MINISTRY OF HEALTH MALAYSIA

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CRISIS PREPAREDNESS AND RESPONSE CENTRE (CPRC)

STANDARD OPERATING PROCEDURE

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MINISTRY OF HEALTH MALAYSIA

First Printing 2025

Crisis Preparedness and Response Centre (CPRC)
Standard Operating Procedure

TABLE OF CONTENTS

FOREWORD
DIRECTOR GENERAL OF HEALTH

I commend the authors for their unwavering dedication to crafting this essential manual, the Crisis Preparedness and Response Centre (CPRC) Standard Operating Procedure. Their tireless efforts and expertise have culminated in a resource that will undoubtedly serve as a cornerstone of emergency response protocols. This book stands as a testament to their commitment to excellence and their profound understanding of the importance of standardized procedures in ensuring the safety and well-being of our communities.

As emergencies can unfold rapidly and unpredictably, the importance of having well-defined SOPs cannot be overstated. They serve as vital tools for maintaining order, optimizing resource allocation, and ultimately saving lives. However, SOPs are not static documents; they must be regularly reviewed, updated, and practiced to ensure their relevance and effectiveness.

As you familiarize yourself with the contents of this manual, I encourage you to embrace its principles and procedures, incorporating them into your daily practices and training activities. Together, let us uphold the highest standards of emergency response and serve as beacons of hope and assistance in times of crisis.

Thank you.

DATUK DR. MUHAMMAD RADZI ABU HASSAN
Director General of Health
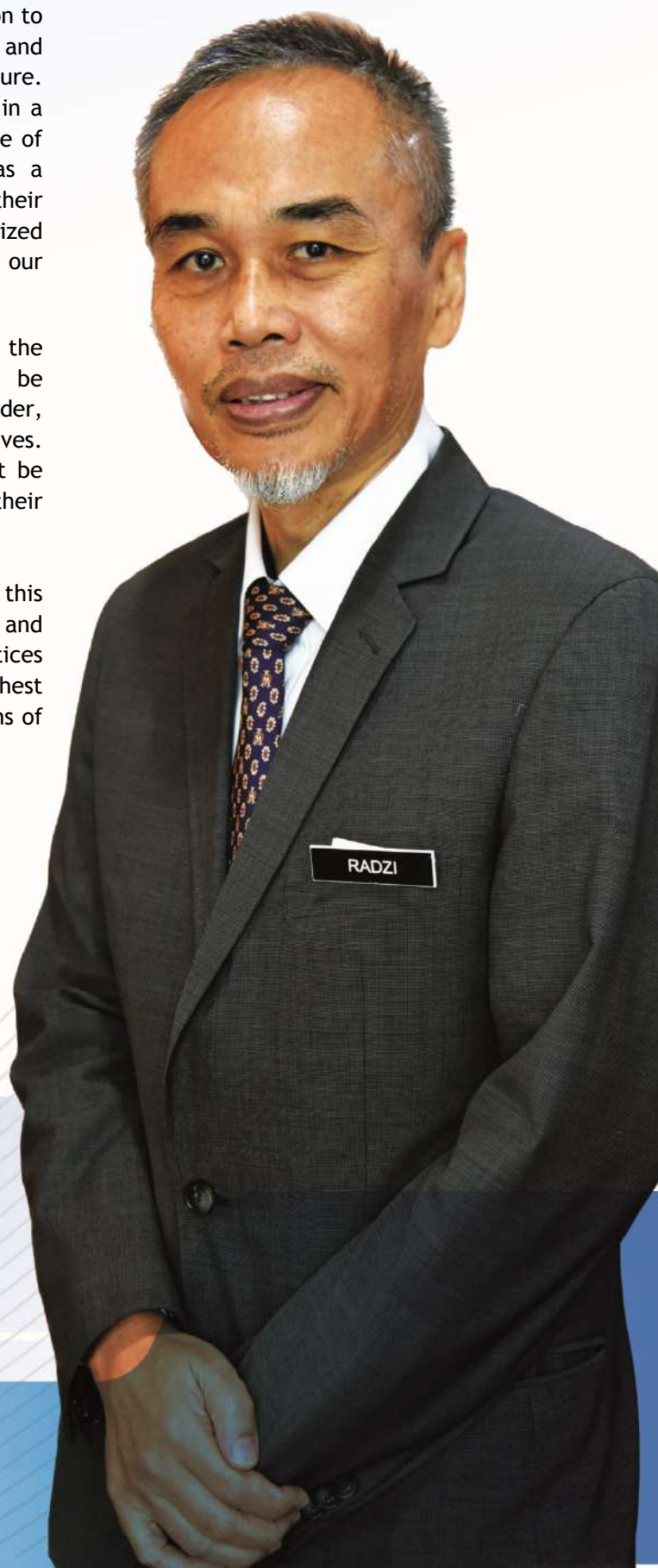
FOREWORD
DEPUTY DIRECTOR GENERAL OF HEALTH (PUBLIC HEALTH)

Welcome to the Crisis Preparedness and Response Centre (CPRC) Standard Operating Procedure manual. In the dynamic and critical environment of emergency response, standardized procedures are the cornerstone of effective and efficient operations. This manual serves as a comprehensive guide for all personnel involved in emergency operations, providing a structured framework for decision-making and action.

Developed through collaboration among experts in emergency management, healthcare professionals, and frontline responders, this manual reflects the best practices and protocols established to ensure the highest standards of care and coordination during emergencies. It is a testament to our collective commitment to preparedness, resilience, and the safety of our communities.

I extend my sincere appreciation to the Disaster, Outbreak, Crisis, and Emergency Management Sector, as well as to all those who contributed to the development of this CPRC Standard Operating Procedure, including subject matter experts, emergency responders, and support staff who dedicated their time and expertise to this endeavor. It is through our collective efforts that we can enhance the resilience of our communities and mitigate the impact of emergencies.

Stay prepared, stay vigilant, and stay safe.

Thank you.

DATUK DR. NORHAYATI RUSLI
Deputy Director General of Health (Public Health)

ACKNOWLEDGEMENT

The development of Crisis Preparedness and Response (CPRC) Standard Operating Procedure has been a collaborative effort involving the dedication and expertise of numerous individuals and organizations. We would like to extend our heartfelt gratitude to the following:

- Special Acknowledgement
  We extend our heartfelt gratitude to ASEAN Secretariat, Global Affairs Canada (GAC), Datuk Dr. Chong Chee Kheong, Senior Advisor for ASEAN Mitigation of Biological Threats (MBT) Programme and Dr. Novia Kuswara, Project Coordinator for ASEAN Emergency Operations Centre (EOC) Network for their unwavering dedication in developing this manual. Your vision and commitment have significantly impacted our progress, inspiring us all to strive for excellence. Thank you for your guidance and support.

- Expert Contributors
  We express our deepest appreciation to the experts in emergency response, disaster management, public health, and related fields who generously shared their knowledge and insights throughout the development of this manual. Your expertise has been invaluable in ensuring the relevance, accuracy, and effectiveness of the manual.

- Stakeholders and Partners
  We extend our sincere thanks to the governmental agencies, non-governmental organizations, academic institutions, and other stakeholders who provided valuable input, feedback, and support during the development process. Your collaboration and commitment to improving emergency response capabilities have been instrumental in shaping this manual.

- Reviewers and Evaluators
  We are grateful to the individuals and organizations who diligently reviewed and evaluated the draft manual, providing constructive feedback and suggestions for improvement. Your thorough assessments have contributed significantly to the refinement and enhancement of the final document.

- Administrative and Technical Support
  We would like to acknowledge the administrative and technical support teams who facilitated the logistics, coordination, and communication throughout the development and dissemination of the manual. Your dedication and professionalism have been indispensable in ensuring the smooth progression of this project.

- Funding Agencies
  We acknowledge the financial support provided by funding agencies and donors that enabled the development, publication, and distribution of this manual. Your investment in strengthening emergency response capacities is greatly appreciated and will have a lasting impact on the resilience of communities worldwide.

- End Users
  Finally, we express our gratitude to the end users of this manual, including emergency responders, healthcare professionals, policymakers, and community leaders. It is your commitment to excellence and your tireless efforts to safeguard lives and livelihoods that inspire and drive our collective pursuit of preparedness and resilience.

The successful completion of this manual would not have been possible without the dedication, collaboration, and support of all those mentioned above. Thank you for your unwavering commitment to excellence in emergency response and for your tireless efforts to build a safer, more resilient future for all.

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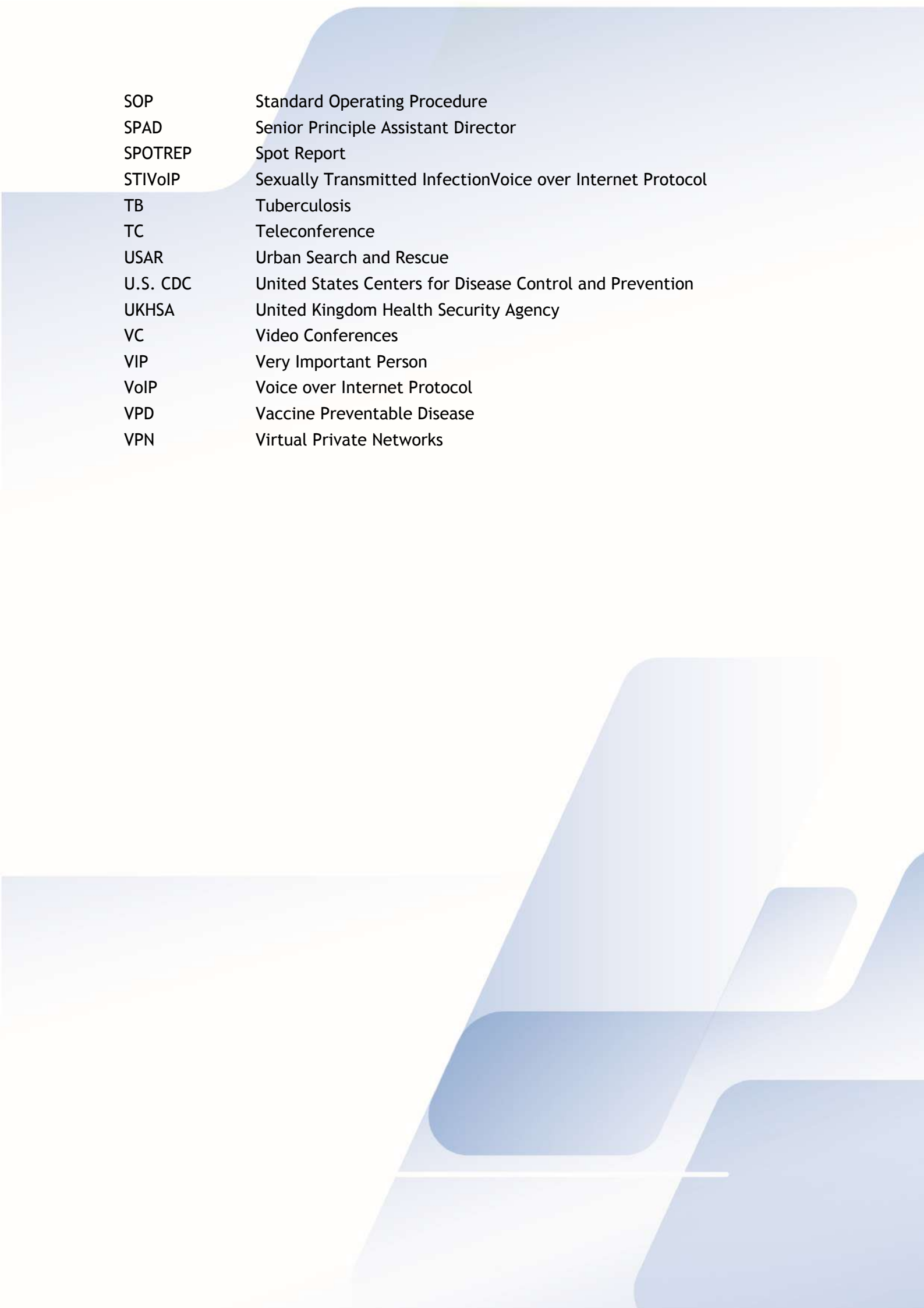
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ABBREVIATIONS

AAR	After-Action Review
ACD	Active Case Detection
AEHO	Assistant Environmental Health Officer
ASEAN	Association of Southeast Asian Nations
CBRNe	Chemicals, Biologicals, Radiological, Nuclear, and explosives
CDC	Communicable Disease Control
CERC	Crisis Emergency Risk Communication
CIR	Critical Information Requirement
COP	Common Operating Picture
CPRC	Crisis Preparedness and Response Centre
DDC	Director of Disease Control
DDDC	Deputy Director of Disease Control
DDG	Deputy Director General
DEO	District Epidemiology Officer
DG	Director General
DHO	District Health Officer/ District Health Office
DOCE	Disaster, Outbreak, Crisis, and Emergency
DRP	District Risk Profiles
DSHD	Deputy State Health Director
DVD	Digital Versatile Disc
EEI	Essential Elements of Information
EHO	Environmental Health Officer
EIP	Epidemic Intelligence Programme
EM	Emergency Management
EMT	Emergency Medical Team
EOC	Emergency Operations Centre
EP	Emergency Physician
ERP	Emergency Response Plan
FMS	Family Medicine Specialist
FP	Focal Point
FWBD	Food and Waterborne Disease
GAC	Global Affairs Canada
GIS	Geographic Information System
GPS	Global Positioning System
HIV	Human Immunodeficiency Virus
HVAC	Heating, Ventilation, and Air Conditioning
IAP	Incident Action Plan
ICCS	Integrated Communications Control System
ICP	Incident Command Post
ICT	Information and Communication Technology
ID	Infectious Disease

IHR	International Health Regulations
ILI	Influenza-Like Illness
IM	Incident Manager
IP	Improvement Plan
IT	Information Technology
IVMS	Integrated Video Management System
JEE	Joint External Evaluation
JIBC	Justice Institute of British Columbia
JIC	Joint Information Centre
JIS	Joint Information System
LAN	Local Area Network
MA	Mission Assignment
MACS	Multiagency Coordination Systems
MBT	Mitigation of Biological Threats
MCH	Maternal and Child Health
MCI	Mass Casualty Incidents
MERT	Medical Emergency Response Team
MHPSS	Mental Health and Psychological Support
MO	Medical Officer
MOH	Ministry of Health
NADMA	National Disaster Management Agency
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
OR	Operation Room
PABX	Private Automatic Branch Exchange
PHEIC	Public Health Emergency of International Concern
PHEOC	Public Health Emergency Operations Centre
PHL	Public Health Laboratory
PIO	Public Information Officer
PPE	Personal Protective Equipment
PSTN	Public Switched Telephone Network
RAT	Rapid Assessment Team
RFA	Request for Assistance
RFI	Request for Information
RFID	Radio Frequency Identification
RRT	Rapid Response Team
SA	Situational Awareness
SDN	Software-Defined Networks
SH	Section Head
SHD	State Health Director
SITREP	Situation Report
SMART	Special Malaysia Disaster Assistance and Rescue Team
SME	Subject Matter Expert

SOP	Standard Operating Procedure
SPAD	Senior Principle Assistant Director
SPOTREP	Spot Report
STIVoIP	Sexually Transmitted InfectionVoice over Internet Protocol
TB	Tuberculosis
TC	Teleconference
USAR	Urban Search and Rescue
U.S. CDC	United States Centers for Disease Control and Prevention
UKHSA	United Kingdom Health Security Agency
VC	Video Conferences
VIP	Very Important Person
VoIP	Voice over Internet Protocol
VPD	Vaccine Preventable Disease
VPN	Virtual Private Networks

CHAPTER 1

INTRODUCTION

CHAPTER 1

INTRODUCTION

1.1   Background

The Public Health Emergency Operations Centre (PHEOC) for the Ministry of Health (MOH) Malaysia is known as the National Crisis Preparedness and Response Centre (CPRC). At the state level, it is called the State CPRC, while at the district level, it is referred to as the Operation Room (OR).

In terms of administration, the National CPRC falls under the Disease Control Division (see Figure 1.1). At the state level, the State CPRC is under the Surveillance Unit of the Public Health Division, and at the district level, the OR is under the Communicable Disease Control Unit.
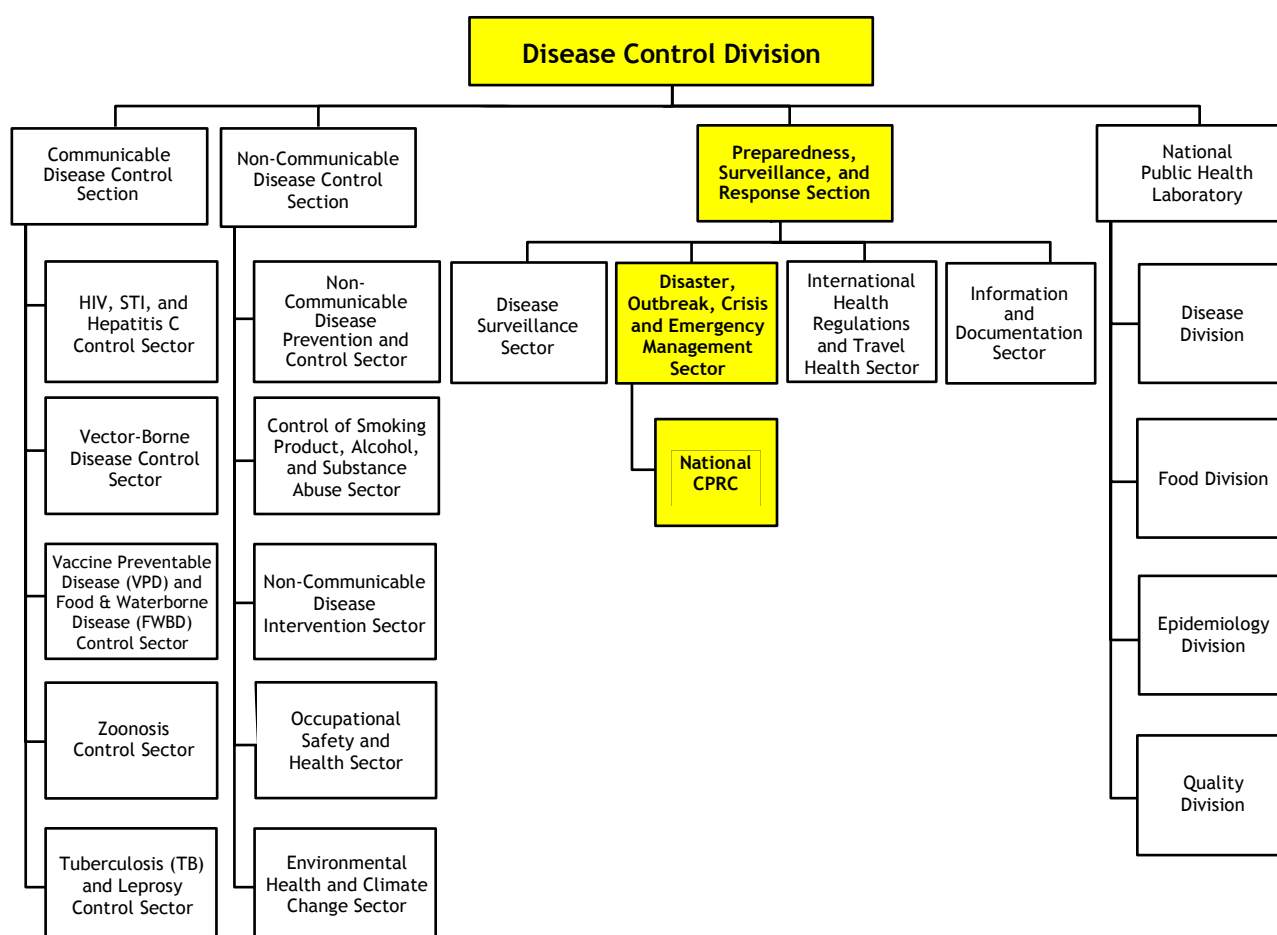
Figure 1.1 Organizational Structure of Disease Control Division

The establishment of the CPRC is part of a preparedness strategy for the effective management of Disasters, Outbreaks, Crisis, and Emergency (DOCE). It serves as the central point where decision-makers and representatives of response activities coordinate operational information and resources for the strategic management of DOCE. This close coordination ensures an efficient and timely response with minimal duplication of effort.

Regarding the National Disaster Management Agency (NADMA) Directive No. 1, the Ministry of Health (MOH) Malaysia is the lead agency for managing epidemics and catastrophic events resulting from biological accidents. To fulfill its role as the lead agency, the National CPRC was planned and completed during the 9th Malaysia Plan (2006 to 2010) and was successfully inaugurated on 7th May 2007.

Initially, it served as a centre for preparedness and response to outbreaks of infectious diseases but later expanded to include all hazards in 2013. These hazards encompass all types of public health events, such as natural disasters, technological disasters, crises, and emergencies, including Mass Casualty Incidents (MCI), violence, and Chemical, Biological, Radiological, Nuclear, and explosives (CBRNe) incidents, as well as disease outbreaks. The Standard Operating Procedure (SOP) for CPRC was formulated in 2016 to guide MOH personnel in managing DOCE events.

Therefore, the roles and functions of the CPRC need to be reviewed to ensure strategic and smooth operations while coordinating and handling all forms and situations of DOCE within the MOH.

1.2   Objectives

1.2.1   Objectives of the document

This Standard Operating Procedure (SOP) will be used as reference material by personnel in CPRC to manage DOCE events. This document also explains in detail the infrastructure, organizational charts, lines of command, roles and responsibilities, and work processes at all levels.

1.2.2   Objectives of the CPRC

1.2.2.1 General Objective

To monitor DOCE events, organize an effective and immediate public health response, and disseminate pertinent information to relevant stakeholders.

1.2.2.2 Specific Objectives

      i.   To increase the level of preparedness.

     ii.   To develop strategies for addressing public health issues.

   iii.   To coordinate all health-related activities to ensure an effective and immediate response.

    iv.   To reduce morbidity and mortality before, during, and after the DOCE event.

     v.   To facilitate recovery after the DOCE event.

    vi.   To enhance inter-sector collaboration and coordination.

CHAPTER 2

CORE COMPONENTS OF CPRC

CHAPTER 2

CORE COMPONENTS OF CPRC

The following core components are required to achieve the objectives and ensure the optimal functioning of CPRC:

     i.   Organizational structure;

    ii.   Physical infrastructure;

   iii.   Plans and procedures;

   iv.   Information systems and data standards; and

    v.   Human resource.

2.1 Organizational Structure

The term CPRC is used at the national and state levels, while at the district level, it is referred to as the OR.

2.1.1 National CPRC

The National CPRC's function is to monitor and coordinate DOCE events and maintain communication networks with all agencies, both locally and internationally. The National CPRC also plans the management of resources and conducts training and exercises related to CPRC activities.

Since 2016, Malaysia has been the lead country for the ASEAN Emergency Operations Centre (EOC) Network. The ASEAN EOC Network for public health, led by the Ministry of Health Malaysia, provides a platform for ASEAN Member States' officials working at their respective crisis centres and/ or in disease prevention and control to share information in a timely manner through various communication mechanisms.

As the lead country for the ASEAN EOC Network, Malaysia has fostered collaboration with international organizations such as Global Affairs Canada (GAC), the Justice Institute of British Columbia (JIBC), the United Kingdom Health Security Agency (UKHSA), the United States Centers for Disease Control and Prevention (U.S. CDC), neighboring countries, and relevant stakeholders by conducting regular training sessions and simulation exercises on various disease outbreaks and disaster scenarios. These include Avian Influenza, massive floods, CBRNe incidents, and coordination of Emergency Medical Teams (EMTs) to ensure that response teams are familiar with their roles and can effectively coordinate in the event of an emergency. Participants include healthcare professionals, emergency responders, and public health officials.

During Joint External Evaluation (JEE) 2019, the JEE team found many strengths in Malaysia, particularly well-established mechanisms for command, control, and coordination of multisectoral health emergency preparedness and response, as guided by the National Security Council Directive No. 20 and facilitated by the NADMA, while the MOH CPRC provides the functional centre for preparedness planning, synthesizing information, and coordinating health sector responses.

The National CPRC serves as the command and coordination centre for DOCE at the national level, located on Level 6, Block E10, Disease Control Division, Ministry of Health Malaysia. Figure 2.1 refers to the organizational structure for the National CPRC.

```
┌─────────────────────────────────────────┐
│           CPRC MANAGER                    │
│    Deputy Director of Disease Control     │
│            (Surveillance)                 │
└─────────────────────────────────────────┘
                     │
┌─────────────────────────────────────────┐
│        DEPUTY CPRC MANAGER                │
│      Head of DOCE Management Sector       │
└─────────────────────────────────────────┘
                     │
┌─────────────────────────────────────────┐
│        CORE CPRC PERSONNEL                │
│    Personnel of DOCE Management Sector    │
└─────────────────────────────────────────┘
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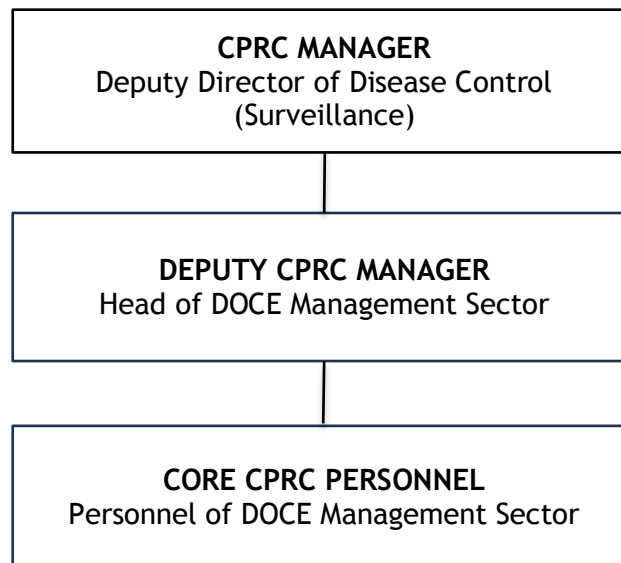
Figure 2.1 Organizational Structure for National CPRC

2.1.2   State CPRC

The State CPRC is the command and coordination centre for DOCE events at the state level, which includes 13 states and two (2) Federal Territories, namely Perlis, Kedah, Penang, Perak, Selangor, Negeri Sembilan, Melaka, Johor, Pahang, Terengganu, Kelantan, Sarawak, Sabah, the Federal Territory of Kuala Lumpur and Putrajaya, and the Federal Territory of Labuan. The organizational structure for the State CPRC is shown in Figure 2.2.

```
┌─────────────────────────────────────────┐
│           CPRC MANAGER                    │
│      Deputy State Health Director         │
│            (Public Health)                │
└─────────────────────────────────────────┘
                     │
┌─────────────────────────────────────────┐
│        DEPUTY CPRC MANAGER                │
│        Head of Surveillance Unit          │
└─────────────────────────────────────────┘
                     │
┌─────────────────────────────────────────┐
│        CORE CPRC PERSONNEL                │
│       Personnel of Surveillance Unit      │
└─────────────────────────────────────────┘
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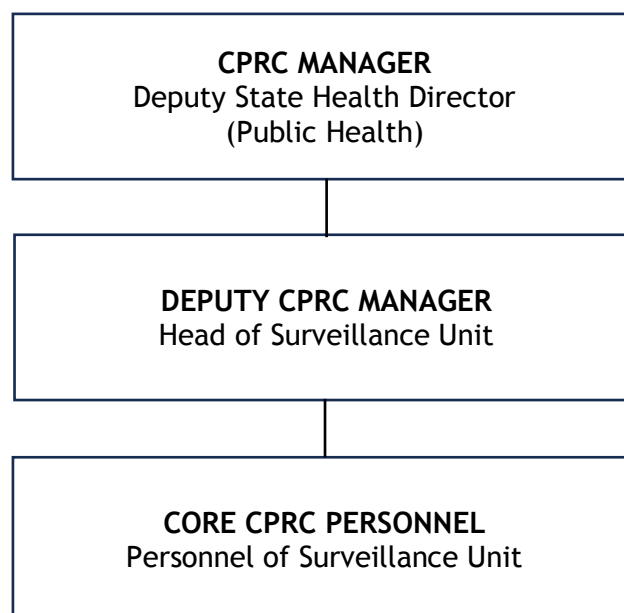
Figure 2.2 Organizational Structure for State CPRC

2.1.3 District Operation Room (OR)

The OR function at the district level is as Figure 2.3.

```
┌─────────────────────────────────────┐
│            OR MANAGER                │
│      Medical Officer of Health       │
│           (Epidemiology)             │
└─────────────────────────────────────┘
                  │
┌─────────────────────────────────────┐
│          DEPUTY OR MANAGER           │
│           Medical Officer/           │
│     Environmental Health Officer/    │
│   Senior Assistant Environmental     │
│            Health Officer            │
└─────────────────────────────────────┘
                  │
┌─────────────────────────────────────┐
│          CORE OR PERSONNEL           │
│     Personnel of Surveillance Unit   │
└─────────────────────────────────────┘
```
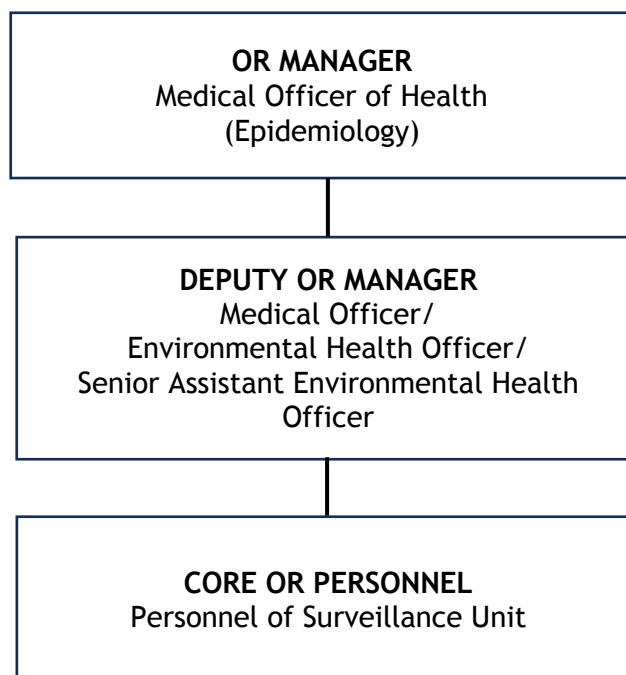
Figure 2.3 Organizational Structure for District Operation Room

2.2 Physical Infrastructure

CPRC consists of meeting rooms and working spaces for personnel with granted access only. The workspace must be adequate to accommodate personnel during both passive and active modes. Examples of the basic equipment required for CPRC are shown in **Annex 1**. Additional equipment may be needed depending on the specifics or scale of DOCE events.

2.3   Plans and Procedures

Plans and procedures are needed to ensure the accomplishment of the response mission. CPRC operates on the basis of the following plans:

      i.   CPRC SOP;

      ii.   Event-Specific Management Plans; and

      iii.   Incident Action Plan (IAP).

2.3.1   CPRC SOP

This document serves as the main reference for the operation of the CPRC. It includes specific and functional annexes, including plans for continuity of operations, which allow for more effective development and implementation of an IAP during a DOCE event.

2.3.2   Event-Specific Management Plans

The management of event-specific operations should refer to the available related plans developed by relevant sectors in the Disease Control Division, such as the Disaster Management Plan, CBRNe Management Guidelines, Guidelines for Rapid Assessment Team (RAT) and Rapid Response Team (RRT), Guidelines of Human Resource Mobilization During Public Health Emergencies, as well as other DOCE management plans. These plans should be made available at the CPRC and OR for easy reference.

2.3.3   Incident Action Plan (IAP)

The Incident Action Plan (IAP) is a written document that outlines the objectives related to the strategy for managing an incident (**Annex 2**). An IAP includes incident goals, operational period objectives, and the response strategy defined by the Incident Manager (IM) during response planning.

2.4   Information Systems and Data Standards

CPRC information systems are vital for increasing the availability, accessibility, quality, timeliness, and usefulness of information for effective public health action. It also have the capacity to ensure data security, privacy, and confidentiality. All available systems will be seamlessly integrated with relevant national information systems. The types of data that need to be routinely captured, processed, and displayed in a CPRC are:

     i.   Event-Specific Data

    ii.   Event Management Information

   iii.   Context Data

2.4.1   Event-Specific Data

CPRC provides clinical and epidemiological data with ongoing trends. Indicator-based data is obtained from eNotifikasi while the outbreak data is obtained from eWabak. Other event-specific data will be retrieved through various resources (e.g., email, WhatsApp, etc.).

2.4.2   Event Management Information

Effective resource mapping and tracking interventions, deployments, and partner activities are crucial for ensuring smooth operations and achieving event goals of the CPRC.

2.4.3   Context Data

Geographical information mapping, climate and weather information, population distribution, and any other contextual information provide critical insights into the environment where the event is taking place, helping planners make informed decisions.

2.5   Human Resource

CPRC requires competent and trained personnel to perform effectively during both passive and active modes. Information on human resources should be made available, accessible, and regularly updated to ensure effective human resource management.

CHAPTER 3

CPRC MODES OF OPERATION

CHAPTER 3

CPRC MODES OF OPERATION

3.1   Modes of Operation

CPRC operates in two (2) different modes: Active and Passive. Active mode is based on the incident type, scale, impact, and criteria of activation. Passive mode of CPRC represents a strategic approach to preparedness, primarily focused on information gathering, analysis, and daily planning.

CPRC may operate in both modes simultaneously. The responsible officers and their job descriptions for both Active and Passive Modes are detailed in Table 3.1 and Table 3.2. respectively.

3.2   Table Modes of Operation

3.2.1 Table 3.1 shows the Responsible Officers and Job Descriptions during Passive Mode of Operations in CPRC.

Table 3.1 CPRC Passive Mode of Operation

PASSIVE MODE	NORMAL DAILY ACTIVITIES
Responsible Officers	- Normal CPRC Organization Structure. - CPRC Manager. - Deputy CPRC Manager. - CPRC Staff. - Support team: - Section heads.

Job Descriptions	Preparedness activities:
	  - Conduct risk assessments.
	  - Conduct exercises and training.
	  - Regular training for CPRC staff members.
	  - Update and test CPRC SOPs and guidelines.
	  - Maintain and collect resources and stockpiles.
	  - Develop District Risk Profiles (DRP).

	- Surveillance and monitoring activities:
	  - Monitor daily for events related to DOCE through Indicator and Event Based Surveillance.
	  - Detect adverse health events related to DOCE.
	  - Validate and verify the health events related to DOCE. - Alert Phase activities:
	  - Generate rapid reports or Spot Report (SPOTREP).
	  - Identify and alert Subject Matter Experts (SMEs).
	  - Initiate the Incident Action Plan (IAP).
	  - Form the Rapid Assessment Team (RAT).
	  - Deploy the RAT for initial assessment.
	  - Generate warning notifications and prepare an early report Situational Report (SITREP).
	  - Enhance and analyze all surveillance data and activities.
	  - Initiate coordination with other ministries and agencies.

3.2.2 Table 3.2 shows the Responsible Officers and Job Descriptions during Active Mode of Operations in CPRC.

Table 3.2 CPRC Active Mode of Operation

ACTIVE MODE	DURING ACTIVATION OF CPRC
Responsible Officers	• Incident Management System (IMS) Organization structure: - Incident Manager. - Deputy Incident Manager. - Liaison Officer. - Secretariat Staff for events. - Plans Staffs. - Logistics Staffs. - Operations Staffs. - Finance and Administration Staffs. - Public Information Officer. - Safety Officer.
Job Descriptions	• Activate the IMS. • Mobilize IMS staff and SMEs. • Establish coordination with other ministries. • Finalize the Incident Action Plan (IAP) for the operational period. • Deploy resources. • Conduct situational awareness. • Report the specific response and activities. • Declare deactivation of IMS when the events meet the deactivation criteria.

* Details of passive and active modes are further discussed in Chapter 4 and 5 respectively.

CHAPTER 4

PASSIVE MODE

CHAPTER 4

PASSIVE MODE

The passive mode of CPRC represents a strategic approach to preparedness, primarily focused on information gathering, analysis, and planning. It serves as a centralized repository for situational awareness, consolidating data from various sources, such as emergency alerts, incident reports, weather updates, rumor surveillance, and resource availability.

The primary objective of the passive mode is to facilitate effective decision-making by providing accurate, real-time information to key decision-makers and stakeholders. This includes conducting risk assessments, analyzing the potential impact of incidents, and identifying the resources and capabilities required for an effective response, including training and advice on health education activities.

The passive mode also involves coordinating with external entities such as emergency management agencies, public health departments, law enforcement, and utility providers. By establishing strong lines of communication and information sharing, the CPRC ensures a comprehensive understanding of the crisis, enhances coordination efforts, and maximizes the allocation of resources where they are most needed. Furthermore, the passive mode allows for the development and refinement of emergency response plans, protocols, and SOPs. By conducting tabletop exercises, simulations, and scenario-based drills, the CPRC can assess the effectiveness of existing plans, identify gaps or vulnerabilities, and make necessary adjustments to enhance overall preparedness.

The passive mode of CPRC plays a critical role in the early stages of emergency response. Operations during the passive mode are essential for establishing a solid foundation for effective decision-making. This can assist in determining the alert phase before transitioning into active mode.

4.1   Management of CPRC During Passive Mode

During the passive mode, the core responsibilities of CPRC staff align with day-to-day operations. These responsibilities include:

   i.   Collection, organization, analysis, distribution, and archiving of surveillance data.

   ii.   Analyzing data to determine the significance, impact, and priority of the information for potential action.

   iii. Engaging with internal and external partners, including local and regional partners.

   iv.   Dissemination of data analysis to all stakeholders (e.g., bulletins, daily reports, epidemiological reviews).

   v.   Updating the database of stakeholders (including external partners).

   vi.   Preparation and periodic updates of the DRP.

   vii. Updating the stockpile of Personal Protective Equipment (PPE).

viii. Ensuring the availability of adequate consumables, such as reagents, test kits, and sample transport media.

ix. Keeping visual representations of information updated in the CPRC and disseminating them to respective stakeholders (e.g., spot maps, line listings, and trend graphs, which are the basis for Situational Analysis).

x. Identify the needs based on triage information and maintaining a necessary stockpile inventory/ checklist. Processing Essential Elements of Information (EEI) (e.g., DRP, specialized designated hospitals, designated labs, testing capacity, antidote availability, and medication availability).

xi. Identify Critical Information Requirements (CIR) which refers to the essential information that is required to adequately make decisions (e.g., bed occupancy rates of hospitals to redistribute patients when needed).

Passive mode priorities are guided by the CIR. Situational awareness during passive mode involves being aware of and attentive to what is happening in each environment at a particular time.

During the alert phase of the CPRC, there is an increase in activity in closely monitoring the situation. The alert phase may involve increasing staff and specific monitoring activities. The following activities should be observed and carried out:

i. Addition of staff to carry out monitoring activities.

ii. SMEs could be alerted and made available (on standby).

iii. Enhanced surveillance activities.

iv. Preliminary assessment team convened.

v. Notification mechanisms generated.

vi. Coordination with other agencies initiated.

vii. Initial Action Plan (IAP) initiated.

viii. Deployment preparation initiated.

ix. Deployment of Rapid Assessment Team (RAT) for initial assessment and Rapid Response Team (RRT) for initial response.

Staff in passive mode will compile daily reports, including bulletins and surveillance data updates.

i. SPOTREP is a short narrative report containing unverified information focused solely on critical and pertinent details about an incident (**Annex 3**).

ii. SITREP is a priority message that provides a summary of a situation to designated decision-makers (**Annex 3**).

During passive mode, capacity building activities such as training, risk assessments, and resource management are carried out. The Rapid Assessment Team is deployed during an alert situation to assess the situation and plan for further management.

4.2   Rapid Assessment Team (RAT) and Rapid Response Team (RRT)

The Rapid Assessment Team (RAT) is mobilized from the nearest available District Health Office (DHO) to the incident site immediately upon receiving an alert in order to assess the situation and provide crucial information for immediate response planning.

The RAT needs to be established prior to a DOCE event at all levels (district, state, and national). The team should consist of a multidisciplinary group of trained personnel from various areas of expertise. The selection of team members will be determined by the following criteria:

     i.   Familiarity with the locality, geographical area, or affected population;

    ii.   Knowledge of and experience with the type of DOCE; and

    iii.   Analytical skills and qualities of personnel.

When deployed during passive mode in an alert situation, information from the RAT flows from the field back to the CPRC to foster situational awareness in support of decision-making.

The Rapid Response Team (RRT) is a predetermined, trained team identified based on individual expertise and experience. The team is assembled by matching expertise with event needs to provide a rapid response in managing public health events or emergencies.

The RRT needs to be established during a DOCE event at all levels (district, state, and national). The RRT should consist of a multidisciplinary team of trained personnel from a varied range of expertise. The selection of team members will be determined at the district, state, and national levels.

CHAPTER 5

ACTIVE MODE

CHAPTER 5

ACTIVE MODE

The active mode is initiated when CPRC is activated following a received notification. During the active mode, CPRC is partially or fully activated, with assigned personnel functioning according to the terms of reference for their positions. Activities and staff increase during this period as the IMS is activated.

In an event, CPRC functions mainly to:

i. Plan the policies and strategies related to DOCE incidents.

ii. Plan and coordinate the implementation of activities following the approved policies and strategies.

iii. Act as a one-stop centre for the collection and analysis of data and dissemination of information during a DOCE event.

iv. Plan for sufficient resources, including human resources, vehicles, equipment, and supplies, such as PPE, medicines, and vaccines.

v. Mobilize resources to states or districts if needed.

vi. Plan and provide input for risk communication, including strategic communication such as preparing press statements, relevant infographics, and social media interactions.

vii. Maintain communication networks with all agencies (local and international).

viii. Conduct risk assessments by deploying the Risk Assessment Team (RAT) and rapid response activities by deploying the Rapid Response Team (RRT) during a DOCE event.

ix. Identify resources for IMS.

5.1   Criteria for CPRC Activation

Several factors influence when and at what level the CPRC is activated. Decisions regarding activation should rely on critical judgment and established criteria. The level of activation is not static; it can be mild, moderate, or high as the event develops, based on new information, ongoing risk assessments, changes in resource availability, and contextual factors such as political sensitivities, rumors, and shifting security situations. These changes in activation status must be communicated to IMS functions, detailing the adjustments. If uncertain, it is best practice to over-prepare and over-respond with a higher level of activation to ensure an appropriate response. IMS will manage the DOCE event within the CPRC.

The primary factor determining activation is the increased demand for resources:

    i.   Low CPRC Activation

- In a low CPRC activation, the CPRC utilizes the lowest level of resources, including regular CPRC staffs, a minor increase in costs for the response, and minimal reporting requirements.
- Example: There are a few cases of Poliomyelitis reported in the region and the CPRC is activated to give out vaccinations in response to the minor outbreak.

    ii.   Medium CPRC Activation

- In a medium CPRC activation, the CPRC uses augmentation of resources, including additional staffing (beyond the regular CPRC staffs), moderate costs for the response, and increased but manageable reporting requirements.
- Example: There are multiple cases of Avian Influenza reported and now there has been an outbreak of mpox.

    iii.   High CPRC Activation

- In a high CPRC activation, the CPRC utilizes significant augmentation of resources, including staffs, very high costs for the response, and extensive reporting requirements. This level of activation represents the largest scale efforts, impacting the entire ministry.
- Example: A large-scale outbreak of Avian Influenza has been reported in the country with multiple casualties including ten deaths. All the while there is also a mpox outbreak in the country.

In general, CPRC is activated whenever one or more of the following conditions exist:

    i.   Any suspected, reported, or confirmed outbreak with epidemic potential or any Public Health Emergency of International Concern (PHEIC).

    ii.   Any reportable incidents under IHR 2005.

    iii.   A large-scale disease outbreak of initially unknown etiology.

    iv.   Resource coordination required due to limited local resources and/ or significant need for outside assistance.

    v.   Uncertain conditions pose a significant potential threat to people, property, and/ or the environment.

    vi.   Upon the direction of the Director General (DG)/ State Health Director (SHD)/ District Health Officer (DHO), the CPRC will be activated according to specific criteria at national, state, and district levels.

5.1.1 Criteria for National CPRC Activation

The National CPRC will be activated whenever one or more of the following conditions exist:

     i.   The occurrence of an epidemic in more than one state.

    ii.   An incident with high morbidity and mortality.

  iii.   Death or incidence of extraordinary cases (one or more) due to infectious diseases with unknown pathogenic causes.

  iv.   Any suspected, reported, or confirmed outbreak with epidemic potential or any PHEIC.

    v.   Incidents of natural or man-made disasters requiring resource mobilization from other states.

  vi.   Events likely to arise from biological threats (bioterrorism).

 vii.   Uncertain conditions pose a significant potential threat to people, property, and/ or the environment.

viii.   Upon the direction of the DG.

5.1.2 Criteria for State CPRC Activation

The State CPRC will be activated whenever one or more of the following conditions exist:

     i.   The occurrence of epidemic or cluster cases in more than one district.

    ii.   Incidents with high morbidity and mortality.

  iii.   Death or incidence of extraordinary cases (one or more) due to infectious diseases with unknown pathogenic causes.

  iv.   Events related to PHEIC.

    v.   Incidents of natural or man-made disasters requiring resources mobilization from other districts.

  vi.   Events likely to arise from biological threats (bioterrorism).

5.1.3 Criteria for District OR Activation

The District OR will be activated whenever one or more of the following conditionsexist:

     i.   The occurrence of epidemic or cluster cases in more than one district.

    ii.   Incidents with high morbidity and mortality.

  iii.   Death or incidence of extraordinary cases (one or more) due to infectious diseases with unknown pathogenic causes.

  iv.   Incidents of natural disasters or man-made disasters.

v.   Events likely to arise from biological threats (bioterrorism).

vi.   Events related to PHEIC.

5.2   DOCE Event Activation Committee

When a DOCE event occurs and fulfilled the criteria for activation, a committee will convene a discussion for activation of CPRC and IMS.

5.2.1   MOH Executive Committee for DOCE

MOH Executive Committee for any DOCE event consists of selected MOH top management. The Director General of Health Malaysia chairs the committee sessions. Membership is as follows:

i.   Director General of Health Malaysia – Chairperson.

ii.   Deputy Director General of Health (Public Health).

iii.   Deputy Director General of Health (Medical).

iv.   Deputy Director General of Health (Research and Technical Support).

v.   Deputy Director General of Health (Pharmaceutical Services).

vi.   Deputy Director General of Health (Dental Health).

vii.   Deputy Director General of Health (Food Safety and Quality).

viii.   Deputy Secretary General (Finance).

ix.   Deputy Secretary General (Management).

x.   Director of Disease Control – Secretary.

xi.   Head of Corporate Communications Unit.

xii.   Appointed Members (based on needs).

5.2.2 MOH Technical Committee for DOCE

MOH Technical Committee for any DOCE event consists of Divisional Directors, Programme Service Heads, together with SMEs. The committee chairperson is the Deputy Director-General of Health (Public Health). Membership is as follows:

i. Deputy Director General of Health (Public Health) – Chairperson.

ii. Director of Disease Control – alternate chairperson.

iii. Director of Medical Development Division.

iv. Director of Family Health Development Division.

v. Senior Director of Pharmaceutical Services.

vi. Director of Health Education Division.

vii. Director of Engineering Services Division.

viii. Deputy Director of Disease Control (Surveillance) – Secretary.

ix. Related Heads of Service Programmes.

x. Head of Corporate Communications Unit.

xi. Director of Food Safety and Quality Programme.

xii. Related Public Health Laboratory Director.

xiii. Technical Working Group – SME – based on the type of DOCE event.

5.2.3 State Health Department Committee

The State Technical Committee for DOCE event consists of the following, chaired by the State Health Director.

i. State Health Director – Chairperson.

ii. Deputy State Health Director (Public Health)

iii. Deputy State Health Director (Medical).

iv. Deputy State Health Director (Dental).

v. Deputy State Health Director (Pharmacy).

vi. Deputy State Health Director (Food Security and Quality).

vii. Deputy State Health Director (Management).

viii. Director of State Hospital.

ix. Related Heads of Service Programmes.

x. State Public Health Engineer.

xi. State Health Education Officer.

xii. State Environmental Health Officer.

xiii. State Chief Assistant Medical Officer.

xiv. State Chief Nursing.

xv. Senior Principal Assistant Director (Surveillance/ CDC)

xvi. Technical Working Group – SME – based on the type of DOCE event.

xvii. Appointed Members (based on needs).

5.2.4 District Health Department Committee

The District Technical Committee for DOCE event consists of the following, chaired by the District Medical Officer of Health.

i. District Health Officer – Chairperson.

ii. District Hospital Director (related).

iii. District Epidemiology Officer - Secretariat.

iv. District Environmental Health Officer.

v. Family Health Physician.

vi. District Pharmacy Officer.

vii. Family Health Officer.

viii. Senior Assistant Medical Officer.

ix. District Nursing Supervisor.

x. Entry Point Medical Officer of Health (Dr) if available.

xi. Technical Working Group – SME – based on the type of DOCE event.

5.3   Incident Management System (IMS)

IMS is the standardized structure and approach adopted to manage the CPRC's response to public health events and emergencies, ensuring that the organization follows best practices in emergency management. The early activation of an IMS within the CPRC is an important component of emergency response, from which other public health actions flow.

The IMS structure has four (4) core sections that are scalable, expandable, adaptable, and modular, designed to appropriately support an emergency response. These include the Plans Section, Operations Section, Logistics Section, and Finance/ Administration Section. The Incident Management team consists of the Incident Manager, Deputy Incident Manager, Liaison Officer, Public Information Officer, and Safety Officer. Figure 5.1 shows the organizational structure of the IMS.
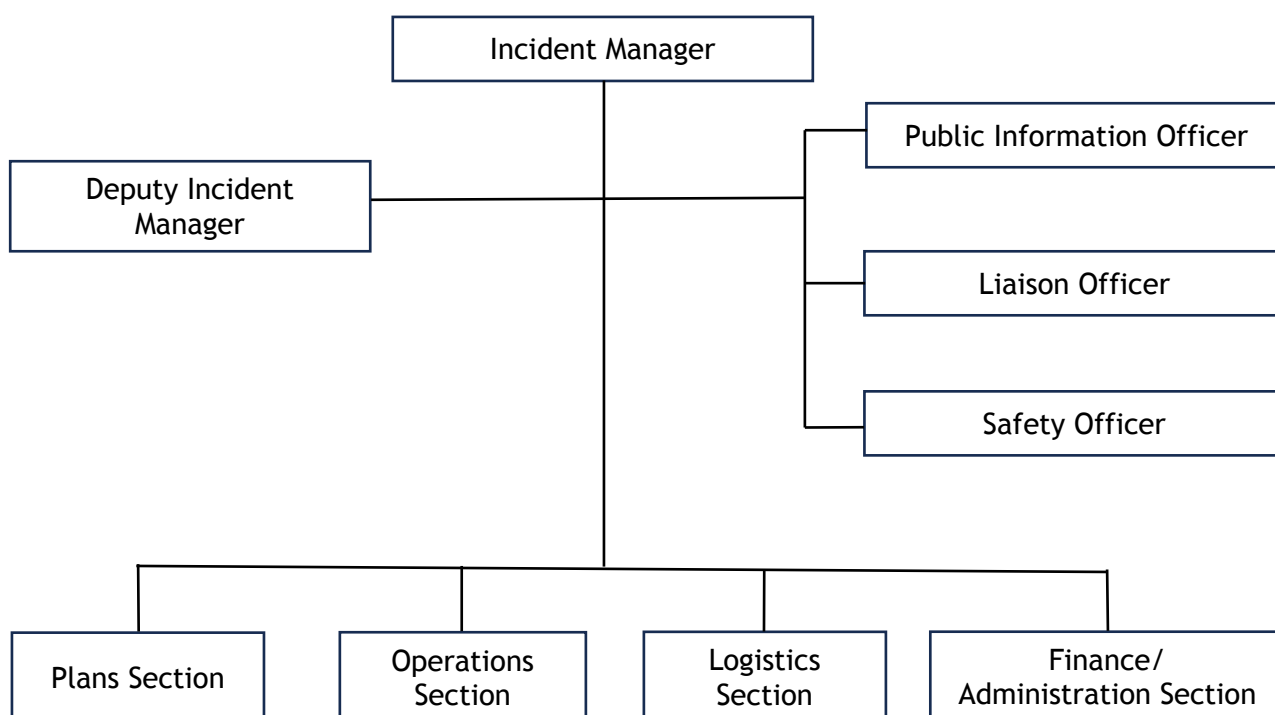
Figure 5.1 Organizational Structure of Incident Management System (IMS)

IMS components are adaptable to any situation, ranging from planned special events to routine local incidents, as well as incidents involving interstate mutual aid or federal assistance. Some incidents require multi-agency, multijurisdictional, and/ or multidisciplinary coordination. This flexibility allows IMS to be scalable and applicable for incidents that vary widely in terms of hazards, geography, demographics, climate, culture, and organizational authorities. The CPRC can have more than one IMS activation on some occasions.

5.3.1   IMS Core Structure

The CPRC coordinates all activities and responses related to DOCE events based on the IMS Organizational Chart, the roles of personnel, and the functions of each section. During a response, surge capacity refers to the ability to draw on additional resources to sustain operations and increase capacity.

5.3.2 Responsibilities of the IMS Team

5.3.2.1 Incident Manager (IM)

i. Establishes consolidated incident objectives, priorities, and strategic guidance, updating them every operational period.

ii. Selects a single section chief for each position on the General Staff needed based on current incident priorities.

iii. Establishes a single system for ordering resources.

iv. Ensures a single system for resource management is used.

v. Approves a consolidated IAP for each operational period.

vi. Establishes procedures for joint decision-making and documentation.

vii. Captures lessons learned and best practices.

5.3.2.2 Deputy Incident Manager

i. Perform specific tasks as requested by the IM.

ii. Perform the incident management function in a relief capacity.

iii. Represent an assistance agency that shares jurisdiction.

5.3.2.3 Public Information Officer (PIO)

i. Recommend and develop strategies for messages, briefings, and news releases.

ii. Obtain approval from those in authority before releases are made.

iii. Conduct Joint Information Centre (JIC) briefings (live or virtual) to update staff regarding Incident Command activities.

iv. Interface with the public, the media, and other jurisdictions/ organizations with incident-related information needs.

v. Gather, verify, coordinate, and disseminate accurate, accessible, and timely information regarding the incident.

vi. Monitor the media and other sources of public information to collect relevant information and transmit this information to the appropriate personnel at the CPRC.

vii. Participate in the national, state, or district Joint Information System (JIS).

Joint Information System (JIS) is a network that supports the integration and coordination of sharing health protection information in an emergency. It provides the mechanism to organize, integrate, and coordinate information to ensure timely, accurate, accessible, and consistent messaging across multiple jurisdictions and/or disciplines, including the private sector and Non-Governmental Organization (NGOs).

Joint Information Centre (JIC) is an organizational structure based on functions that must be performed whether a person is responsible for a routine emergency or a major response to a disaster. The JIC is a central location that facilitates the operation of the JIS to ensure coordination of public information during incidents that involve multiple agencies and/ or jurisdictions.

In the early stages of response to an incident, the PIO shall consult with the IM regarding the opening of a JIC. The IM shall retain authority to order the opening of a JIC, although the lead PIO may recommend when it is appropriate. JICs are established:

i. At the direction of the IM at various levels of government.

ii. At pre-determined or incident-specific site.

iii. As components of national, state, district, or local Multiagency Coordination Systems (MACS).

5.3.2.4 Liaison Officer

i. Act as a point of contact for agency representatives.

ii. Monitor incident operations to identify current or potential inter-organizational issues.

iii. Maintain a list of assisting and cooperating agencies, agency representatives, and their contact information.

iv. Assist in setting up and coordinating inter-agency contacts.

v. Participate in planning meetings and provide current resource status, including limitations and capabilities of agency resources.

vi. Provide agency-specific demobilization information and needs.

5.3.2.5 Safety Officer

i. Recognize potentially hazardous and unsafe situations.

ii. Maintain awareness of active and developing situations.

iii. Incorporate safety messages in each IAP.

iv. Participate in planning meetings.

v. Advise the IM on issues regarding safety.

vi. Provide safety and security briefings to response teams.

vii. Give guidance on the psychological and emotional challenges that staff may face during response activities.

viii. Establish a safety plan.

ix. Develop measures to ensure responder's safety and well-being.

x.   Correct unsafe acts or conditions.

xi.   Ensure special precautions are taken when hazards exist.

xii.   Ensure adequate rest is provided to all responders.

5.3.2.6 Plans Section

i.   Collects, processes, analyzes, and evaluates information in order to respond to the event.

ii.   Identifies strategies and objectives for addressing an emergency.

iii.   Prepares and distributes plans for operation.

iv.   Prepares and disseminates status reports and documents activities.

v.   Conducts monitoring and evaluations of activities and responses.

5.3.2.7 Logistics Section

i.   Organize the section based on the needs of the response.

ii.   Coordinate deployment of resources.

iii.   Rapidly mobilize IMS Logistics personnel and resources.

iv.   Ensure the support requirements are met.

v.   Document and maintain all logistic section related activities for reference purpose e.g., Resource Typing and Inventory (**Annex 6** and **Annex 7**).

vi.   Ensure the support requirements are met.

vii.   Implement Standard Operating Procedures (SOPs).

viii.   Move response resources to desired location.

ix.   Deploy resources rapidly/ anticipate demobilization.

x.   Serve as the Logistics SME for the IM.

xi.   Speak with authority about the state of logistics.

5.3.2.8 Operations Section

i.   Put in motion the strategies and plans set out in the IAP.

ii.   Establish tactics and direct operational resources to achieve incident response objectives.

iii.   Inform, coordinate, and enable daily response activities.

iv.   Ensure that ERP or hazard-specific plans and strategic plans are both operational and executable.

v. Develop emergency operations plans, policies, and procedures.

vi. Monitor, track, and distribute necessary internal and external Mission Assignments (MAs).

vii. Develop, monitor, and track Requests for Information (RFIs) and Requests for Assistance (RFAs).

viii. Collaborate across ministries and with other partners.

ix. Provide coordination and technical guidance for response operations.

5.3.2.9 Finance and Administration Section

i. Manage cash flow.

ii. Track materials and human resource costs.

iii. Prepare and monitor the budget.

iv. Produce and maintain administrative records.

v. Process compensation claims.

vi. Prepare procurement contracts.

vii. Manage incentives and insurance payments.

5.3.3 Incident Action Plan (IAP)

The Plans Section is one of the most important sections for enabling the achievement of response objectives and is responsible for the analysis, planning, training, and evaluation of any public health events or hazards. During an event, response planning is conducted, which describes strategies and objectives for each operational period. The document for this response planning is known as the IAP (**Annex 2**).

An Incident Action Plan (IAP) is a written plan that outlines the objectives related to the strategy for managing an incident. An IAP includes:

i. The identification of operational resources.

ii. Assignments.

iii. Risk assessment.

iv. Attachments that provide direction.

v. Important information for incident management during an operational period (the operational period is the length of time assigned to complete the objectives of an IAP).

Functions of the IAP include:

    i.   Providing direction for both current and future actions for a response.

    ii.   Forming the basis for defining operational periods based on response needs and the time required to achieve objectives.

    iii.   Ensuring continuity of action.

    iv.   Describing what needs to occur throughout the next operational period (may extend for several days or more).

The purpose of the IAP is to:

    i.   Ensure common goals among response personnel.

    ii.   Provide direction for actions.

    iii.   Provide a means of communication for incident objectives.

    iv.   Ensure a coordinated response.

During a response, the IAP is written during a meeting led by the Plans Section. There is one representative from each functional area as well as SMEs. The best practice is for the entire IAP to be completed in no more than four (4) hours.

The IAP contains the following elements:

    i.   Incident Name: An Incident Name is a title provided by the IM that should describe the incident, such as the year, type of response, and location of the response.

    ii.   Operational Period: The duration of time defined by the IM, based on the needs of the incident, anticipated changes, and the time required to achieve response objectives.

    iii.   Types of IAP: Three (3) types, which are initial, update, and final.

        a.   Initial   - indicates the first or initial version of the IAP.
        b.   Update   - indicates new information added or that changes have been made to the IAP since the last operational period. The document is saved as an updated version.
        c.   Final   - indicates that the response is deactivated. The IAP should be saved as a final version.

In summary, Plans Section is designated to:

i.   Maintain accurate, complete, and up-to-date incident files.

ii.   Ensure each section maintains and provides appropriate documents for the post-incident documentation process.

iii.   Provide duplication services to support incident operations.

iv.   Compile and reproduce the IAP (**Annex 2**).

v.   Order and track the delivery of incident-related resources and supplies.

vi.   Coordinate with other units to care for and maintain arriving, staged, and employed mutual aid resources.

vii.   Coordinate with the Demobilization Unit to track demobilizing mutual aid resources.

viii.   Collect, process, and organize ongoing situation information.

ix.   Prepare situation summaries.

x.   Prepare graphical and numerical projections and displays of incident information relating to movement, growth, mitigation, or intelligence activities.

xi.   Project and forecast changes to provide and maintain a common operational picture, including preparing maps.

xii.   Gather and disseminate information and intelligence for the IAP.

xiii.   Prepare for and participate in planning meetings, providing up-to-date situational awareness and incident status.

xiv.   Collect, evaluate, and disseminate information regarding all incident resources.

xv.   Develop and disseminate the demobilization plan.

xvi.   Monitor the demobilization process and progress.

xvii.   Coordinate the implementation of the demobilization plan.

5.4   Management of CPRC During a DOCE Event

CPRC management, especially the flow of command, differs between national, state, and district levels. Figure 5.2, Figure 5.3, and Figure 5.4 depict the management and flow of command at the national, state, and district levels.

Person in Charge	Work Process

DOCE Event

AEHO — Receive initial report on disaster/ outbreaks/ crisis/ public health emergencies via SMS/ emails/ WhatsApp/ e-Notification.

AEHO — Verify public health emergencies – DOCE. (No / Yes)

.

AEHO — Report to SPAD/ SH/ DDDC/ DDC.

DDC — Decision to activate CPRC. (No / Yes)

SPAD/ SH/ DDDC — Activate CPRC, form IMS.

DDC — Inform WHO when assistance is needed/ PHEIC. (No / Yes)

SPAD/ SH/ DDDC — IMS formed and responders deployed. IAP prepared. Daily monitoring as in active mode.

DDC — Plan for deactivation.

SPAD/ SH/ DDDC — Deactivation and demobilization.

SPAD/ SH/ DDDC — Close operational room and prepare final DOCE report.

SPAD/ SH/ DDDC/ DDC — Finalize IAP and conduct AAR.

Figure 5.2 Flowchart for DOCE Management at the National CPRC

33

Person in Charge	Work Process

DOCE Event

AEHO — Receive initial report on events/ outbreaks/ public health emergencies via SMS/ emails/ WhatsApp/ e-Notification.

AEHO — Verify public health emergencies – DOCE.

No

Yes

AEHO — Report to SPAD/ DSHD/ SHD.

SHD — Report to National CPRC.

No   Yes

DDC — Decision to activate CPRC.

SPAD/ DSHD — Activate CPRC, form IMS.

DSHD — Decision to activate CPRC and to inform National CPRC if assistance is needed.

SPAD/ DSHD

Yes

No

DSHD — Initiate IAP, deploy responders.

SPAD/ DSHD

CPRC — Receive reports, updated IAP, plan for deactivation.

DSHD — Deactivated CPRC and prepare final DOCE event reports.

SPAD/ DSHD — Finalize IAP and conduct AAR.

Figure 5.3 Flowchart for DOCE Management at the State CPRC

34

Person in Charge	Work Process

DOCE Event

AEHO — Receive initial report on events/ outbreaks/ public health emergencies via SMS/ emails/ WhatsApp/ e-Notification.

AEHO — No — Verify public health emergencies – DOCE.

Yes

AEHO — Report to EHO/ District Epidemiology Officer (DEO)/ DHO.

EHO/ DEO/ DHO — Report to State CPRC if needed.

DHO — No — Yes — Decision to activate OR.

EHO/ DEO — Activate OR.

DHO — Form IMS, initiate IAP, deploy responders.

EHO/ DEO — Yes

No

DOH — Inform State CPRC if assistance is needed.

EHO/ DEO

OR — Receive reports, update IAP, and plan for deactivation.

EHO/ DEO — Deactivate OR and prepare for final DOCE report.

EHO/ DEO — Finalize DOCE report and prepare for AAR.

Figure 5.4 Flowchart for DOCE Management at the District OR

5.5 Flow of Command During DOCE Event

Figure 5.5 illustrates the flow of command during a DOCE event. During a disaster, the management follows NADMA Directive No. 1. Disaster Management Level 1 refers to disaster management within a district, managed by multiple agencies at the district level with minimal assistance from the state. Disaster Management Level 2 involves disaster management that includes more than one district within the state, managed at the state level with minimal assistance from the national level. Disaster Management Level 3 pertains to disaster management involving more than one state within the country, managed at the national level.
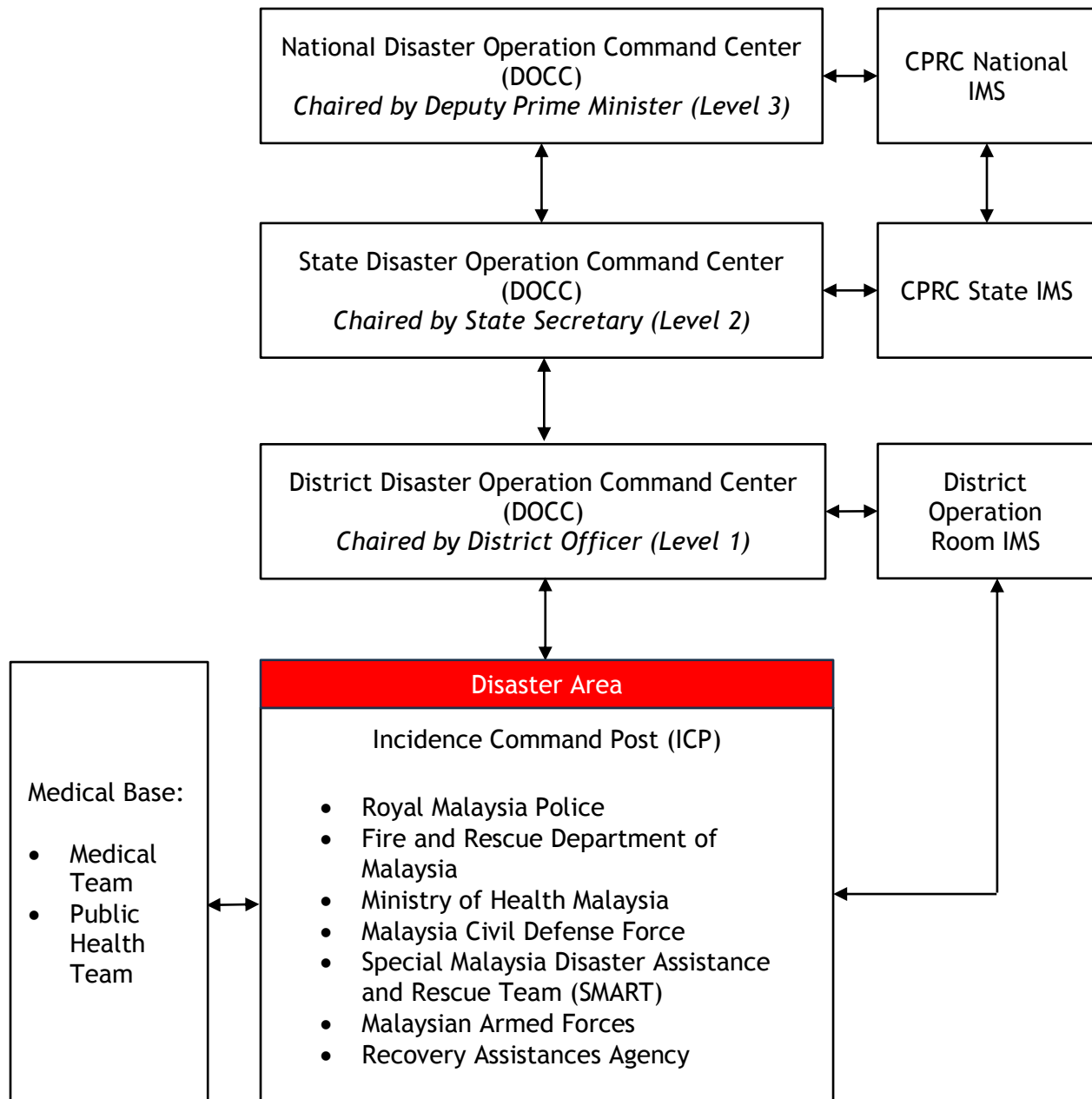
Figure 5.5 Framework of DOCE Communication During Response Mode

5.6   Deactivation

The function of the CPRC and IMS will be deactivated under the following conditions:

i.   When the MOH declares that the DOCE event is over.

ii.   The scope or scale of the incident has been reduced, and requirements can be managed without PHEOC capabilities and resources.

iii.   Response and/ or recovery IAP objectives have been satisfied.

iv.   The epidemic curve of confirmed cases has peaked and shows continuous deceleration for an extended timeframe.

v.   There is no evidence of sustained or efficient human-to-human transmission for a predetermined timeframe.

vi.   Media attention shows a continuous downward trend in news and social media for a two-week timeframe.

vii.   Cases have minimal impacts on national, social, business, or economic affairs.

5.7   After-Action Review

The After-Action Review (AAR) requires CPRC members, key stakeholders, and decision-makers to systematically and critically analyze actions taken (or not taken) to promote strengths and address challenges, thereby better informing future responses. It is best conducted immediately or at the close of the event, when responders are present and still have a clear memory of what occurred.

After the AAR and the Improvement Plan, the Plans Section will write a report that serves multiple purposes, namely:

i.   Records what occurred during the exercise (based on response evaluations, such as the AAR).

ii.   Provides feedback on the achievement of capabilities and associated activities.

iii.   Suggests recommendations for improved preparedness.

iv.   Establishes consensus and buy-in on next steps.

The suggested format for the AAR and Improvement Plan is in **Annex 4** and **Annex 5**. The corrective actions captured in the AAR/ Improvement Plan should be tracked and continually reported on. Each corrective action should be assigned to the organization best qualified to execute it. It is important that agencies are assigned corrective actions that they have the authority to carry out.

5.8   Operations Section

The Operations Section is responsible for acting based on the IAP and conducting direct response activities for the event, such as informing, coordinating, and enabling daily response activities. This section is also responsible for the management and identification of IMS staffing needs, including staff required for field deployment (Source: WHO Framework for a PHEOC). The structure should be modular and scalable, capable of being elaborated on, expanded, and adapted to particular types of emergencies, from the tactical to the strategic level.

5.8.1 Levels of Operations

The Operations Section functions at the national and sub-national (state/ district) levels. At the national level, Operations Section is responsible for coordination, technical guidance, and decision-making for all response operations. At the state and district levels, Operations Section is responsible for managing direct response activities for the incident or event. An example of the Operations Section structure at the state and district levels is shown in Figure 5.6.
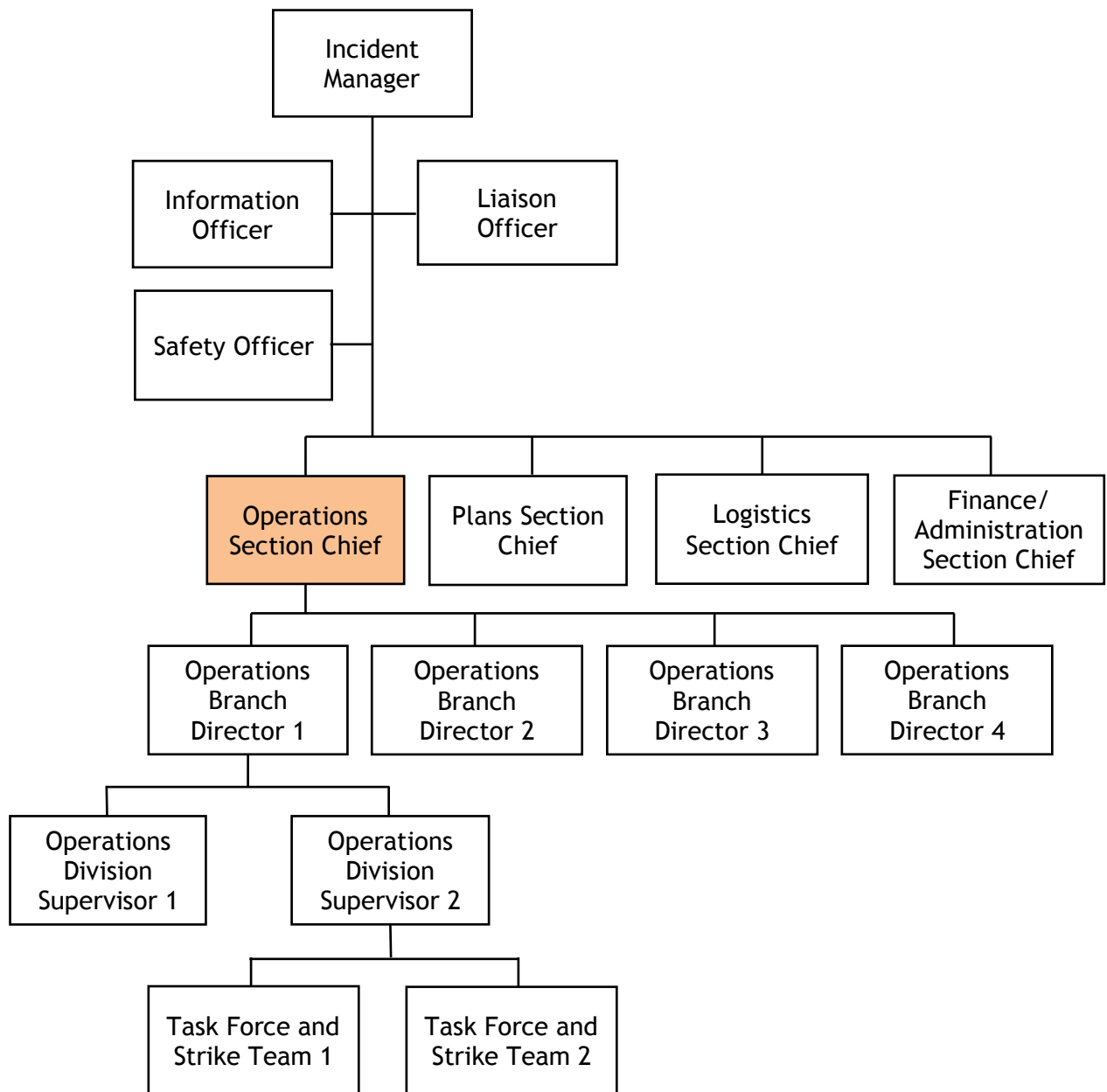
Figure 5.6 Operations Section Structure at the State and District Level

Operations section is designated to:

     i.   Put in motion the strategies and plans set out in the IAP.

    ii.   Establish tactics and direct operational resources to achieve incident response objectives.

   iii.   Inform, coordinate, and enable daily response activities.

   iv.   Ensure that the Emergency Response Plan (ERP) or hazard-specific plans and strategic plans are both operational and executable.

    v.   Develop emergency operations plans, policies, and procedures.

   vi.   Monitor, track, and distribute necessary internal and external Mission Assignments (MAs).

  vii.   Develop, monitor, and track Requests for Information (RFIs) and Requests for Assistance (RFAs).

 viii.   Collaborate across ministries and with other partners.

   ix.   Provide coordination and technical guidance for response operations.

5.8.2   Functions within the Operations Section

Table 5.1 Functions within the Operations Section

FUNCTION	RESPONSIBILITY
Operations Section Chief	a) Manage and supervise the implementation of strategies and tactical resources. b) Accountable to the IMS core committee.
Watch Staffs	a) Monitor and triage incoming information. b) Compile Essential Elements of Information (EEI). c) Distribute reports (SPOTREPs and SITREPs). d) Ensure that the PHEOC has supplies and that equipment is operational.
Rapid Response Team	a) A technical, multi-disciplinary team that is readily available for quick mobilization and deployment. b) Responds to health-related events and supports emergency operations as needed.
Others	a) Laboratory Team: • Specimen collection, testing, and communication of results. b) Mental Health Psychosocial Support (MHPSS).

Sample of IMS Structure for VPD Outbreak is as shown in Figure 5.7.
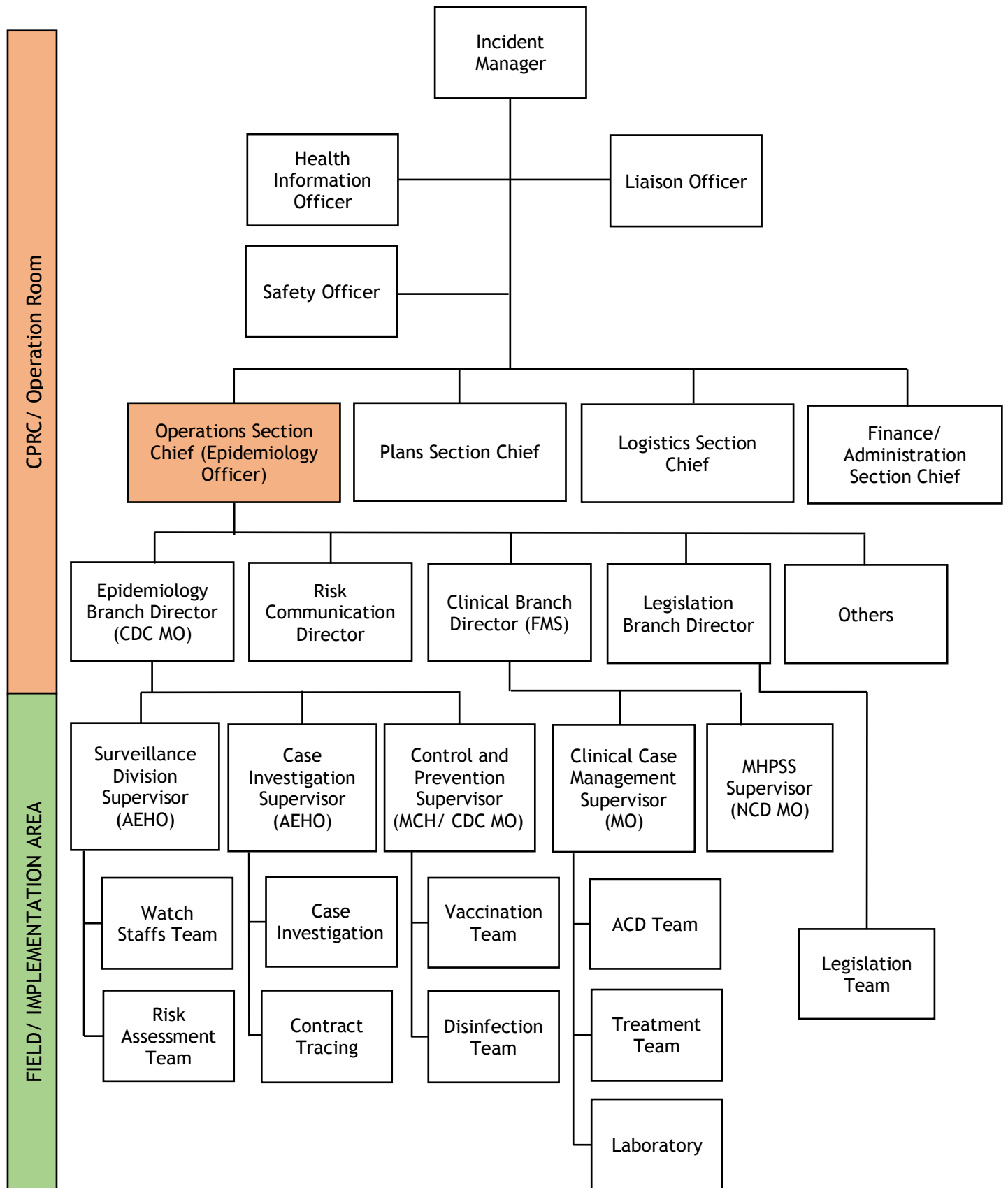
Figure 5.7 Example of IMS Structure for VPD Outbreak

CHAPTER 6

RISK COMMUNICATION

CHAPTER 6

RISK COMMUNICATION

6.1 Introduction to Risk Communication

Risk communication is a key strategy for managing the risks associated with public health concerns or security, whether they arise from natural or man-made disasters, emerging and re-emerging diseases, mass casualty incidents, or all hazards, including CBRNe. Risk communication has played a vital role in disseminating risk-related health messages during outbreaks such as H1N1, MERS-CoV, malaria, rabies, and other hazard threats. Additionally, it is also applied during crises such as major floods, tsunamis, earthquakes, and public demonstrations.

Effective risk communication confers confidence and builds trust in the authorities. It improves the willingness of populations to take action based on informed decisions and comply with recommended measures. Furthermore, it hastens the return to normalcy after a crisis peak. A favorable public attitude allows those engaged in the technical response to concentrate on the rapid containment of the incident.

6.2 Crisis Emergency Risk Communication (CERC)

CERC consists all elements of crisis communication and risk communication as applied during an emergency response. Decisions made under CERC must be prompt to provide information that helps stakeholders and the public make the best possible decisions regarding their well-being. Typically, a DOCE event that necessitates the application of CERC is an incident that:

    i.   Occurs unexpectedly.

    ii.   May be beyond the organization's control.

    iii.   Requires an immediate response.

    iv.   May cause harm to the organization's reputation, image, or viability.

6.2.1 CERC Principles

There are six (6) principles in CERC:

    i.   Be first - Provide information as soon as possible. If information is unavailable, explain how you are working to get it.

    ii.   Be right - Give facts in brief messages; tell people what and when you know, what you don't know, and what is being done to find more information.

    iii.   Be credible - Tell the truth.

    iv.   Express empathy - Acknowledge suffering in words.

    v.   Promote action - Empower people's participation to promote health action and reduce anxiety.

    vi.   Show respect - Showing respect to people is important when they feel vulnerable.

6.2.2 Crisis Emergency Risk Communication Plan

    i. Should be developed with realistic expectations in mind and consider the possibility of a worst-case scenario.

    ii. Should be fully integrated into the overall emergency-response plan for the organization.

    iii. Should address all roles, lines of responsibility, and resources you can reasonably expect to encounter as you provide information to the public, media, and partners during a public health emergency.

    iv. Obtain signed endorsements from senior leadership; senior leadership must support the emergency risk communication planning process.

    v. Designate responsibilities for the release of information. Decide who determines when to share information via the media, social media, and partner channels.

    vi. Information verification and clearance procedures; specify who must review information before it is released from the organization.

    vii. Have all contact lists, with after-hour numbers, in place. The list includes key leaders and representatives of stakeholder groups, partners, and the media.

6.2.3 Steps for CERC

There are four (4) steps in an ongoing cycle for informing the public and additional audiences during an incident:

Step 1: Gather Information

Information is collected from the IM and General Staff, which are a source of ongoing, official information on the response effort and other sources such as:

    i. Response agencies.

    ii. Media.

    iii. Calls from public and elected officials.

    iv. Technical specialists.

    v. Other agencies such as the Meteorological Department and the Environmental Department.

    vi. Emergency response guidelines.

Step 2: Verify Information

Verify the accuracy of the information collected by consulting with:

 i. CPRC sources and technical specialists.

 ii. Ensuring that information is consistent and accurate, striving toward accessibility to all affected by the incident.

 iii. Other PIOs: Compare notes, especially with the lead PIO and PIOs who are liaisons to the various assistance programs or response/ recovery partners, to verify the accuracy of information.

Step 3: Coordination of Information (Internal)

Coordination includes, but is not limited to:

 i. Coordinating between IM and General Staff.

 ii. Coordinating between CPRC participants.

 iii. Obtaining approval from appropriate authorities before information is disseminated.

Initial information should include:

 i. Actions the public should take.

 ii. Impact of the incident.

 iii. Actions the response agencies are taking.

 iv. Actions businesses and industries should take.

 v. A summary of the incident.

Step 4: Dissemination of Information (External)

Information should be disseminated to:

    i.   Disaster victims.

    ii.   Outside general public.

    iii.   Affected jurisdictions.

    iv.   Community leaders.

    v.   Private sector.

    vi.   Media.

    vii.   NGOs.

    viii.   Response and recovery organizations [e.g., Urban Search and Rescue (USAR), utilities].

    ix.   Volunteer groups.

    x.   Other impacted groups.

PIOs also need to monitor the media to verify that the public and officials are getting accurate and complete information through the media in a timely manner.

Inaccuracies and rumors that affect health and safety should be addressed immediately with the media, and correct information should be distributed through the media or other means.

6.3   Stages of Risk Communication

There are four (4) stages for risk communication response: preparedness, the initial response within 48 hours, the maintenance stage, and finally, the recovery stage. Some of the responses taken are interrelated between these stages.

Preparedness

Recovery

Initial Response First 48 hours

Response Maintenance
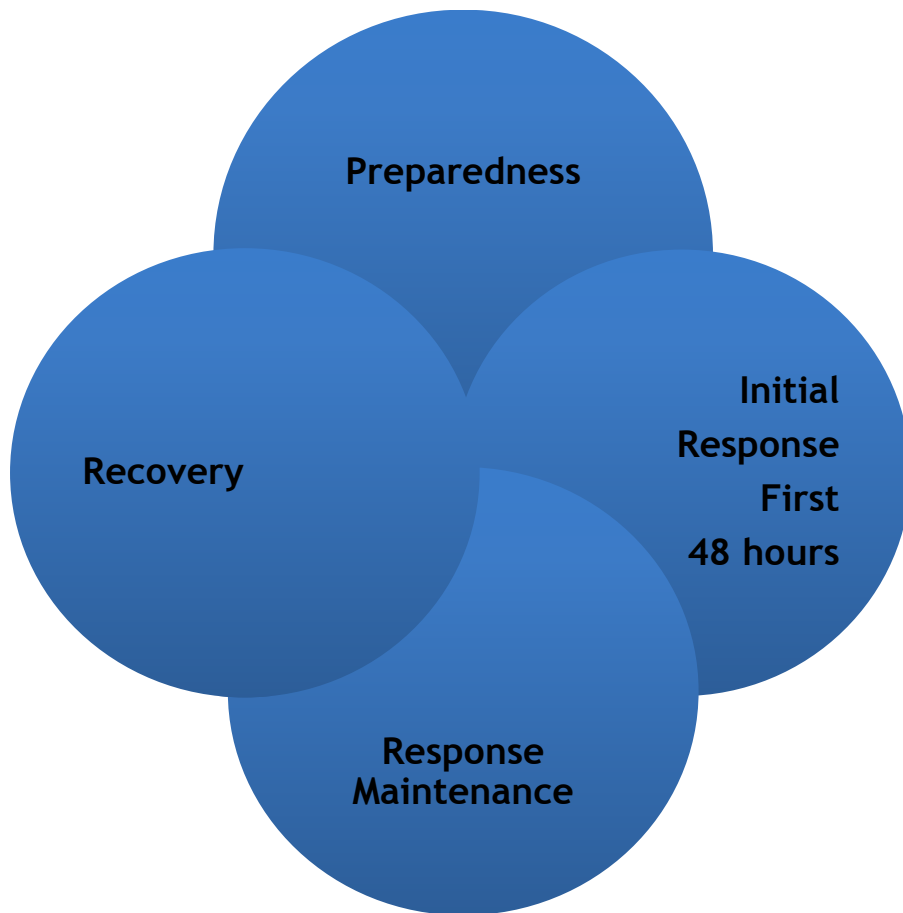
Figure 6.1 Stages of Risk Communication

6.3.1   Preparedness Phase

Risk communication during preparedness focuses on creating awareness among various audiences, including the public, responders, staff, and special target groups depending on the hazard (s). The objective of risk communication during preparedness is to build the capacity and capability of all relevant stakeholders in managing a crisis or event. Operational risk communication in the preparedness phase is crucial, and the organization needs to have the following:

Establishment of Risk Communication Plan:

    i.   Simulation exercises to be conducted to test the plan.

    ii.   Improvement of the risk communication plan based on the AAR.

    iii.   Organize official and informal meetings to establish or enhance networking with relevant organizations.

    iv.   Risk communication training to increase knowledge and competency.

    v.   Establishment of a network to prepare for risk communication.

    vi.   Identify spokespersons and resources.

    vii.   Develop strategies to train and refine plans and messages.

    viii.   Foster alliances with partners and stakeholders to ensure that officials and experts speak with one voice and that resources are available and shared.

    ix.   Develop systems and redundancies such as hotlines, joint information centres, and websites.

6.3.2   Initial Response First 48 Hours

The aim of risk communication response within 48 hours is to manage the crisis/ event and to act quickly in order to address stakeholder needs/ concerns as well as to allay anxiety, especially among the affected population.

6.3.2.1 At the Ministry of Health Level

    i.   The PIO and JIC team will go through all the issues received from various channels daily.

        The issues will be analyzed, categorized, and determined, either to develop new messages or improve existing ones, develop follow-up news releases, and manage rumor control.

    ii.   Monitor and analyze public opinions daily via various channels as below:

        a.   Phone lines and Hotlines.
        b.   Social media – 24 hours.
        c.   Emails.
        d.   Newspapers.
        e.   Rumors.

iii. Share the result with relevant stakeholders:

   a. To the public using fact sheets, press releases, infographics through social media, press conferences, town hall sessions, and interpersonal communication (face-to-face, focus group discussions, talks, and announcements).
   b. To internal and external stakeholders locally at all levels through specific committees and written documents [e.g., alert letters, teleconferences (TC), video conferences (VC), etc.].
   c. To international bodies through the IHR National Focal Point, if indicated.

iv. Other roles of PIO:

   a. Obtain policy guidance and approval from the IM regarding all information to be released.
   b. Advise the IM of all unusual requests for information and critical or unfavorable media comments.
   c. Develop and publish a media briefing schedule, including location, format, preparation, and distribution of handout materials.
   d. Establish a media briefing area.
   e. Prepare media briefings for elected officials and other leaders.
   f. Maintain up-to-date status boards and other references for the media.
   g. Establish a call centre to manage public inquiries and provide emergency support information.
   h. Develop talking points or scripts for the call takers of the call centre.
   i. Interact with and coordinate with other CPRCs (national, state), District Operations Room, other agencies' EOCs, and/or JICs to share information.
   j. Establish distribution lists.
   k. Ensure that announcements, emergency information, and materials are translated and prepared for special populations (non-Malay speaking, hearing impaired, etc.).
   l. Ensure that file copies are maintained of all information released.
   m. Provide copies of all media releases to the IM.
   n. Conduct shift change briefings in detail, ensuring that current activities are identified and follow-up requirements are known.

6.3.2.2 At the Sate or District Level

i. Monitor and analyze public opinions daily via various channels:

   a. Phone lines and Hotlines.
   b. Social media – 24 hours.
   c. Emails.
   d. Newspapers.
   e. Rumor.

ii. Share the result with relevant stakeholders:

   a. To the public using flyers, pamphlets, media, town hall sessions, and interpersonal communication (face-to-face, focus group discussions , talks, and announcements).

   b. To internal and external stakeholders locally at all levels through government and private health facilities, specific committees, and written documents (e.g., alert letters, TC, VC, etc.).

6.3.3   Maintenance Phase

The maintenance phase of risk communication continues to assist the public in understanding the risk of the crisis/ event and to empower them to act on informed decisions. The frequency of activities will decrease; for example, press statements that were released daily will change to a weekly basis.

During this phase, continue providing background information to those who need it. Work to answer questions such as:

     i.   How could this happen?

    ii.   When has this happened before?

   iii.   What processes can be put in place so that this does not happen again?

   iv.   What will it take for me to be all right in the long-term?

    v.   What does it take to recover?

The aim of the maintenance phase is to generate support for response and recovery plans, listen to stakeholder and audience feedback, and correct any misinformation.

6.3.4   Recovery Phase

    i.   Conduct AAR by evaluating and analyzing risk communication responses in terms of:
       a. Message content.
       b. Channels of delivery.
       c. Public perception – through surveys, from the public's input via hotlines, social media etc.

    ii.   Documentation of risk communication during the event.

   iii.   Preparation of final news releases and advising media representatives of contacts for follow-up information.

   iv.   Improvement of public response through education for future emergencies.

    v.   Persuasion of the public to support public policy and resource allocation to address the problem.

   vi.   Promotion of the activities and capabilities of the agency, helping to reinforce the identity of the agency as capable and responsive.

6.4 Joint Information System (JIS) and Joint Information Centre (JIC)

6.4.1 Joint Information System (JIS)

The JIS provides the mechanism to organize, integrate, and coordinate information to ensure timely, accurate, accessible, and consistent messaging across multiple jurisdictions and/ or disciplines, including the private sector and NGOs. It includes the plans, protocols, procedures, and structures used to provide information to:

     i.   General public.

     ii.   Disaster victims.

     iii.   Affected jurisdictions.

     iv.   Elected officials.

     v.   Community leaders.

     vi.   Private sector.

     vii.   Media.

     viii.   NGOs.

     ix.   Response and recovery organizations (e.g., urban search and rescue, utilities).

     x.   Volunteer groups.

     xi.   International interests (e.g., international media and donations).

     xii.   Other impacted groups.

The critical supporting elements for JIS include the following:

     i.   Gathering, verifying, coordinating, and disseminating consistent messages;

     ii.   Interagency coordination and integration;

     iii.   Support for decision-makers; and

     iv.   Flexibility, modularity, and adaptability.

The release of information messages needs to be coordinated to ensure message consistency.

6.4.2   Joint Information Centre (JIC)

The JIC is a central location that facilitates the operation of the JIS, ensuring coordination of public information during incidents that involve multiple agencies and/ or jurisdictions. In the early stages of response to an incident, the PIO shall consult with the IM regarding the opening of a JIC. The IM shall retain the authority to order the opening of a JIC, although the lead PIO may recommend it when it is appropriate.

    i.   JICs are established:

        a.   At the direction of the IM at various levels of government.
        b.   At predetermined or incident-specific sites.
        c.   As components of National, State, District, or local Multiagency Coordination Systems (MACS).

    ii.   JICs are led by the PIO:

        a.   Responsible for managing the JIC.
        b.   Serves as advisor to the IM.
        c.   Provides overall communication policy direction.
        d.   Recommends and develops strategy for messages, briefings, and news releases.
        e.   Obtains approval from those in authority before releases are made.
        f.   Conducts JIS/ JIC briefings (live or virtual) to update staff regarding Incident Command activities.

    iii.   JICs may be staffed:

        a.   By representatives from all agencies and jurisdictions involved in the response and recovery operation; and
        b.   Through intrastate and interstate mutual aid agreements, which could serve as a supplemental source or vehicle for bringing trained personnel together to support a JIC.

The JIC should be located close to the best sources of information, such as a CPRC or District OR, without compromising the safety or security of the personnel staffing the facility.

The JIC location can be flexible and adaptable enough to accommodate virtual or multiple JIC locations, as required. The following table (Table 6.1) provides a description of different types of JICs:

Table 6.1 Types of Joint Information Centres (JICs)

Incident	Typically, an incident-specific JIC is established at a single, on-scene location in coordination with National, State, District, and local agencies, if the situation warrants. It provides easy media access, which is paramount to success. This is a typical JIC.
Virtual	A virtual JIC is established when physical co-location is not feasible. It connects PIOs through email, cell and landline phones, faxes, video teleconferencing, web-based information systems, and more. For a pandemic incident, where PIOs at different locations communicate and coordinate public information electronically, it may be appropriate to establish a virtual JIC.
Satellite	A satellite JIC is smaller in scale than other JICs. It is established primarily to support the incident JIC and operates under its direction. These subordinate JICs are typically located closer to the scene.
Area	An area JIC supports multiple-incident Incident Command System structures that are spread over a wide geographic area. It is typically located near the largest media market and can be established on a local, state, or multi-state basis. For example, multiple states experiencing flood damage may participate in an area JIC.
Support	A national JIC is established when an incident requires federal coordination and is expected to be of long duration (weeks or months) or when the incident affects a large area of the country. A national JIC is staffed by numerous departments and agencies.
National	A national JIC is established when an incident requires federal coordination and is expected to be of long duration (weeks or months) or when the incident affects a large area of the country. A national JIC is staffed by numerous departments and/or agencies.

iv. Roles and responsibilities

The following are roles and responsibilities of a JIC.

a. JIC Planning
The JIC integrates incident information and public affairs to provide consistent, coordinated, accurate, accessible, timely, and complete information during crisis or incident operations. It is advisable to have location(s) identified that could be used as a JIC before an incident occurs, ideally within the CPRC. The PIO should develop standard operating procedures for the actual use of the JIC, as well as for the equipment and staff that may be needed.

b. Contact lists
PIOs need to review and update all contact lists (e.g., media, PIOs, and other agencies) every six months. These lists should include basic information such as telephone numbers (e.g., office, home, mobile), fax numbers, email addresses, and websites.

c. Tools and resources
It is important for the PIO to have tools and resources available for use during an incident, such as office supplies, a laptop computer, a portable printer, maps, a fax machine, PIO and other emergency operations plans, contact lists, and pre-scripted messages and template releases.

d. Information Gathering
- Response Partners – Coordination with supporting response agencies and their PIOs at EOCs, incident command posts, and other locations to gather information on the incident.
- Media Monitoring Analysis/ Rapid Response – Entails reviewing media reports for accuracy, content, and possible response.
- Research and Writing.

e. Information Dissemination
- Briefing/ Special Events – Entails handling events such as news conferences, media briefings, Very Important Person (VIP) visits, and tours for senior officials of affected areas.
- Media Relations:
  - News Desk – Serves as the primary point of contact for the media.
  - Spokesperson – Prepares and conducts regular news briefings and conferences.

f. Operations Support
- Special Needs/ Multilingual – Entails providing language translation and other services to ensure appropriate and timely information reaches those in the affected areas with special needs.
- Facility Support – Coordinates with the JIC Facility Liaison to maintain and support the JIC operations concerning the facility and resources.

g. Liaison
- Provides a coordinated two-way communication link with key program areas and other entities involved in the response and recovery operation (e.g., elected officials, community leaders, VIPs, and other governmental and NGO support agencies).

     v.   Demobilizing the Joint Information Centre

When operational activities begin to decline, public information functions will be transferred back to responsible jurisdictions and agencies. The decision to transition will be made by the IM in consultation with the lead PIO and other Section Chiefs.

The major steps the PIO would take in deactivating a JIC:

a. Prepare a comprehensive deactivation news release for lead-agency headquarters approval and distribution.
b. Notify community, media, agency communications managers and local officials about closing and provide regional contact information.
c. Provide passing over notes to communication managers whose organizations will assume responsibility for ongoing information.
d. Complete an AAR report and participate in evaluation discussions.
e. Return borrowed equipment and supplies.
f. Inventory equipment and supplies; and replenish Kits as necessary.

The Rapid Assessment Team (RAT) is a team mobilized from the nearest available District Health Office (DHO) to the incident site immediately upon receiving an alert in order to assess the situation and provide crucial information for immediate response planning.

The RAT needs to be set up prior to a DOCE event at all levels (district, state, and national). The RAT should consist of a multidisciplinary team of trained personnel from various ranges of expertise. The selection of team members will be determined by the following criteria:

i. Familiarity with the locality/ geographical area or population effected.

ii. Knowledge of and experience with the type of DOCE.

iii. Analytical skills and qualities of personnel.

When deployed during Passive Mode in alert situation, information from the RATs flows from the field back to the CPRC to foster situational awareness in support of decision making.

CHAPTER 7

TRAINING AND EXERCISES

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Training and exercises are essential for the functioning of the CPRC. This ensures that all public health events are responded to effectively. The staff involved in the management of the CPRC must be equipped with the skill set, orientation, and training specific to the CPRC's functions, roles, and procedures. Guidelines and SOPs can be further improved based on experiences gained during the exercises.

7.1   Types of Training

Examples of training modules that can be offered are as follows:

      i.   Training for specific functions within CPRC.

          a.   Incident Management System (IMS).
          b.   Emergency Medical Team [RAT/ RRT, Medical Emergency Response Team (MERT), and MHPSS].
          c.   Human Resource mobilization.

     ii.   Training in the field of epidemiology.

    iii.   Training in conducting risk assessments and carrying out exercises.

    iv.   Training on Risk communication.

     v.   Training in Information and Communication Technology (ICT) skills.

    vi.   Training in data analytics.

   vii.   Training in Geographic Information Systems (GIS).

  viii.   Training for SMEs in related subjects.

The types of training methods that can be conducted are:

      i.   Seminar

          a.   Informal discussions in a group setting using various presentation methods.
          b.   Provide an overview of new or current plans, resources, strategies, concepts, or ideas.
          c.   Involves single or multiple agencies.

     ii.   Workshop

          a.   Informal discussions in a group setting using various presentation methods, which may include group activities.
          b.   Aims to achieve a specific goal or build a product, such as standard operating procedures, policies, or plans.
          c.   Involves single or multiple agencies.

7.2   Simulation Exercises

Exercises are an important training tool for validating existing SOPs and guidelines. Additionally, they ensure the optimal functioning of the CPRC on a day-to-day basis. Categories of exercises can be divided into:

  i. Discussion based exercise:

   a. Tabletop.
   b. Indoor simulation of operations; may be in the form of games.
   c. Consists of scenarios and theoretical discussions of possible actions.
   d. Explores the decision-making process and examines the consequences of those decisions.
   e. Single agency or cross-functional.

  ii. Operation based exercise:

   a. Drill.
   b. It is a coordinated, supervised exercise activity normally used to validate a single specific operation or function in a repeated manner.
   c. Aims to practice and perfect one small part of a response plan.
   d. Personnel from the single agency for the function being tested.
   e. Should be as realistic as possible in employing any equipment or apparatus necessary for that part.

  iii. Functional:

   a. It is a real-time, fully simulated interactive exercise that tests the capability of an organization to respond to a simulated event.
   b. Tests multiple functions of the organization's operational plan.
   c. Focuses on the coordination, integration, and interaction of an organization's policies, procedures, roles, and responsibilities before, during, or after the simulated event.

  iv. Full Scale (Field Exercise):

   a. A realistic event with all personnel gathering at the assigned site, which typically involves multiple agencies.
   b. Requires enactment, where actions at the scene serve as input to the CPRC and are conducted in real-time.
   c. Validates plans, policies, procedures, and cooperative agreements developed in previous exercises through actual implementation and execution.
   d. Includes actual mobilization of resources and the conduct of operations.
   e. Utilizes actual facilities and resources that would be used.
   f. Should test and evaluate most functions of the emergency management plan or operational plan.

ANNEXES

Annex 1   CPRC Infrastructure

The table gives examples of items required for CPRC systems and infrastructure at basic, general, and optimal evolution levels of the CPRC and for different emergency management phases.

Legend:
B=Basic, G=General, O=Optimal, S=Specialized, M=Mitigation, P=Preparedness, R=Response, A=Throughout all phases

Items	Permanent/ Static/ Portable/ Field CPRC	OR	CPRC
1. ICT hardware, services and security			
1.1 Office equipment	Printer	B	B
	Writing board	B	B
	Copier	B	B
	Fax (if applicable)	B	B
	Scanner	B	B
	Multi-functional printer (as alternative to the above)	B	B
	Plotter	O	O
	Multi-line fax system (if applicable)	O	O
	Supplies for office equipment	B	B
1.2 Telecommunication equipment and services	Radio base station	G	G
	Handheld portable radios	G	G
	Satellite data communication (primary or backup)	O	O
	Satellite telephones	O	G
	Public Switched Telephone Network (PSTN)	B	O
	Basic internet connectivity	B	B
	High speed internet connectivity	G	G
	Audio-visual multi-point conferencing bridge or equivalent services	G	O
	Repeater/ tactical communication bridge	S	S
	Permanent network connections between sites and centres located outside CPRC/ Operation Rooms (if applicable)	O	O
	Private Automatic Branch Exchange (PABX)	G	O
	Telephone/ video conferencing	B	G
	Web conferencing	G	G
	Messaging system (telephone, instant messaging)	G	G
	Email system/ services	B	B
	Video/ Voice over Internet Protocol (VoIP)	G	O
	Integrated Communications Control System (ICCS) (radio and telephone)	S	S

Items	Permanent/ Static/ Portable/ Field CPRC	OR	CPRC
1.3 Network infrastructure	Network devices (switch, router)	B	B
	Local Area Network (LAN)	B	O
	Wireless network	G	G
	Information broadcast and exchange	O	O
	Network redundancy	O	O
	Network virtualization/ Software-Defined Networks (SDN)	S	S
1.4 Technological infrastructure	Computers (desktop/ laptop/ tablet)	B	B
	Data storage (physical/ virtual)	B	B
	Servers (physical/ virtual)	G	G
	Cable/ satellite/ internet television	G	G
	DVD/ Blu-Ray player/ recorder	B	G
	Large video display/ video wall/ projector	B	B
	Video and audio matrix switch	G	O
	Central (remote) control system	O	O
	Media streaming	O	O
	Field substance detectors	S	S
	Audio system	B	B
	Wireless sensor networks	S	S
	Radio Frequency Identification (RFID)	S	S
	GPS devices	S	G
	Remote imaging system	S	S
	Digital recorder	O	O
1.5 IT security	Firewall	B	B
	Encryption	B	B
	Virtual Private Networks (VPN)	G	G
	Anti-virus/ malware	B	B
	Vulnerability scanning	G	G
	Local data redundancy	B	B
	Network data storage/ redundancy	G	O
	Cold off-site backup strategy	B	B
	Warm off-site backup strategy	G	G
	Hot off-site backup strategy	O	O
	Rapid service recovery	O	O
	System administration security	G	G

Items	Permanent/ Static/ Portable/ Field CPRC	OR	CPRC
2. Information management software			
2.1 Functions	Predictive analysis and modelling	GA	GA
	Surveillance (health/ all hazard), mapping, analytics, and statistics	GA	GA
	Alert/ early warning	BP	BP
	Monitoring core indicators	BA	BA
	Health resources availability mapping	OA	OA
	Planning	BP	BP
	Emergency call-taking and dispatch	GA	GA
	Emergency evacuation system	SR	SR
	Risk management	GA	SA
	Data/ situation analytics	GR	GR
	Tasking and on-scene command	BA	BA
	Deployment/ post-deployment briefing/ debriefing	GA	GA
	Deployment briefing/ debriefing	OR	OR
	Contact management	BA	BA
	Action summary	BA	BA
	Activity logging	BA	BA
	Collaboration platform	GR	GR
	Data management	BA	BA
	Document management	BA	BA
	Training	GA	GA
	Reporting/ visualization	BA	BA
	Geographic information system	GA	GA
	Registering and mapping partners	GPR	GPR
	Public communication	BA	GA
3. Infrastructure (facilities, security, furniture)			
3.1 Premises support	Dedicated building in proximity to decision makers	O	O
	Multi-purpose space converted within reasonable time frame (e.g. one hour)	B	B
	Dedicated room/ suites	G	G
	Emergency service call room	B	B
	Separate meeting rooms for priority discussion	G	O
	Conference room	G	O
	Surveillance room	G	O
	Operations room	G	G
	Briefing space for visitors and media	G	O
	Public Information Office (PIO)/ Joint Information Centre (JIC) and media	G	G
	Room to house external and non-jurisdictional entities	O	O
	Communication equipment room	G	O
	Separate communication centre (Emergency call room)	O	O

Items	Permanent/ Static/ Portable/ Field CPRC	OR	CPRC
	Storage room	G	G
	Cloakroom	O	O
	Medical treatment space	O	O
	Break and recreational space	O	O
	Staging area for transport (air or land)	O	O
	Access to personal hygiene facility	B	B
	Personal hygiene (shower and laundry) and related supplies	G	O
	First aid	G	G
	Water and food availability and storage	B	B
	Standalone water supply	S	S
	Lighting	B	B
	Mains electricity power supply	B	B
	Backup diesel generator	B	B
	Uninterruptible power system (potentially with filtering) capability)	B	G
	Broadcasting system	G	G
	General environment control (air conditioning, ventilation, lighting, etc.)	G	O
	Stand-alone HVAC (Heating, Ventilation and Air Conditioning) system	O	O
	Cabling system infrastructure	B	O
	Acoustic treatment	O	O
	Built-in levelling system	S	G
	Light tower/ remote area lighting system	S	O
	Emergency alarm system	G	G
	Weather-resistant fold-out shelter system	S	B
	Mobile signal blocker/ booster	S	S
	Dedicated space for ICT support	G	O
3.2 Furniture	Workstation with space for computer, display, key-boards, mouse, telephone, stationery, etc. Retract-able arm stand for display may be considered	B	B
	Chairs	B	B
	Console with adjustable viewing angles and sight lines	G	G
	Easy access to personal power outlets	B	B
	360 degree chair rotation	G	G
	Pneumatic seat height	G	G
	Backrest angle/ height/ depth	G	G
	Ergonomic and modular design of console	O	O
	Dimmable workstation task lighting	O	O
	Seat angle and tension control	O	O
	Seat lumbar pump	O	O
	Seat armrest height/ rotation/ swivel/ width	O	O
	Seat headrest height/ depth	O	O

Items	Permanent/ Static/ Portable/ Field CPRC	OR	CPRC
3.3 Premisessecurity	Surveillance/ Integrated Video Management System (IVMS)	G	G
	Perimeter protection	G	G
	Dangerous goods scanning	G	G
	Access control	G	G
	Flood prevention	G	G
	Disaster protection (natural or human-incurred)	B	B
	Public address system	G	G
	Fire protection	B	B
4. Training and exercises for ICT and infrastructure			
4.1	Improve relevant ICT skills of the CPRC/ Operation Room users	B	G
4.2	Specialized training for ICT support staff	G	G
4.3	Induction for CPRC/ Operation Room users on facility utilization	B	G
4.4	Simulation involving use of facilities and ICT infra-structure	G	O
4.5	Testing the interoperability of CPRC/ Operation Room information systems with other sectors	G	O
4.6	Evaluate readiness based on results of simulation(s)	O	O
5. Human resource needs for ICT and infrastructure			
5.1	CPRC/ Operation Room facility manager	G	O
5.2	Information management	G	G
5.3	ICT support	B	B
5.4	GIS specialist	O	O
6. Support and maintenance			
6.1	Hardware support and maintenance	B	B
6.2	Software support and maintenance	B	B
6.3	Maintenance of premises	B	B

Annex 2   Incident Action Plan (IAP)

Incident Name and Incident Action Plan Version			
Incident Name:	Operational Period (Date/ Time):	IAP Type:	
Functional IMS Position	**Name**	**Email**	**Phone No.**
IMS Management Leadership and Staff			
Incident Manager			
Deputy Incident Manager			
Core IMS Functions			
Operations Section			
Plans Section			
Logistics Section			
Finance and Administration Section			
Expanded IMS Functions			
Liaison Officer			
Safety Officer			
Public Information Officer			
Response Branches Operations			
Current Operations Branch			
Laboratory Branch			
Case Management Branch			
Epidemiology Branch			
Situation/ Actions for Current Operational Period			
Background:			

Situation/ Actions for Current Operational Period (continued)

Current Activities:

Ministry/ Department Response Mission:

Planning Assumptions (Evidence based facts and assumptions in the context of developing the plan)

Response Objectives (SMART: Specific, Measurable, Achievable, Realistic, Timeframe)

Sections/ Functional Area Operational Objectives
(Based on the Incident Management System Functions)

Triggers That May Increase the Response and/ or Raise the Response Level

Triggers That May Increase the Response Tempo and/ or Raise the Response

Triggers That May Return Centralized Response Operations to a Program Management Level

Pending Briefings for Operational Period

Scheduled Meetings for the Operational Period

Safety and Security Concerns

Place a visual depiction of the incident location or locations

Current Organization

Annex 3   SPOTREP and SITREP

Reports Generated by CPRC:

Type of Report	Spot Reports (SPOTREP)	Situation Reports (SITREP)
Definition	A short narrative report for only critical, pertinent information about an incident.	A priority message that provides a summary of a situation to designated decision makers.
Format	WhatsApp message template.	Health Related Event Reporting Format to CPRC.
Information	Unverified.	Verified.
	Within 1 hour of event notification.	Within 4 hours of initial event notification and on a daily basis henceforth.
	CPRC Officer	Subject Matter Expert (SME)
	- Details of incident: Date/ Time, Incident Title or Name. - Information Source. - Description of Incident: Narration of who, what, when, where, why, and how. - Ministry Actions: Includes actions taken and/or not taken, next steps, notifications, health and safety actions, follow-up requirements, etc. - Sensitive information: If information is sensitive in nature, describe information control, release, or dissemination restrictions. - Submitter: Name, Duty/ Position, Contact Number, Email Address.	- Details of incidents: Summary of verified incidents during the Watch Mode. - Status update: A status update of the current situation, such as the status of resources. - Reporting period progress: A description of significant activities accomplished towards meeting operational objectives during the reporting period. - Public risk management messages. - Submitter: Name, Duty/ Position, Contact Number, Email Address.

Annex 4　　After-Action Review

The suggested AAR format includes:

Format	Contents
Title page	Signed by the Incident Manager.
Executive Summary	This section is a one to two-page synopsis highlighting the incident scope, successes, and areas for improvement.
Executive Overview	This section provides background information on the incident date and time, location, type, hazard, participating organizations, and evaluation methodology.
Exercise Goals and Objectives	The section lists the IAP identified and achieved Response Goals and Section/Functional Operational Objectives.
Analysis of Capabilities Demonstrated	This section provides an analysis of demonstrated capabilities during the incident. The analysis should include a detailed assessment of the organization's ability to perform activities and tasks associated with these capabilities.
Conclusion	This section summarizes the key findings of the report and describes the implication of these findings on future action.

Annex 5   Improvement Plan

This section may be an appendix of the After-Action Review (AAR) Report. The Improvement Plan matrix lists each area for improvement that was identified by evaluators in the AAR.

Tasks	Recommendations	Improvement Actions	Responsible Party	Due Date

Annex 6   Resource Typing and Inventory - Category: Vehicles

Kind	Type	Vehicle Number	Engine capacity (cc)	Location	Status	Remarks
Ambulance	Type A					
	Type B					
	Type C					
4W Drive						
Lorry						
Van						
MPV						
Sedan car						
Bus						
Boat						
Others						

Prepared by   : _____   Date: _____

Verified by   : _____   Date: _____

Note: Resource typing and inventory should be updated quarterly.

Annex 7   Resource Typing and Inventory - Category: PPE

Kind	Type	Amount	Expiry date	Location	Remarks
Mask	N95				
	Surgical 3 ply				
	R95				
	With respirator				
Coverall					
Gloves					

Prepared by   : _____   Date: _____

Verified by   : _____   Date: _____

Note: Resource typing and inventory should be updated quarterly.

REFERENCES

75

1.   World Health Organisation (WHO). International Health Regulations, 2005.
2.   National Disaster Management Agency (NADMA) Directive No. 1, 2004.