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National Focal Point for IHR

SOPs for Contact Tracing

Definition of Contact:

A contact is a person who experienced any one of the following exposures during the 2 days before and the 14 days after the onset of symptoms of a probable or confirmed case:

1. Face-to-face contact with a probable or confirmed case within 1 meter and for more than 15 minutes;

2. Direct physical contact with a probable or confirmed case;

3. Direct care for a patient with probable or confirmed COVID-19 disease without using proper personal protective equipment

Identification of contacts:
All persons categorized as a contact of confirmed cases should be followed-up, and monitored for the development of symptoms for 14 days after the last exposure to the case (i.e. the maximum incubation period). Contacts of suspected cases should also be considered for contact management if there is likely to be a delay in confirming or excluding COVID-19 infection in the suspected case, such as delayed testing.

Close contact definition:
A close contact is defined as requiring greater than 15 minutes face-to-face contact with a symptomatic confirmed case in any setting, or the sharing of a closed space with a symptomatic confirmed case for a prolonged period (e.g. more than 2 hours).
For the purposes of surveillance, a close contact includes a person meeting any of the following criteria:

- Living in the same household or household-like setting (e.g. in a boarding school or hostel).
- Direct contact with the body fluids or laboratory specimens of a case without recommended PPE.
- A person who spent 2 hours or longer in the same room (such as a GP or ED waiting room).
- A person in the same hospital room when an aerosol generating procedure is undertaken on the case, without recommended PPE.

- Face-to-face contact for more than 15 minutes with the case in any other setting not listed above.

Contact needs to have occurred within the period extending from the day of onset of symptoms in the case until the case is classified as no longer infectious by the treating team (usually 24 hours after the resolution of symptoms).

Casual contact definition:

Casual contact is defined as any person having less than 15 minutes face-to-face contact with a symptomatic confirmed case in any setting, or sharing a closed space with a symptomatic confirmed case for less than 2 hours. This will include healthcare workers, other patients, or visitors who were in the same closed healthcare space as a case, but for shorter periods than those required for a close contact. Other closed settings might include schools or offices.

Note that healthcare workers and other contacts who have taken recommended infection control precautions, including the use of full PPE, while caring for a symptomatic confirmed COVID-19 case are not considered to be close contacts. However, these people should be advised to self-monitor and if they develop symptoms consistent with COVID-19 infection they should isolate themselves and notify their public health unit or staff health unit so they can be tested and managed as a suspected COVID-19 case.

Other casual contacts may include:

- Extended family groups, e.g. in an Aboriginal community.
- Aircraft passengers who were seated in the same row as the case, or in the two rows in front or two rows behind a symptomatic confirmed COVID-19 case. Contact tracing of people who may have had close contact on long bus or train trips should also be attempted where possible, using similar seating/proximity criteria.
- All crew-members on an aircraft who worked in the same cabin area as a symptomatic confirmed case of COVID-19. If a crew member is the symptomatic COVID-19 case, contact tracing efforts should concentrate on passengers seated in the area where the crew member was working during the flight and all of the other members of the crew.

Where resources permit, more active contact tracing may be extended to other persons who have had casual contact (as defined above), particularly in school, office, or other closed settings. In these circumstances, the size of the room/space and degree of separation of the case from others should be considered in identifying contacts.

Contact assessment:

All persons identified as having had contact with a symptomatic confirmed case should be assessed to see if they should be classified as a close contact and have demographic and epidemiological data collected. Information on close contacts should be managed according to jurisdictional requirements. Identification and assessment of the contacts of suspected cases may be deferred pending the results of initial laboratory testing.

Close contact testing:

Routine laboratory screening for COVID-19 infection is not recommended for asymptomatic contacts.

Procedure:

- RRT team shall reach the locality where case reports as per SOPs.
- Team member shall conduct risk assessment of the area and identify the close contacts as per plan
- The team shall take the sample from the contacts available at the site as per SOPs
- The detailed information about contacts which are not present at the area of site must be informed to NIH and the respective agencies.
- The team shall coordinate with local civil authorities about the risk assessment and advice
- PHEOC team shall facilitate the respective agencies and organization where relevant contacts may be living or residing

Records:

1. Contact Tracing Forms
2. Contact information forms
3. Sample referral forms
4. PHEOC contract management registers/forms (if any)