerships, arrangements with pharmaceutical companies, centralized one-stop shop, and others.

1.2 LGUs are primarily responsible for providing the logistics needed by their affected population during an emergency or disaster. As such, they must be self-sufficient for at least 10 days of the emergency/disaster, allowing enough time for augmentation or for assistance from the DOH-CO and ROs to arrive.

1.3 The ROs shall be the first to augment the needs of the LGUs. They must maintain a buffer stock of at least two months supply of goods/commodities over and above their requirements for normal operations.

1.4 All DOH hospitals shall ensure availability of logistics to treat victims of health emergencies or disasters who are brought to their facilities. They shall also provide all medicines and

supplies to equip their response teams when deployed. They must maintain a buffer stock of at least three months.

1.5 The DOH-CO shall augment the logistics needs of the ROs and hospitals upon request. Existing stocks of DOH programs for regular operations can be used during emergencies and disasters if buffer stocks are not enough.

1.6 All procurements must follow government rules and regulations. Drugs and medicines shall be those listed in the latest PNDF edition. Should there be items not in the list, an exemption shall be sought from the Drug Committee; otherwise, an alternative should be identified.

1.7 The DOH-CO, ROs and DOH hospitals shall develop systems for the transport of logistics to the affected areas within 24 hours, or not more than 48 hours at most. As such, all efforts must be exerted to distribute these commodities through any means of transport by air, land and sea.

1.8 Drugs and medicines and other essential commodities must be properly and strategically stored to prevent wastage, and be located in the nearest possible area for easy access and timely distribution. Alternate warehouses must be identified and established in addition to the existing storage facilities in the regions and LGUs.

1.9 DOH shall coordinate with eligible pharmaceutical companies, distributors, etc. to provide logistics through emergency procurement, using the Electronic Drug Price Monitoring System (EDPMS) to estimate a reasonable price. They shall be considered as internal creditors and shall be paid within three working days from the time of delivery, provided that all supporting documents are complete.

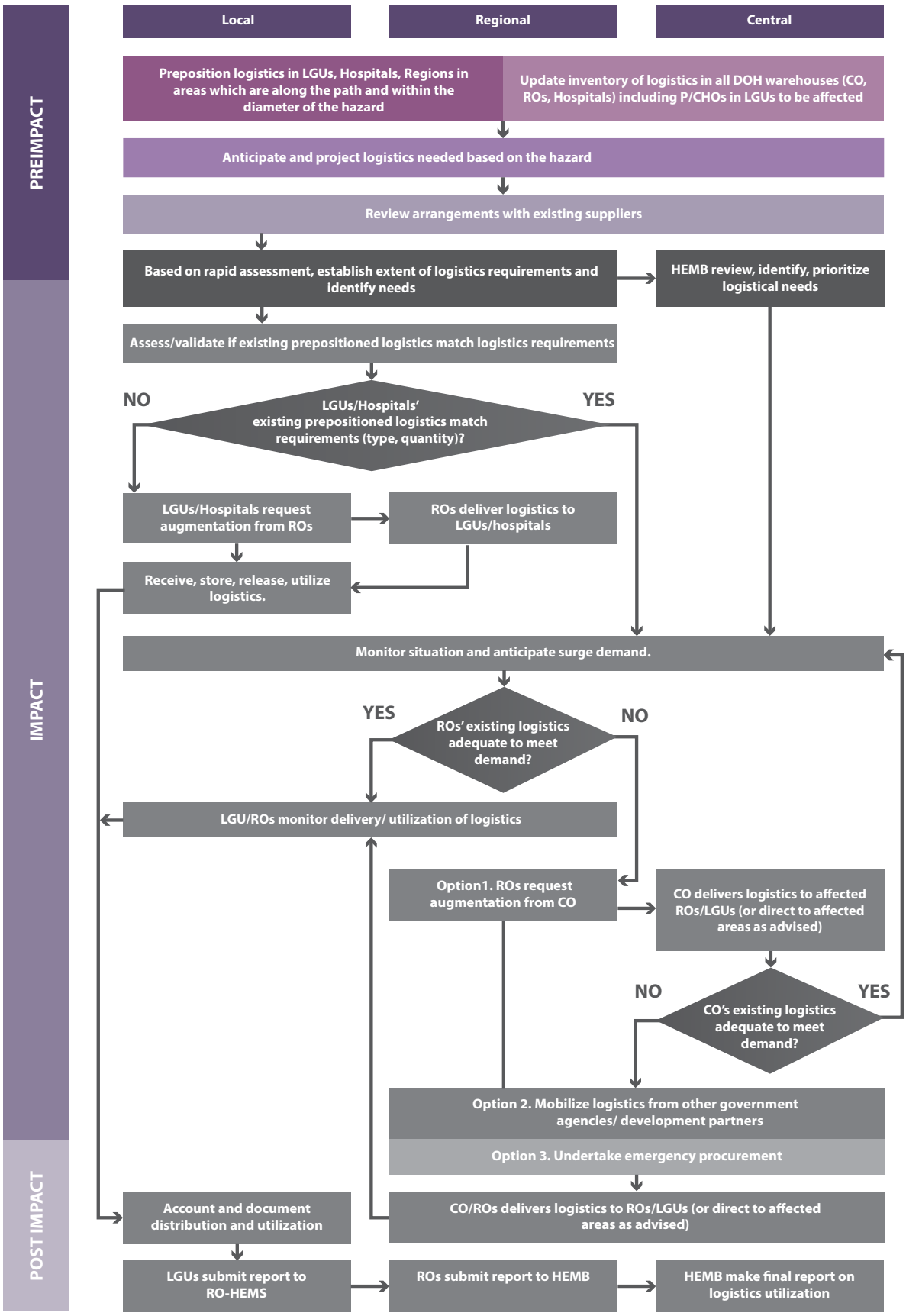
1.10 The distribution, allocation and utilization of health emergency logistics and finances must be documented and accounted for. Hence, a regular monitoring of these must be undertaken following a standard reporting form from HEMB.

1.11 The CO, ROs and DOH hospitals shall establish a one-stop shop during emergencies and disasters to facilitate processing of emergency procurement.

2. Specific Guidelines

2.1 The mobilization and management of logistics during an emergency or disaster comprise several processes, from pre-impact to post-impact at various levels of operation, as shown in Figure 27.

Figure 27. Processes in the Management and Mobilization of Logistics During an Emergency or Disaster



2.2 There are five major kits that must be prepared and prepositioned during an emergency or disaster: (i) Family Kit, (ii) First Aid Kit, (iii) Trauma Kit, (iv) Hygiene Kit, and (v) CAMPOLAS kit.

a. ***Family Kit.*** This kit is intended for families living in far-flung areas to meet their medical needs during the emergency to minimize their movements. One kit is estimated to be adequate for a family of five members.

Table 43. Components of the Family Kit

Items Specifications	Qty	Unit
A. Drugs and medicines		
Hydrogen peroxide 3% solution , 60 ml plastic bottle	1	Plastic bottle
Povidone iodine 10% solution , 60 ml plastic bottle	1	Plastic bottle
Calamine lotion , 60 ml bottle	1	Plastic bottle
Fucidate sodium/fusidic acid 2% cream , 5 grams tube in a box	1	Tube
Oral rehydration salts (ORS 75 replacement) total weight - 20.5 g. per sachet in aluminum foil Composition : Sodium chloride - 2.6 g Trisodium citrate dihydrite - 2.9 g Potassium chloride - 1.5 g Glucose anhydrous - 13.5 g Total weight - 20.5 g Reduced osmolarity ORS- equivalent in mmol/L: Sodium - 75 Chloride - 65 Potassium - 20 Citrate - 10 Glucose anhydrous - 75 Total osmolarity - 245	1	Packet/ sachet
Paracetamol 500 mg tablet	10	Tablet
Mefenamic acid 500 mg capsule	10	Capsule
Silver sulfadiazine 1% cream 20 or 25 grams	1	Tube
Lagundi 300 mg tablet	10	Tablet
B. Medical supplies		
Gauze pads, 2 x 2 inches, 8-ply, 24 x 20 mesh, sterile , individually packed	5	Pack
Surgical paper tape, hypoallergenic, 1/2 inch x 10 yards	1	Roll
Cotton, absorbent, 12 grams, individually packed	1	Roll
Plaster strips, strong adhesive, perforated strips, sterilized, soft absorbent layer , nonstick film	5	Piece
Bayabas (herbal) soap, 25 grams , bar in box	1	Bar
Instruction Guide for Family Kit , laminated	1	Piece
Family Kit bag	1	Piece

b. ***First Aid Kit.*** These kits are intended to be brought by the team of responders on site. Each kit must contain the following items.

Table 44. Components of the First Aid Kit

Items Specifications	Qty	Unit
Surgical gloves, latex , disposable, sterile	5	Pairs
Elastic bandage, 10 cm. x 1.6 (unstretched) approx. 4.5 m. stretched, permanent strong compression bandage with high stretch for controllable compression, with selvedges and fixed ends, made of cotton, compression bandage with high stretch, individually packed	2	Rolls
Cotton, absorbent, 25 grams, individually packed	1	Packs
Bandage scissors, standard, stainless steel, length 5 ½" (14 cm) approximately	1	Pair
Triangular bandage, 100% cotton, white, non -sterile, 40 "x 40" x 56", with 2 safety pins, individually packed	1	Pieces
Gauze pads , 2 x 2 inches , 8-ply , 24 x 20 mesh, sterile, individually packed, 100 packs per box	10	Packs
Gauze pads , 4 x 4 inches , 8-ply , 24 x 20 mesh, sterile, individually packed, 100 packs per box	10	Packs
Surgical paper tape, hypoallergenic, 1 inch x 10 yards , roll	1	Rolls
Gauze bandage, 2 " x 6 yards , 24 x 20 mesh, individually packed in box	1	Rolls
Gauze bandage, 4 " x 6 yards, 24 x 20 mesh, individually packed in box	1	Rolls
Plaster strips , soft absorbent layer, perforated strips, strong adhesive, nonstick film	10	Piece
Hydrogen peroxide 3% solution, 60 ml plastic bottle	1	Plastic Bottle
Povidone iodine 10% solution , 60 ml plastic bottle	1	Plastic Bottle
Calamine lotion 60 ml	1	Plastic Bottle
Oral rehydration salts (ORS 75 replacement), 20.5 grams per sachet	5	Packet
Paracetamol 500 mg tablet	30	Tablet
Lagundi 300 mg. tablet	30	Tablet
Mefenamic acid 500 mg capsule	30	Capsule
Silver sulfadiazine 1% cream, 25 grams tube	1	Tube
Fucidate sodium/ fucidic acid , 5 grams tube	1	Tube
Amoxicillin 500 mg capsule	30	capsule
Bayabas herbal soap, 65 grams	1	Bar
First Aid Kit bag	1	Piece
Instruction Guide for First Aid Kit , laminated	1	Piece

c. ***Trauma Kits.*** These kits are intended for affected areas with moderately or severely damaged Barangay Health Stations (BHS), for initial response.

Table 45. Components of the Trauma Kit

Items Specifications	Qty	Unit
Personal safety		
Surgical gloves, sterile , size 7, 50 pairs per box	10	Pairs
Safety goggles individually packed with plastic	1	Pair
Minor cuts and scrapes		
Elastic bandage, 4 inches width, 2 metal locked, length unstretched 60 " or 5 ft, permanent strong compression bandage with high stretch for controllable compression with selvedges and fixed ends, made of poly cotton, individually packed	10	Rolls
Gauze pad/swab 2 inches x 2 inches , 12-ply, 24 x 20 mesh, sterile, individually packed, 100 packs per box	25	Pack
Tongue depressor , wooden , individually packed , sterile	2	Piece
Surgical paper tape, hypoallergenic, 1/2 inch x 10 yards, 24's box	1	Roll
Larger trauma/injuries		
Gauze pad/swab 4 inches x 4 inches , 12-ply , 24 x 20 mesh, sterile, individually packed, 100 packs per box	25	Packs
Gauze bandage , 4" x 6 yards, 24 x 20 mesh , individually boxed	4	Rolls
Triangular bandage, muslin cloth, cream, non – sterile, approximately 90 cm x 90 cm x 127 cm, individually packed	2	Pieces
Elastic bandage, 4 inches width, 2 metal locked, length unstretched 60 " or 5 ft, permanent strong compression bandage with high stretch for controllable compression with selvedges and fixed ends, made of polycotton, individually packed	10	Rolls
Survival blanket	1	Piece
5 Oral airways	1	Set
Stethoscope	1	Set
Sphymomanometer, aneroid with case	1	Set
Cold packs, large	2	Pack
Wound Dressing		
Sodium chloride irrigation solution, 250ml	2	Bottle
Antiseptic wipes	20	Pack
Alcohol hand sanitizer 4oz	1	Bottle
Antibiotic ointment	5	Tube
Splinter forceps	1	Pairs
Alcohol prep pads	12	Pack
Resealable plastic bag	1	Piece
Biohazard trash bag	2	Piece
Ballpen	1	Piece
Bag/container for the contents	1	Piece
Minor suturing set: needle holder, tissue scissor, tissue forcep, eye towel, cotton swab, betadine swab	3	Sets
PNSS 1 liter	1	Bottle
Asepto syringe 50 cc (plastic)	2	Piece
Suture set 2.0	12	Piece

d. ***Hygiene Kit.*** These are intended for families primarily in the evacuation center to ensure personal cleanliness and minimize infection. One kit is good for a family of five members.

Table 46. Components of the Hygiene Kit

Items Specifications	Qty	Unit
Detergent bar, 420 grams	2	Bar
Toothbrush	5	Pieces
Toothpaste, 145 grams	1	Tube
Shampoo 10 ml	5	Sachet
Sanitary napkin/pads, 8 pads	3	Pack
Water dipper (tabo)	1	Piece
Towel, rectangular, white, cotton	5	Pieces
Utility pail w/ cover, plastics, 12 L, lock-zip tie	1	Piece
Bath soap, 135 grams	2	Bar
Panty (4 small, 4 medium, 4 large)	12	Pieces
Malong	1	Piece

e. ***CAMPOLAS*** (Cotrimoxazole, Amoxicillin, Mefenamic, Paracetamol, Oresol, Lagundi and Skin ointment) ***Plus Kit***. This contains two kits: one which includes treatment for 100 diagnosed patients normally seen in evacuation centers; plus a kit which includes medicines for non-communicable diseases like diabetes, hypertension, and for the treatment of wounds. Each kit can address 100 patients diagnosed. Each kit is good for 1000 evacuees. It is assumed that 10% of a given population is expected to get sick. Hence, about 1,000 people are expected to get sick in a population of 10,000 in each affected municipality.

Table 47. CAMPOLAS Plus Kit For Municipality

Items Specifications	Qty	Unit
Cotrimoxazole 800 mg tablet 100 tabs/box	45	Treatment pack
Cotrimoxazole syrup 200 mg 60 ml	20	Bottles
Amoxicillin 500 mg capsule, 100 tabs/box	45	Treatment pack
Amoxicillin 250 mg, 5 ml powder susp. 60 ml	20	Bottles
Metformin 500 mg tablet, 100 tabs/box	2	Boxes
Paracetamol 250 mg, 5 ml powder susp. 60 ml	20	Bottles
ORS, 10 sachet/box	30	Sachets
Lagundi 300 mg, 5 ml syrup, 120 ml	20	Bottles
Lagundi 300 mg tablet, 100 tabs/box	600	Tablets
Skin ointments		
Plus		
Sulfur ointment, 30 grams tube	10	Tubes
Fusidate/fucidic acid tube	20	Tubes
Imidazole	10	Tubes
Losartan 500 mg tablet/100 tablet/box	3	Boxes
Vitamin A (Retinol) 200,000 IU/ 100 caps/bottle	1	Bottle

Vitamin B complex, 100 tabs/box	6	Boxes
Doxycycline 100mg, 100tabs/box	3	Boxes
Amlodipine 10 mg, 100 tabs/box	3	Boxes
Sambong 300 mg tabs, 100 tabs/box	2	Boxes
Gauze pad 4 x 4, 100 pads/box	1	Box
Gauze pad 2 x 2, 100 pads/box	1	Box
Plaster strip, 100 pcs/box	1	Box
Surgical tape 1/2 inch, 24 rolls/box	1	Box
Cotton 100 grams	1	Roll
Povidone Iodine	5	Bottles

2.3 In addition to the medical station tent (6 m by 9 m, 3 pcs per region), the following are the recommended medical equipment in setting up a field hospital:

- Response personnel tents
- Surgical instruments (explore Lap set, ORIF set, minor sets, dressing sets, etc.)
- Portable anesthesia machine
- Portable autoclave
- Portable OR lamp
- ECG machine
- Portable cardiac monitor with pulse oximeter
- Portable pulse oximeter
- Portable ultrasound with Doppler
- Portable suction machine
- Portable defibrillator
- Manual resuscitator (adult and pedia set)
- Gen set (50KVA)
- Air conditioner (window type 2.5 HP)
- Portable X-ray machine
- Surgical instrument cabinet
- Portable nebulizer

2.4 Some logistics (e.g., cadaver bags, tents, cots and beds, water filtration, etc.) are available at the DOH-CO and prepositioned at the regions.

2.5 Drugs and medicines for emergency use must conform with standard specifications and appropriateness to emergency conditions:

- Dosage
- Size
- Volume
- Preparation
- Ingredients
- Required packaging
- Appropriate storage and transport (e.g., cold chain management)
- Necessary supplies for administration (e.g., vaccines need syringes, needles, and special puncture-proof container for containment prior to waste treatment and disposal)

2.6 For hospitals, check the following equipment and supplies:

a. Ready the necessary supplies and equipment for immediate distribution to appropriate locations in the hospital:
   - Emergency room (e.g., stretchers, wheelchairs to receiving area)
   - X-ray
   - Laboratory
   - Blood bank
   - Operating rooms
   - Intensive care units
   - Special units – Burn, Toxicology, etc.

b. Conduct tests of equipment to ensure they are in good working condition.

a. Check if the following categories of logistics are in place:
   - Emergency kit for the responders
   - Emergency stocks of reagents
   - Emergency drugs, and medical supplies for the emergency room
   - Power generators
   - HEMB Trauma Kit (first responder medical supplies)

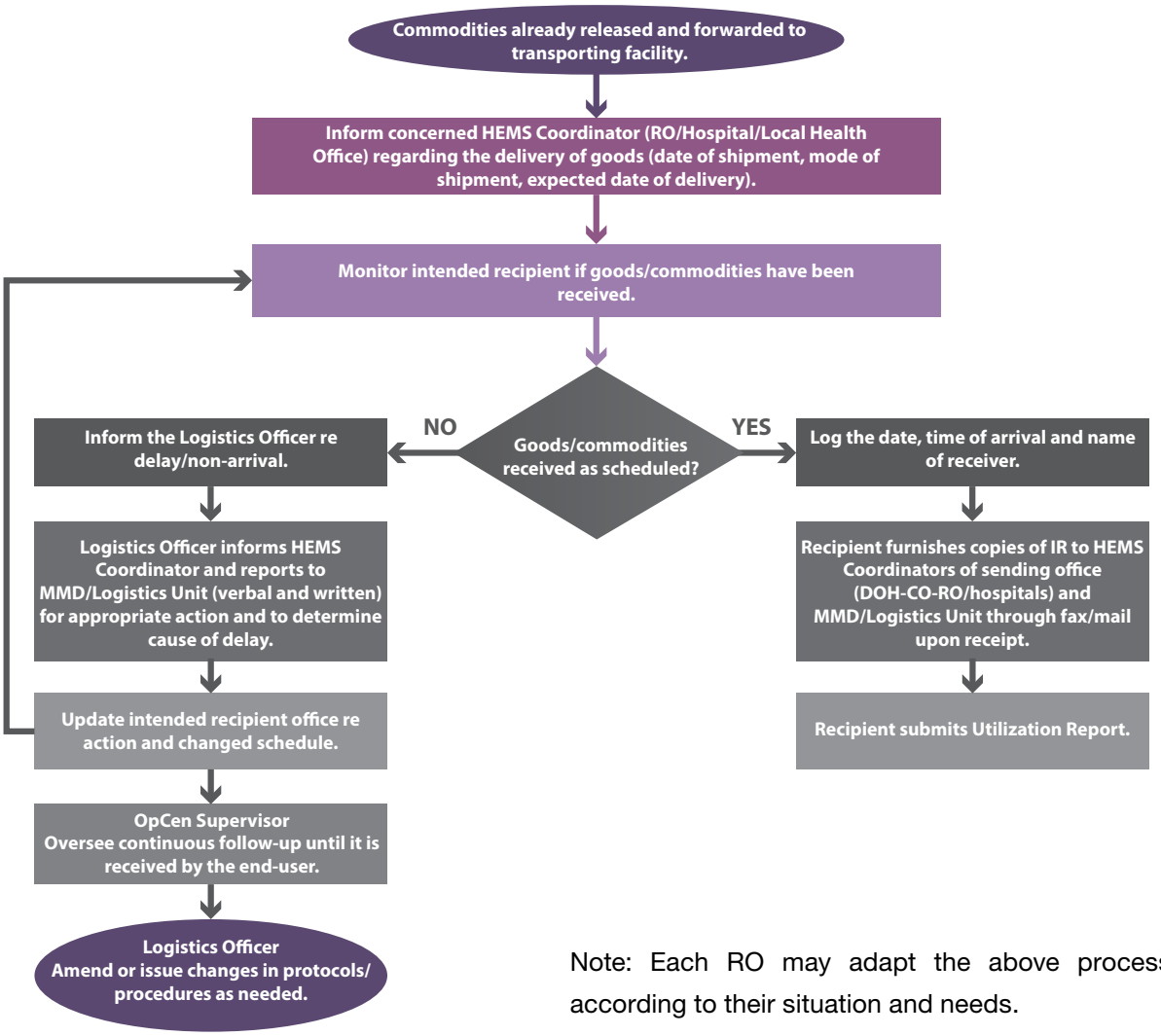
2.7 Vital information are needed for the proper management of logistics during response. These are essential for determining the right type and quantities to be allocated and to monitor the receipt and utilization of these logistics.

Table 48. Logistics Information to be Reported to Concerned Agencies/Office

Information Details on Logistics	Whom to Coordinate with
a. Inventory report b. Amount prepositioned to provinces/municipality c. Logistics mobilized from DOH-CO to RO - Items, quantity and amount - Date picked up by forwarder - Mode of transportation - Expected date of arrival d. Tracking of logistics up to end-user (province, city/ municipality) - In-transit - Received: Request the recipient to fax a copy of IR to HEMB-CO once logistics were received e. Utilization report	• Regional offices • Hospitals • Partner agencies

2.8 Monitor the movement of the goods and commodities from the source to the intended recipients. The following is the recommended protocol in monitoring the movement of logistics from source to end-user:

Figure 28. Flow in Monitoring the Movement of Logistics at DOH-CO



Note: Each RO may adapt the above process according to their situation and needs.

3. Procedures

Pre-Impact	Impact	Post-Impact
• Preposition the necessary logistics in identified strategic areas along the path and within the diameter of the hazard. • Check/update inventory of all essential logistics (drugs/ medicines, equipment, supplies/ materials) in all DOH warehouses at the CO, ROs and hospitals. Check prepositioned logistics in all implementing agencies, most especially in areas that might be affected by the incident. • Anticipate and project requirements for drugs/medicines, equipment and other logistical needs (e.g., food, clothing of medical staff, linens for patients, housekeeping/cleaning materials, etc.) Validate these against the commodities identified in rapid health assessment; • Assess adequacy and status of essential drugs and medicines currently maintained by the ROs, hospitals and LGUs where the event is expected to occur. • Source out logistics from DOH warehouses, regional offices or hospitals as needed, and also tap all possible sources, both internal and external. Based on the inventory and assessment, decide to make emergency procurement. • Review existing data on available suppliers and special arrangements made with the following: - Credible pharmaceuticals/ suppliers (e.g., credit lines) to ensure continuous supply of needed drugs/medicines/supplies - Maintenance service providers to ensure prompt repair and/or temporary replacement of critical medical equipment that may break down during disasters - Forwarders, to be informed of theneed; also identify other sources as NDRRMC and other means. • Orient all staff involved in logistics management on their tasks and the proper protocols and procedures. • Coordinate with HEMS Coordinator, Logistics and Supply Officer, Budget Officer, and the person in charge of warehouse management to ensure a single coordinated logistics operation involving the DOH-CO, RO and hospitals.	• Coordinate with the IC or on-site coordinators for additional logistics needed in addition to what have been previously prepositioned (in terms of additional quantity or other types of drugs/medicines or supplies). • Facilitate the release of all essential logistics to the response teams, health facilities, on-site advance medical post, and evacuation centers needing logistics assistance in addition to those prepositioned. • Monitor the movement of the goods and commodities from source to intended recipients. • Coordinate with concerned offices/agencies, health facilities and other previously identified sources for augmentation of commodities and other logistical needs, determining which source to mobilize and for affected areas/sites to be prioritized for assistance. • Receive, store and distribute commodities from various sources (DOH-CO, ROs, contiguous ROs, LGUs) including donated commodities. • Assess the situation and make necessary adjustments in the allocation and delivery of goods/commodities according to number of victims and those affected or severity of the damages and loss. • Anticipate surge demand for commodities and undertake emergency procurement as needed. • Identify and organize Logistics Team on-site to help load/unload commodities, carry, and unpack/repack as needed. • Ensure that all commodities/logistics received are in accordance to DOH recommended protocol. • May set up a one-stop shop for emergency procurement to facilitate acceptance of procured drugs, medicines and equipment and facilitate processing of payment if Code Red or Code Orange. • Record the end distribution destination for items in the stock records to ensure that they are used appropriately and to provide reliable reports.	• Evaluate logistics assistance provided during the Response Phase, covering adequacy of the logistics, timeliness of delivery, quality of commodities, prioritization, wastage incurred and how this can be minimized in the future, alternative measures undertaken, contributions and sharing from other sources, and condition of warehouses/ storage areas. • Update inventory of resources and submit inventory to concerned offices. • Review and update systems and plans. • Replenish utilized resources and endorse remaining logistics to concerned facilities/offices. • Reposition regional resources for emergency. • Document the logistics management process and outcome and submit report to DOH. • Provide reports to donors.

B. Management of Lifeline Facilities

Lifeline facilities are central to the overall management of the response. The absence of one not only slows down the delivery of the needed assistance but also jeopardizes the whole response operation as it compromises coordination among all concerned players. It is important, therefore, that lifeline facilities are made available and ready prior to impact, with redundant items/units in place and functional. Alternative mechanisms for these items/facilities should have also been identified and arranged way before the onset of the health emergency or disaster.

1. Transport Facility

1.1 There are different categories of transport facilities that must be readied and mobilized during the Response Phase to serve various purposes, as described below:

a. Ambulance Facilities: These transport facilities are needed by the response teams to conduct rescue operations at the disaster site and to transport those affected to appropriate health care facilities. These must take the form of the following:
- Emergency Response Vehicle (4x4 pickup, with camper shell, front wrench and backup pulley and snorkel)
- MCI Trailer with 20 pcs folding stretcher beds
- Sea Ambulance (complete with medical supplies and equipment
- Mobile OR Van
- Transport Ambulance (with basic equipment)

b. Delivery Vans/Trucks: These transport facilities are needed to move commodities/logistics from warehouses/seaports/airports to affected areas. Transport facility for commodities/logistics can also take the form of C-130 helicopters and cargo ships. For the transport of commodities/logistics, require the sending/requesting offices to indicate the following:
- Dimensions such as weight, length, width, height and type of storage and items for transport
- Proper labeling of all boxes with recipient name, office, address and contact number

c. Service Vehicles: These transport facilities are needed to bring health officials/staff monitoring the operations at various levels of administration and those providing administrative support to the team of responders.
- Passenger Commuter Van (12-seater, dual aircon, etc.)
- Motorcycle (125 cc 4-stroke)

1.2 The designated Transport Officer/Logistics Officer identifies the most appropriate transport mode to take (by air, land, sea) and the best/fastest route to take.

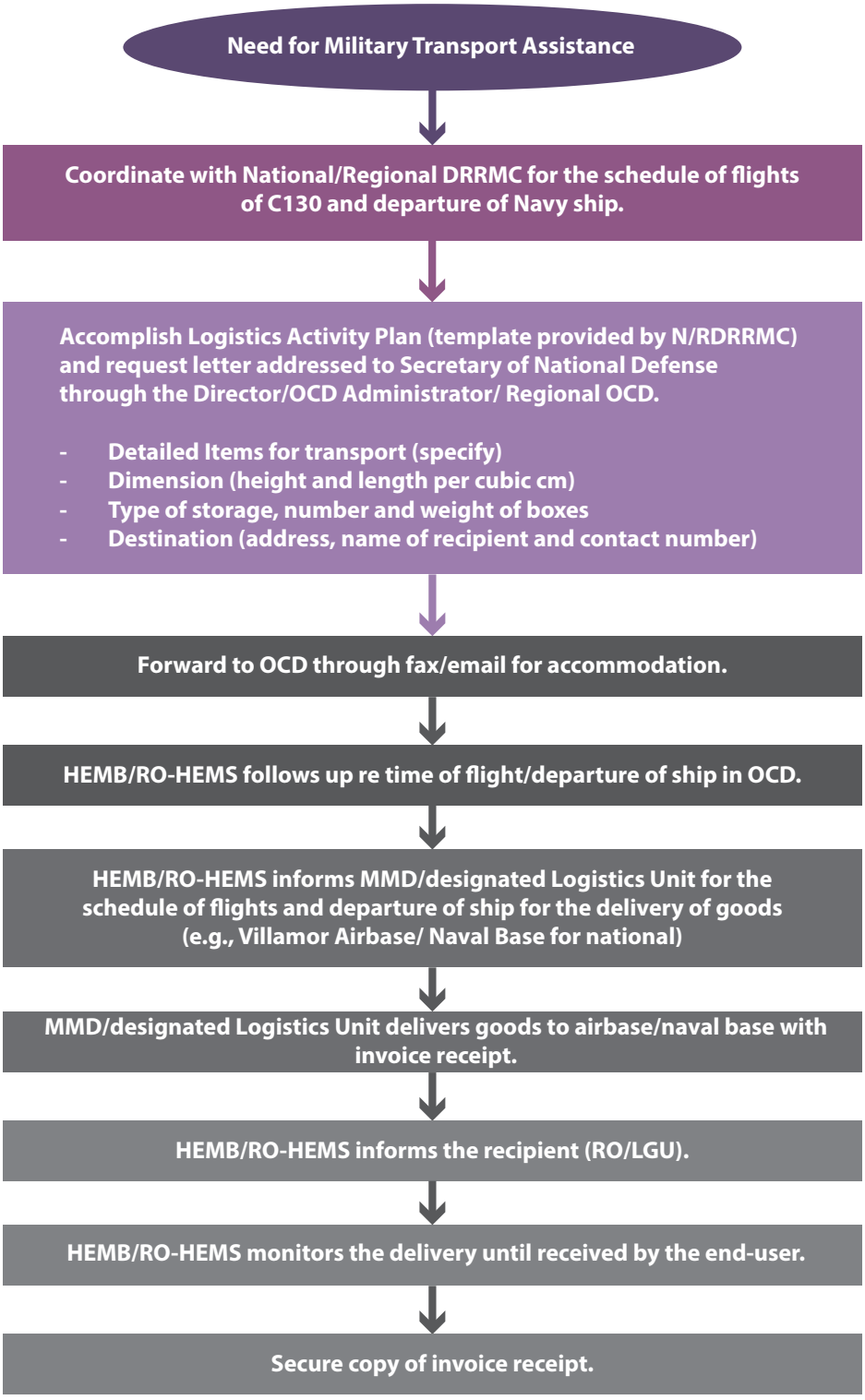
1.3 Mobilize transport facilities for both the teams of responders and for the victims and their loved ones.

1.4 Mobilize transport facilities accordingly:

a. Within the control of DOH (hospital ambulances, dedicated emergency vehicles, health office service vehicles, etc.)

b. Transport facilities of other government agencies (DepEd school clinics, etc.)
c. Local transport facilities with local transport groups, e.g., Tricycle Operators and Drivers Organizations (TODA), passenger jeepney associations, bus companies, etc.
d. Military asset vehicles (C130, navy ships, military vehicles, etc.). For the use of these, coordinate with NDRRMC/OCD following the protocol at various levels of operations.

Figure 29. Flow in Coordinating the Use of Military Transport Facilities During a Health Emergency/Disaster



2. Communication Facilities

2.1 Ideally, the following communication facilities must be installed in each RO, DOH hospital, and DOH Central Office, particularly the OpCen and Command Center.

DOH-CO

- Per ComVan
  - 1 set of base radios (HF) with accessories, extra batteries, base antenna
  - 1 unit of portable generator set 50 KVA
  - 4 units of laptop computers
  - 1 unit computer printer
  - 1 unit of Broadband Global Area Network (BGAN)
  - 1 unit power/electric converter
- 1 unit BGAN satellite terminal (includes BGAN SIM and airtime load)
- 3 pcs portable satellite phone and iphone (including operational cost for 1 year)

DOH-RO

- Per ComVan
  - 1 set of base radios (HF) with accessories, extra batteries, base antenna
  - 1 unit of portable generator set 50 KVA
  - 2 units of laptop computers
  - 1 unit computer printer
  - 1 unit of Broadband Global Area Network (BGAN)
  - 1 unit power/electric converter
- 1 unit BGAN satellite terminal (includes BGAN SIM and airtime load)
- 1 pc portable satellite phone and iphone (including operational cost for 1 year)

2.2 Command Center in each region and DOH-CO must also be equipped with the following:

- LED TV monitor (touch screen with wall mounting)
- Fax machines
- Computer printer with xerox capability (colored)
- Desktop computer set

2.3 Alternative options of communication facilities during a health emergency or disaster need to be arranged prior to impact. These may include but are not limited to:

- Arrangement with other government agencies: NDRRMC family and partners (e.g., WHO, Red Cross, etc.)
- Arrangement with commercial mobile phone companies operating in the area
- Special arrangement with private individuals and commercial establishments
- Coordination with radio and TV stations to use their communication facilities in reporting situation/status to DOH-CO, RO and vice versa

3. Power/Energy Supply

3.1 Each RO must be equipped with at least 1 unit of the following power supply generators and other equipment:

- Generator set 100-150 KVA (silent type) on trailer
- Generator set 5-10 KVA (silent type) on trailer
- Generator set 50 KVA (silent type, diesel) on trailer
- Solar cell power generator on trailer
- Portable generator set 50 KVA for the ComVan

3.2 For the hospitals: Generator set 240-250 KVA (silent type) on trailer

3.3 Other health facilities must also be equipped with additional standby power generator (generator set 5-10 KVA (silent type) on trailer)

C. Management of Locally and Foreign-Donated Commodities During an Emergency or Disaster

1. General Guidelines

1.1 Conditions on Donations

a. There shall be no donations for purposes of emergencies and disaster situations, whether from international or local sources, unless a formal acceptance for the purpose is issued by the Secretary of Health or his designated representative.

b. The need for formal acceptance shall be waived in situations of extreme sudden-onset emergencies/disasters, provided that the items for donation are within the "DOH Package List for Emergencies and Disasters" or well within the UN List of Emergency Relief Items. Those not included in those mentioned above may be accepted after evaluation of the FDA on a case-to-case basis.

c. For sudden-onset disasters, donations can be accepted directly by the regional offices or LGUs as long as guidelines are followed and they are reported to the Central Office for documentation purposes.

d. Items for donation may be in any form, such as drugs/medicines, medical supplies, medical equipment, processed foodstuff (in coordination with DSWD), micronutrients, WASH needs, and other items that may be substantial in addressing the emergency/disaster.

e. DOH shall not be responsible nor incur liabilities for unaccepted donations. It shall limit its monetary obligation to the payment of logistics for the transfer of donated items to emergency and disaster areas. Customs duties, brokerage fees, handling fees, warehouse fees, and others shall be borne by the donor unless they are part of existing guidelines of the NDRRMC and the Department of Finance in relation to the establishment of the One-Stop Shop (OSS) activated in some emergencies and disasters.

f. In the event that medical equipment are to be donated and left in the country, the Regional Office should ensure that these will be accepted and kept in the region so as to be used by the whole region in times of emergencies and disasters.

1.2 On Accepting Donated Commodities

a. The Department of Health through, HEMB shall be responsible for all donations in relation to emergencies and disasters both local and international. The Bureau for International Health Cooperation (BIHC) shall work closely with HEMB for all international donations.
b. Acceptance of donations for emergencies and disasters shall be based on the expressed need of the beneficiaries and their relevance to the disease pattern and health concerns that are prevailing in affected areas.
c. The "DOH Package List for Emergencies and Disasters" shall be the guide for accepting donations. This package shall be updated regularly and will be issued during emergencies and disasters.
d. Infant formula, breast milk substitutes, feeding bottles, artificial nipples and teats shall not be items for donation. No acceptance for donation shall be issued for any of the enumerated items.
e. Acceptance of food donations for emergency and disaster situations should consider if the foodstuffs have a shelf life of at least three months from the time of arrival to the Philippines.
f. Acceptance of donations in drugs/medicines for purposes of emergency and disaster situations should comply with the following minimum criteria:
    - Shelf life of at least 12 months from the time of arrival to the Philippines
    - Labeling with English translation or in a language that is understood by Philippine health professionals
    - Packaging that complies with international shipping regulations accompanied by a detailed packing list that specifies:
        - Weight per carton not exceeding 50 kilograms
        - Exclusive packaging with regard to other supplies
        - Documentary proof of compliance with applicability quality standards
        - Documentary proof that the items were obtained from reliable sources
g. Acceptance of donations of medical equipment for purposes of emergency and disaster situations should comply with the following minimum criteria:
    - With attached manual of instructions for installation and operation, written in or translated into English
    - Accompanied by a list of service centers in the Philippines where services and spare parts are available

1.3 Distribution

a. The DOH shall distribute the donated items to emergency and disaster affected areas through the Regional Office. The tracking of the distribution should be clearly

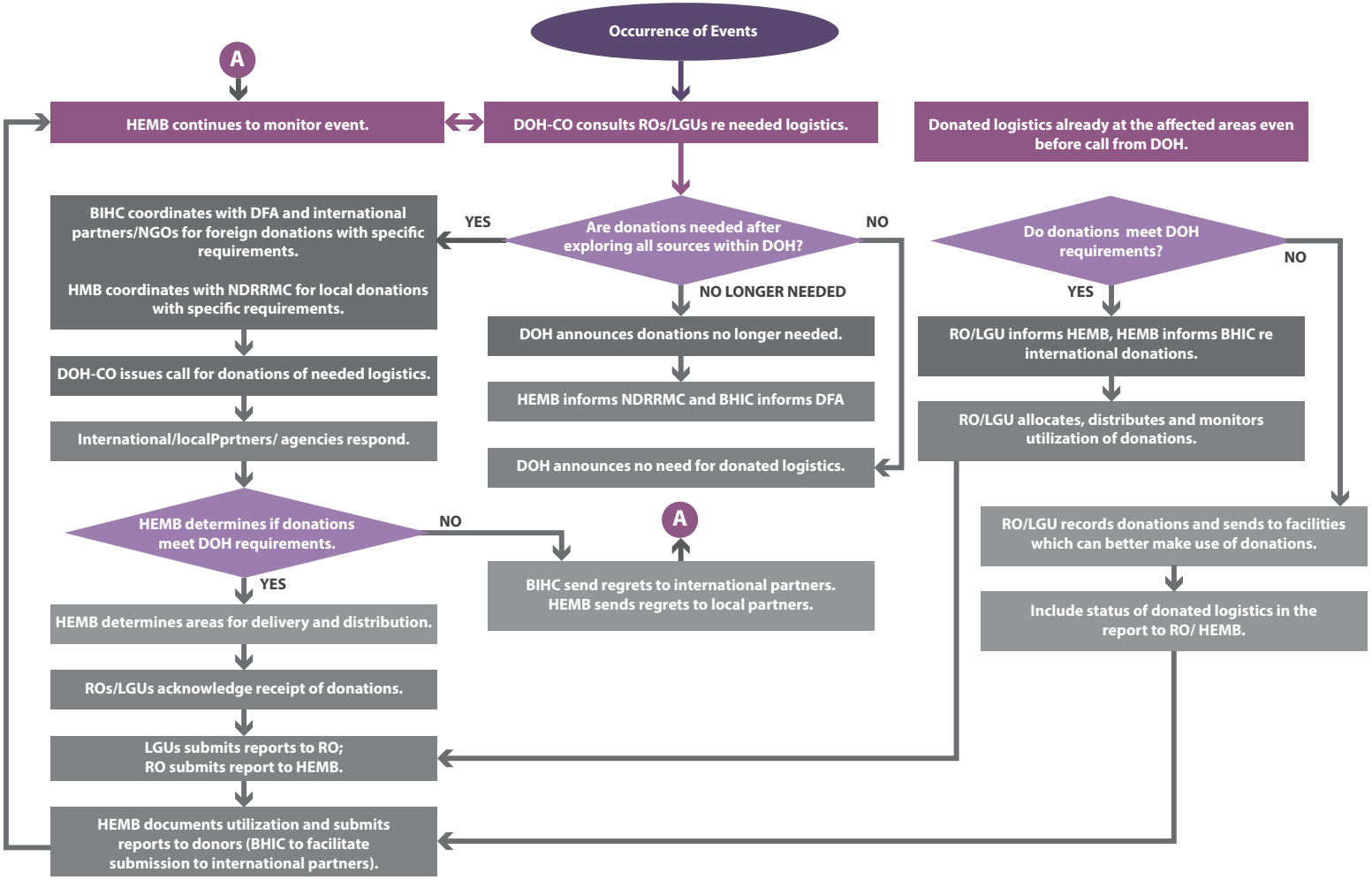
documented down to the municipal level and reports submitted to HEMB Central Office.

b. A certain quantity of the items for donation, specifically drugs and medicines, shall be retained and kept within a certain period of time as reference samples for validation and further testing purposes in case problems will arise in the medication of patients.

2. Specific Guidelines

2.1 The following illustrates the process of managing donated commodities during health emergencies or disasters.

Figure 30. Process of the Mobilization and Distribution of Donations



2.2 The following summarizes the key actions to be undertaken at various stages of the Response Phase.

Table 49. Key Actions to Be Taken Pre- During- Post Impact

Pre-Impact (A day or days before)	During Impact (0 hour to 48 hours)	Post-Impact (After 48 hours and onwards)
• Disseminate logistics needs of DOH based on the current situation. • Check database of logistical standby in warehouses to determine availability of possible needs. • Coordinate with partners and donors to generate commitments. • Monitor all implementing agencies with regards to logistical needs.	• Based on the Rapid Health Assessment and other information, determine immediate needs and requirements. • Central Office to coordinate with DFA, embassies and partners for pledges. • Organize point persons to oversee the donations, at the Central Office, regional offices and hospitals.	• BIHC to evaluate, facilitate and process documents for immediate entry of foreign donations. • MMD to facilitate movement of all logistics, including donations to the regions and the hospitals. • HEMB to review, evaluate and facilitate acceptance of all donations. • Continuously monitor all logistical requirements and determine what to request from donors. • HEMB to evaluate utilization of donations and formalize this in a written report; BIHC to forward report to foreign donors, HEMB to send to local donors. • Document all donations. • Annually review, together with all concerned offices, all donations accepted by DOH.

3. Procedures

3.1 The procedures to be performed by HEMB, BIHC and ROs in managing local and foreign donations are given in Table 50.

Table 50. Procedures in the Management of Local and Foreign Donations

HEMB	BIHC	ROs
• Prepare and update the DOH Package List for Emergencies and Disasters. • Prepare and disseminate additional list per event/ disaster based on the needs of the affected population. • Review , evaluate and facilitate the formal acceptance of donations from both local and foreign donors. • Prepare allocation list for distribution to regional offices and hospitals. • Coordinate with other offices like BIHC for international donations; with FDA for acceptance of incoming drugs not in the formulary; with RO and hospitals for tracking of donated goods; with NDRRMC or DOF for other matters related to the government policies and guidelines in relation to donations.	• Lead in the coordination of assistance with foreign donors. • Coordinate closely with HEMB for review, evaluation and facilitation of possible formal acceptance; and with BHDT for clearance of medical equipment. • Prepare all necessary documentation, acceptance, pertinent clearance and reports in relation to foreign donations. • Coordinate with other agencies, such as DFA, DOF, BOC, etc. for anything related to foreign donations.	• Oversee the distribution and utilization of donated items in their catchment area. • Ensure tracking of all donated goods up to the municipal level. • Document and prepare reports to be included in Situation Updates and in the Final Report. • Ensure that all donated equipment (medical or lifelines) be properly documented and stored in safe warehouses. • Report all donations directly received by the RO, and possibly LGUs under its jurisdiction, to HEMB-Central for documentation.

- Monitor and track all donations, if possible down to the municipal level.
- Document and prepare reports (to include the donors) for the utilization of all donations and the recipients.
- Prepare a database of all foreign donations passing through all channels (Central Office, regional offices, LGUs) to include the following information, among others: types of goods, amount, cost and recipients. This should also include all donated equipment, especially those coming from Foreign Medical Teams and left with the regions
- Monitor and evaluate the handling of donations; recommend improvement or amendment to existing policy

D. Financial Management

1. All implementing agencies shall ensure the availability of funds for logistics to be used in emergencies and disasters. At least 5% of the MOOE shall be allotted annually solely for his purpose and be made accessible at any given time. In the event that this is not utilized by the third quarter, this will be used for the procurement of emergency drugs as buffer stocks for the next year.
2. All implementing agencies shall sub-allot an amount for procurement of standby logistics based on the criteria mentioned above, to be regularly replenished if consumed within the year. In the event of an emergency and disaster, the agency may utilize any amount in their budget for emergencies and disasters.
3. All implementing agencies shall have a ready cash advance (range: PhP1M-5M) that shall be used for the management of the emergency and disaster. This may be used not only for logistical needs but also for administrative needs required in responding to the emergencies. The amount shall be determined by the head of office based on the magnitude, extent and impact of the disaster.
4. Cash donations shall be used for procuring items that are necessary for addressing all phases of emergencies and disaster situations, including recovery and rehabilitation, subject to the rules and guidelines of COA and DBM.
5. The Finance Office at the CO, ROs and DOH hospitals should establish a one-stop shop to expedite payments of supplies for emergency procurement, needs of responders, administrative needs, and other concerns.

Department of Health
Philippines