Republic of the Philippines
OFFICE OF THE SECRETARY
Elliptical Road, Diliman
1100 Quezon City

March 31, 2021

MEMORANDUM FROM THE SECRETARY

TO : ALL UNDERSECRETARIES
ALL ASSISTANT SECRETARIES
ALL SERVICE DIRECTORS
ALL BUREAU DIRECTORS
ALL HEADS OF ATTACHED AGENCIES/CORPORATIONS
ALL REGIONAL EXECUTIVE DIRECTORS
ALL PROGRAM DIRECTORS

SUBJECT : GUIDELINES ON ISOLATION FOR DA EMPLOYEES DURING THE COVID-19 PANDEMIC

This is to reiterate that any employee reporting in your respective offices should be isolated and ***no longer*** be required to be physically present if they are experiencing any of the following symptoms:

1. Fever;
2. Cough;
3. Fatigue;
4. Loss of Appetite/Anorexia;
5. Loss of taste/Loss of smell preceding the onset of respiratory symptoms;
6. Other non-specific symptoms such as sore throat, nasal congestion, headache, diarrhea, nausea, vomiting and the like.

Severe symptoms include:

1. Shortness of breath;
2. Chest Pain or other signs of respiratory distress;
3. Worsening of above symptoms.

Employees who are experiencing any of the above-mentioned symptoms should immediately report to their immediate heads/supervisors for proper endorsement to our Safety and Health Officer in Personnel Division for RT-PCR testing, and for assignment of alternative work arrangements.

Confirmed cases, whether symptomatic or asymptomatic, suspected cases, probable cases, and asymptomatic close contacts of probable and confirmed cases shall be **strictly isolated for at least ten (10) days** from the first day of manifestation of symptoms.

Asymptomatic close contacts of probable and confirmed cases shall be **strictly quarantined for at least fourteen (14) days** from last day of exposure from the probable or confirmed case.

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

Symptomatic cases who are **NOT** close contacts of a suspected, probable and confirmed case may return to work upon resolution of symptoms.

As provided in *DOH Deparment Memorandum No. 2020-0512*, close contacts shall refer to persons who has experienced any one of the following exposures during the 2 days before and the 14 days after the onset of symptoms of a probable or confirmed case:

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

Facility-based isolation is recommended, unless there is a proof of adequate capacity to isolate at home with their own bedroom and bathroom.

Employees may return to work when symptoms resolve and after completion of the required quarantine or isolation period, in compliance with DOH guidelines. Securing a Medical Certification is not mandatory for returning to work.

For strict compliance.

WILLIAM D. DAR. Ph.D.
Secretary

DEPARTMENT OF AGRICULTURE
in replying pls cite this code :
For Signature: S-04-21-0000
Received : 05/04/2021 08:19 AM

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

March 18, 2021

DEPARTMENT MEMORANDUM
No. 2021- 0140

FOR : **ALL UNDERSECRETARIES, ASSISTANT SECRETARIES, DIRECTORS OF CENTRAL/REGIONAL OFFICES/CHIEFS OF MEDICAL CENTERS/ REGIONAL HOSPITALS/SANITARIA, REHABILITATION CENTERS, HEADS OF ATTACHED AGENCIES AND ALL OTHER DOH UNITS CONCERNED**

SUBJECT : **Reiteration of Department Memorandum No. 2020-0512 entitled "Revised Omnibus Interim Guidelines on Prevention, Detection, Isolation, Treatment, and Reintegration Strategies for COVID-19"**

We would like to reiterate the Department Memorandum No. 2020-0512 dated November 26, 2020 entitled "Revised Omnibus Interim Guidelines on Prevention, Detection, Isolation, Treatment, and Reintegration Strategies for COVID-19"

For your information and strict compliance.

By Authority of the Secretary of Health:

LEOPOLDO J. VEGA, MD, FPCS, FPATACSI. MBA-H
Undersecretary of Health/Chief of Staff
OIC- Administration and Financial Management Team

Obm/as/pad/21-44

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

November 26, 2020

DEPARTMENT MEMORANDUM
No. 2020 - 0512

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

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

I. BACKGROUND

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

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

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

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

II. GENERAL GUIDELINES

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

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

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

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

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

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

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

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

applicable (See Annex B).

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

2. Exposure Assessment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. SPECIFIC GUIDELINES

A. Surveillance General Process

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

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

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

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

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

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

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

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

B. Contact Tracing General Processes

1. Contact identification

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

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

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

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

2. Case investigation or contact listing

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

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

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

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

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

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

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

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

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

3. Case Management

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Treatment of COVID-19 Cases

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

IV. REPEALING CLAUSE

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

For strict compliance.

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