Republic of the Philippines
Department of Education
REGION I

REGIONAL MEMORANDUM
No. 254 s. 2025

ADVISORY ON THE PREVENTION OF HAND, FOOT AND MOUTH DISEASE

To: Schools Division Superintendents

1. This refers to the attached Memorandum OM-OUPS from the Officer-In-Charge, Office of the Undersecretary for Operations, ASEC. Dr. Dexter A. Galban, Department of Education, Central Office, Meralco Avenue, Pasig City, on the above mentioned subject dated February 5, 2025 for information and guidance.

2. To ensure the health and safety of learners, teachers and nonteaching staff, the following preventive measures must be implemented. It is crucial to work closely with school division health personnel, local health offices and DOH for guidance on measures and outbreak management:

a. Promote Proper Hygiene and Sanitation;
b. Monitor and Report cases;
c. Strengthen Health Education and Awareness;
d. Implement Infection Control Protocols.

3. For report consolidation use the attached template and submit through email at **ursulojohn.ursua@deped.gov.ph** for consolidation.

4. Immediate compliance of this memorandum is requested.

TOLENTINO G. AQUINO
Director IV

Incls.: As Stated.

To be included in the Perpetual Index
under the following subjects:

PROGRAMS REPORTS

ESSD-SQC/mar/RM-General
February 18, 2025

Occurrence of HAND, FOOT AND MOUTH DISEASE
For the month of January 2025

	School Division Offices	Number of Personnel/ Learners	Number of Cases
1	Alaminos City		
2	Batac City		
3	Candon City		
4	Dagupan City		
5	Ilocos Norte		
6	Ilocos Sur		
7	Laoag City		
8	La Union		
9	Pangasinan I		
10	Pangasinan II		
11	San Carlos City		
12	San Fernando City		
13	Urdaneta City		
14	Vigan City		
	Total		

Republika ng Pilipinas
Department of Education
OFFICE OF THE UNDERSECRETARY FOR OPERATIONS

MEMORANDUM
OM-OUOPS-2025-__-_____

FOR : **REGIONAL DIRECTORS**
SCHOOLS DIVISION SUPERINTENDENTS
PRINCIPALS/SCHOOL HEADS/TEACHERS-IN-CHARGE
CONCERNED
ALL OTHER CONCERNED

FROM : **DEXTER A. GALBAN**
Assistant Secretary, Officer-In-Charge
Office of the Undersecretary for Operations

2/11/25

SUBJECT : **ADVISORY ON THE PREVENTION OF HAND, FOOT AND MOUTH DISEASE**

DATE : February 5, 2025

The Department of Education, through the Bureau of Learner Support Services-School Health Division (BLSS-SHD) hereby issues this Advisory on the Prevention of Hand, Foot and Mouth Disease (HFMD).

HFMD is a highly contagious viral infection that commonly affects children and is caused by enteroviruses such as Coxsackievirus. It spreads through direct contact with an infected person's saliva, nasal discharge, blister fluid, or contaminated surfaces. Symptoms include fever, sore throat, reduced appetite, and characteristic rashes or sores on the hands, feet, and mouth.

To ensure the health and safety of learners, teacher and nonteaching staff in the schools, the following preventive measures must be observed and followed:

1. **Promote Proper Hygiene and Sanitation**
   - Encourage frequent handwashing with soap and water.
   - Provide alcohol-based hand sanitizers in classrooms and common areas.
   - Regularly disinfect high-touch surfaces such as doorknobs, tables, and learning materials.
2. **Monitor and Report Cases**
   - Require learners and staff with symptoms to stay at home until fully recovered.
   - Establish a reporting system for suspected cases and coordinate with local health offices.

3. **Strengthen Health Education and Awareness**
    - Conduct information drives on HFMD transmission, symptoms, and preventive measures.
    - Involve parents and guardians in promoting personal hygiene and early detection of symptoms.
4. **Implement Infection Control Protocols**
    - Limit sharing of personal items such as utensils, towels, and toys.
    - Ensure proper ventilation in classrooms and common areas.
    - Isolate affected individuals and provide support for their recovery.

Schools are advised to work closely with the schools division health personnel, local health offices and the DOH for guidance on response measures and outbreak management.

For further queries regarding this concern, please contact Dr. Maria Corazon C. Dumlao and/or Dr. Mariblanca C.P. Piatos, from the BLSS-SHD at telephone no. (02) 8632-9935 or email at blss.shd@deped.gov.ph.

Your attention and adherence to this advisory is highly appreciated.

II. GENERAL GUIDELINES

A. Prevention

1. Perform mandatory hand washing with soap and water, and hand hygiene using alcohol-based sanitizer, in all opportunities and occasions, especially in the hospital and household settings;
2. Strengthen infection prevention and control measures in all settings;
3. Avoid sharing of personal items such as spoons, cups, and utensils;
4. Use appropriate personal protective equipment (i.e. properly fitted face mask, gloves, and gown) when caring for a patient with HFMD; and
5. Observe Minimum Public Health Standards (MPHS), especially when sneezing and coughing, as well as physical distancing.

B. Detection

1. Assess the presence of common clinical manifestations for HFMD such as fever, mouth sores, and papulovesicular skin rash, which is usually seen in the palms of the hands and soles of the feet but may also occur as maculopapular rashes without vesicles and may also involve the buttocks, arms, and legs;
2. Conduct history taking and complete physical examination, with particular attention on BP and HR measurement and neurologic examination to detect or elicit any warning sign of central and autonomic nervous system and cardiorespiratory system involvement (Annex A), which may warrant referral to a higher level of care;
3. Guidelines for public health surveillance are as follows:

   i. All primary care providers, clinicians and public health authorities shall report any suspect, probable, and confirmed case within 24 hours to the DOH through the Local Epidemiology and Surveillance Units (ESU)

   ii. Classify cases of HFMD following these prescribed definitions:
   - ***Suspect case*** *- Any individual, regardless of age, who developed acute febrile illness with papulovesicular or maculopapular rash on palms and soles, with or without vesicular lesion/ulcers in the mouth.*
   - ***Probable case*** *- A suspected case that has not yet been confirmed by a laboratory test, but is geographically and temporally related to a laboratory-confirmed case.*
   - ***Confirmed case*** *- A suspected/ probable case with positive laboratory result for human Enteroviruses that cause HFMD.*

   iii. Local ESUs shall report clusters of **all Suspect, Probable, and Confirmed cases** of HFMD immediately to the Event-based Surveillance and Response Unit of the Epidemiology Bureau

   iv. Specimen samples for laboratory confirmation shall be collected from reported clusters of HFMD cases

4. Laboratory confirmation of HFMD cases shall be done through Reverse Transcription Polymerase Chain Reaction (RT-PCR) of throat swab, vesicles, or stool. However, clinical diagnosis is often sufficient and the absence of a confirmatory laboratory test should not hinder the initiation of case management.
5. A completely filled out Case Report Form (Annex C) along with the specimen for laboratory confirmation shall be submitted to the Research Institute for Tropical Medicine (RITM)

C. Isolation

1. Isolate patients with HFMD following standard precautions with droplet and contact infection control procedures. HFMD is mainly transmitted through person-to-person contact, including contact with infected nose and throat secretions or respiratory droplets, infected fluid from blisters or scabs, and infected fecal material; and
2. Advise parents/guardians to ensure that children with suspect, probable, or confirmed HFMD should remain at home, avoid attending school, day-care facilities, or other face-to-face activities until the patient is already afebrile and all of his/her vesicles have dried up, and adhere to the advice of the Health Care Provider.

D. Treatment

1. Classify the patient's disease stage or severity. Patients with Uncomplicated HFMD may be managed in an out-patient setting, while more severe cases should be given emergent management and referred for admission and inpatient care in a higher level facility with specialists. The classification for disease severity may be found in **Annex A.**

    - **For Uncomplicated HFMD:**
        i. Provide supportive treatment and prevent dehydration by ensuring appropriate fluid intake; and
        ii. Provide over-the-counter medications such as Paracetamol for fever and painful sores; and
        iii. Advise the patient and the parent/guardian to seek medical consultation immediately if symptoms persist beyond 10 days, if the condition becomes severe or is accompanied by nervous system and cardiorespiratory signs and symptoms as shown in Annex A.

    - **For HFMD with CNS Involvement, Autonomic Nervous System Dysregulation, or Cardiopulmonary Failure:** provide basic emergency support and facilitate immediate referral and transfer to a hospital.

E. Reintegration

1. Individuals with uncomplicated HFMD usually recover in 7 to 10 days and can resume regular activities upon recovery. Advise them to continue practicing the Minimum Public Health Standards (e.g., mask-wearing, respiratory hygiene/ cough etiquette, physical distancing, and hand washing/ hand sanitation); and
2. Advise parents/guardians to prepare the child to return to school, day-care facilities, and attend other face-to-face activities depending on the assessment and advice of the attending physician.

For dissemination and compliance.

By Authority of the Secretary of Health:

BEVERLY LORRAINE C. HO, MD, MPH
OIC-Undersecretary of Health
Public Health Services Team

ANNEX A. WHO Warning Signs for CNS Involvement in HFMD

Warning signs of CNS involvement includes one or more of the following:	
Fever ≥ 39°C or for ≥ 48 hours	Limb weakness
Vomiting	Truncal ataxia
Lethargy	"Wandering eyes"
Agitation/irritability	Dyspnea/tachypnea
Myoclonic jerks	Mottled skin

ANNEX B. WHO Classification for Disease Severity in HFMD

Classification	**Criteria**
Uncomplicated HFMD	Patients with no warning signs **AND** any of the following: • Skin rash • Oral Ulcers
HFMD with CNS Involvement	Patients **with HFMD AND** any of the following: • Meningism • Myoclonic jerks • Ataxia, tremors • Lethargy • Limb weakness
HFMD with Autonomic Nervous System (ANS) Dysregulation	Patients **with CNS involvement AND** any of the following: • Resting Heart Rate at 150-170 bpm • Hypertension • Profuse Sweating • Respiratory Abnormalities (Tachypnea, Labored breathing)
HFMD with Cardiopulmonary Failure	Patients with **ANS Dysregulation AND** any of the following: • Hypotension/ Shock • Pulmonary edema/ hemorrhage • Heart Failure

ANNEX C. PIDSR Case Report Form for Hand, Foot and Month Disease and Severe Enteroviral Disease

Philippine Integrated Disease Surveillance and Response

Case Report Form

Hand, Foot and Mouth Disease and Severe Enteroviral Disease

Name of DRU:

Address:

Type: ☐RHU ☐CHO ☐Gov't Hospital ☐Private Hospital ☐Clinic ☐Gov't Laboratory ☐Private Laboratory ☐Airport/Seaport

I. PATIENT INFORMATION

Patient number | Patient's First Name | Middle Name | Last Name

Complete Address | Date of Birth mm/dd/yy | Age | Sex

District: | LHD: | ☐Days ☐Months ☐Years | ☐Male ☐Female

Patient admitted? ☐Y ☐N | Date Admitted/ Seen/Consult | Date Onset of Illness

Date of Investigation | Name of Investigator: | Contact Nos.:

II. CLINICAL INFORMATION

Fever: ☐Y ☐N
Date onset: __/__/__
Rash: ☐Y ☐N
Date onset: __/__/__
☐Palms ☐Fingers
☐Soles of feet ☐Buttocks
☐Mouth ulcers
Pruritic? ☐Y ☐N
Characteristics:
☐ maculopapular ☐ papulovesicular

Other signs/symptoms (please tick):
☐ Pounties of appetite
☐ Body malaise
☐ Sore throat
☐ Nausea & Vomiting
☐ Difficulty of Breathing
☐ Acute Flaccid Paralysis
☐ Meningeal irritation
Others, specify:

Are there any complications?
☐Y ☐N
If YES, specify:

Working/Final Diagnosis:

III. EXPOSURE HISTORY

Is there a history of travel within 12 weeks to an area with ongoing epidemic of HFMD or EV Disease? ☐ Y ☐ N

Are there other known cases in the community? ☐ Y ☐ N

Where did exposure probably occur?

☐Day care ☐Community ☐School ☐Dormitory
☐Home ☐Health Care Facilities ☐Others, specify _____

IV. LABORATORY TESTS

Specimen	If YES, Date Collected	Date sent to RITM	Date received at RITM	Result: Positive, Negative, Not Done	Specify organism	Date of result
☐Throat swab	__/__/__	__/__/__	__/__/__			__/__/__
☐Vesicle swab	__/__/__	__/__/__	__/__/__			__/__/__
☐Rectal swab	__/__/__	__/__/__	__/__/__			__/__/__
☐ Stool	__/__/__	__/__/__	__/__/__			__/__/__

V. CLASSIFICATION

☐Suspected case of HFMD ☐ Suspected case of Severe Enteroviral Disease
☐Probable case of HFMD ☐Confirmed case of Severe Enteroviral Disease
☐Confirmed case of HFMD

VI. OUTCOME

☐ Alive ☐ Died
Date died: __/__/__

Case Report Form

Hand, Foot and Mouth Disease and Severe Enterovirus Disease

CASE DEFINITION/CLASSIFICATION:

Suspected case of HFMD: Any individual, regardless of age, who develops acute febrile illness with papulovesicular or maculopapular rash on palms and soles, with or without vesicular lesions in the mouth.

Probable case of HFMD: A suspected case that has not been confirmed by a laboratory, but is geographically and temporally related to a laboratory-confirmed case.

Confirmed case of HFMD: A suspected case with positive laboratory result for Human Enterovirus that causes HFMD.

Suspected case of Severe Enteroviral Disease: Any child less than ten (10) years of age with fever plus any severe signs and symptoms referable to central nervous system involvement, autonomic nervous system dysregulation or cardiopulmonary failure.

OR a suspect or probable HFMD case with complications
OR who died < 48hours after presenting with fever and CNS involvement.

Confirmed case of Severe Enteroviral Disease: A suspected Severe Enteroviral Disease that has positive laboratory results for Enteroviruses.

COMPLICATIONS ASSOCIATED WITH HFMD AND SEVERE ENTEROVIRUS DISEASE:	
Aseptic Meningitis	Febrile illness with headache, vomiting and meningism associated with of more that 5-10 white cells per cubic millimeter in cerebrospinal (CSF) fluid, and negative results on CSF bacterial culture.
Brainstem encephalitis	Myoclonus, ataxia, nystagmus, oculomotor palsies, and bulbar palsy in various combinations, with or without UMN. In resource-limited settings, the diagnosis of brainstem encephalitis can be made in children with frequent myoclonic jerks and CSF pleocytosis.
Encephalitis	Impaired consciousness, declining lethargy, drowsiness or coma, or seizures or myoclonus.
Encephalomyelitis	Acute onset of hyporeflexic flaccid muscle weakness with myoclonus, ataxia, nystagmus, oculomotor palsies and bulbar palsy in various combinations.
Acute Flaccid Paralysis	Acute onset of flaccid muscle weakness and lack of reflexes.
Autonomic Nervous System (ANS) dysregulation	Presence of cold sweating, mottled skin, tachycardia, tachypnea, and hypertension
Pulmonary edema/hemorrhage	Respiratory distress with tachycardia, tachypnea, rales, and pink frothy secretion that develops after ANS dysregulation, together with a chest radiograph that shows bilateral pulmonary infiltrates without cardiomegaly.
Cardiorespiratory failure	Cardiorespiratory failure is defined by the presence of tachycardia, respiratory distress, pulmonary edema, poor peripheral perfusion requiring inotropes, pulmonary congestion on chest radiography and reduced cardiac contractility on echocardiography.

ANNEX D. References

- **Centers for Disease Control and Prevention:** Hand, Foot and Mouth Disease
  Link: https://www.cdc.gov/hand-foot-mouth/index.html

- **Center for Health Protection - Department of Health**
  The Government of the Hong Kong Special Administrative Region: Management of Hand Foot Mouth Disease (HFMD) in Health Care Settings
  Link:
  https://www.chp.gov.hk/files/pdf/management_of_hfmd_in_health_care_settings_r.pdf

- **World Health Organization - Western Pacific Region:** A Guide to Clinical Management and and Public Health Response for Hand, Foot and Mouth Disease
  Link:
  https://apps.who.int/iris/bitstream/handle/10665/207490/9789290615255_eng.pdf?sequence=1&isAllowed=y