



# **CONTACT TRACING Guidelines DURING COVID -19**

## **Uttarakhand**

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**Disease Surveillance and Response Programme Area  
Disease Prevention and Control Cluster**

# CONTACT TRACING for Covid-19

## Elements of contact tracing

### Contact identification-

Contact identification is an essential part of epidemiologic investigation for all cases meeting the standard/surveillance case definitions of Covid-19. These cases are classified as suspected, probable and confirmed (see Annex 2 for case definition).

The epidemiologist/surveillance officer/ Medical officer conducting the epidemiologic investigation should complete case investigation forms for all the Covid-19 cases meeting the standard/surveillance case definition.

After completing the case investigation form, the epidemiologist/surveillance officer/ Medical officer should systematically identify potential contacts. Contact identification therefore begins from a case. Identification of contacts is done by asking about the activities of the case and the activities and roles of the people around the case (alive/dead) since onset of illness. Although some information can be obtained from the patient, much of the information will come from the people around the patient. In some instances, the patient will have died or have already been admitted to the isolation facility, with limited access. It is mandatory for the epidemiologist/surveillance officer/ Medical officer to visit the home of the patient. The following information should be obtained:

- (A) All persons who lived with the case (alive/dead) in the same households since onset of illness.
- (b) All persons who visited the patient (alive/dead) either at home or in the health facility since onset of illness.
- (c) All places and persons visited by the patient since onset of illness e.g. Hospitals, Clinics, traditional healer, temple, relatives, etc. All these places and persons should be visited and contacts identified.
- (d) All health facilities visited by the patient since onset of illness and all health workers who attended to the patient (alive/dead) without appropriate infection prevention and control procedures.
- (f) During the home visit, the contact tracing/follow-up teams should ask about persons who might have been exposed to the patient (alive/dead) but were not identified and listed as contacts through the above process. Priority should be given to these high risk categories of contacts, persons who within the last 14 days:
  - (a) Touched the patient's body fluids (blood, vomit, saliva, urine, faeces).
  - (b) Had direct physical contact with the body of the patient (alive/dead).
  - (c) Touched or cleaned the linens or clothes of the patient.
  - (d) Slept or ate in the same household as the patient.
  - (e) Have been breastfed by the patient (i.e. babies).
  - (f) Health care workers who suffered a needle-stick injury from a contaminated instrument while attending to a probable or confirmed Covid-19 patient.
  - (g) Laboratory workers who had direct contact with specimens collected from suspected Covid-19 without appropriate infection prevention and control measures.

## Contact listing-

All persons considered to have had significant exposure (falling in the categories described above) should be listed as contacts, using the contact listing form [Annex 2]. Efforts should be made to physically identify every listed contact and inform them of their contact status, what it means, the actions that will follow, and the importance of receiving early care if they develop symptoms. The contact should also be provided with preventive information [Annex 3] to reduce the risk of exposing people close to them.

The process of informing contacts of their status should be done with tact and empathy, since being a contact can be associated with serious health outcomes. Avoid using alarming information, such as 'Covid-19 has no treatment' advise all contacts to:

- (A) Remain at home and restrict close contact with other people.
- (b) Avoid crowded places, social gatherings, and the use of public transport.
- (c) Report any suspicious signs and symptoms such as fever, cold, cough and breathing difficulty immediately (provide telephone numbers for the contact follow-up team, the supervisor or the Covid-19 hotline/call centre numbers). Explain that getting early and good clinical care improves health outcomes, and immediate evacuation from the home and isolation reduces the risk of infecting family members. In addition, provide information on:
  - (a) Covid-19 preventive measures through inter-personal communication and where applicable, provide materials like leaflets and brochures.
  - (b) Preventive measures to mitigate the risk of exposing family members and others if a contact develops symptoms [Annex 3].
  - (c) Guidance for home-based care at onset of illness while waiting for evacuation and isolation [Annex 3]

## Contact follow-up-

The epidemiologist/surveillance officer/ Medical officer responsible for contact tracing should assemble a competent team comprising local surveillance and FLWs (ASHA, AWWs, ANMs& Supervisors) to follow up all the listed contacts.

An efficient contact tracing system depends on a relationship of trust with the community, which in turn fosters optimum cooperation. Communities should have the confidence to cooperate with contact tracing teams and allow the referral of symptomatic contacts to designated isolation facilities. Involving appropriate community members (in particular local leaders) in contact tracing is critical in cultivating this good relationship, trust and confidence. The local surveillance and FLWs (ASHA, AWWs, ANMs& Supervisors) should be involved as early as possible in the response. The local surveillance staff and FLWs be closely supervised by trained epidemiologists/surveillance officers / Medical officer.

The contact follow-up teams and their supervisors should be trained in a ½ day workshop to familiarize the team with basic information on Covid-19, procedures and tools for contact tracing, and the required safety precautions. The training package should cover:

- (A) Basic facts about Covid-19, transmission, and preventive measures.
- (b) The rationale and procedures for contact tracing/follow-up.
- (c) Contact tracing/follow-up tools, temperature monitoring, reporting, etc.

(d) Recommended infection prevention and control measures for contact tracing teams.

(e) Home-based preventive measures at onset of illness.

(f) Linkage/coordination with other response groups.

After the orientation, the contact follow-up teams should be equipped with all the necessary tools, including:

(A) Contact listing, contact follow-up, reporting and monitoring forms.

(b) Pens.

(c) Infrared thermometer.

(d) Alcohol-based hand rub solutions.

(e) Covid-19 fact sheets and posters.

(f) Protocol for reducing risks of transmission at home [Annex 3].

(h) Important contact list (e.g. technical leads, supervisors, call centre, ambulance, etc.)

(i) Disposable gloves.

### Procedures for conducting contact follow-up-

The steps below provide guidance on contact follow-up:

1. Each morning, the epidemiologist/surveillance officer/ Medical officer responsible for contact tracing prepares the list of contacts to be followed that day.
2. The epidemiologist/surveillance officer/ Medical officer responsible provides the list of contacts to the supervisors in a meeting, taking into account the supervisors' route, the number of contacts in a particular area, and the local administrative setting.
3. The supervisors travel to their areas of work and meet the contact follow-up teams at a central meeting point e.g. nearby health facility, school, temple, etc., and the teams are assigned the contacts to visit.
4. After receiving the lists of contacts, the teams go to their respective communities for home visits.
5. The team should observe the culturally recommended practice of greeting, except for those that entail direct physical contact like shaking hands or hugging. Explain to the household that the restrictions have been recommended to contain the spread of Covid-19.
6. If offered seats, inform the household that you will not stay long and need to quickly interview the contacts so that the team sees the other contacts before the day ends.
7. Interview and assess the contact for symptoms using the contact follow-up form [Annex 4], and take their body temperature. Do not take their temperature if they have symptoms (fever, cough, cold, difficulty in breathing)

8. If a contact is not at home, the team should inform the supervisor immediately while trying to establish the contact's location. The role of the community leader becomes critical in such incidents. A satisfactory explanation should be obtained for a contact's absence.

9. After finishing the interview/assessment, ask whether any other person in the house is not feeling well (even if the person is not a contact). This serves to identify any sick person in the community, a process referred to as active case search.

10. The contact follow-up team prepares a report summarizing the findings using the reporting format in Annex 5.

11. After completing the assigned home visits, the teams should assemble in the central meeting point to provide feedback to the supervisor.

12. The supervisor collects all the reports of contacts followed up that day and prepares a summary report with the help of epidemiologist/surveillance officer/ Medical officer. The report should include any other issues encountered during the home visit.

13. The epidemiologist/surveillance officer/ Medical officer makes a consolidated report of all contact tracing, and submit at district to CMO.

### Managing contacts with signs and symptoms-

The contact tracing/follow-up team is usually the first to know when a contact has developed symptoms. This may be volunteered by the contact in a phone call, or the contact tracing team makes the discovery during a home visit. The contact follow-up team must not take the temperature of contacts with symptoms (Fever, Cough, Cold, and Difficulty in breathing). If a contact develops signs and symptoms, the responsible team should immediately notify the supervisor and/or the alert management desk/call centre. The alert management desk/call centre will complete the Covid-19 alert case notification form [Annex 6] and immediately inform the case management team leader. The ambulance team is then dispatched to conduct an assessment and/or evacuation of the symptomatic contact to the treatment centre.

### Supervision of contact follow-up-

Close supervision and monitoring of contact follow-up is necessary to ensure that the local surveillance and FLWs (ASHA, AWWs, ANMs & Supervisors) visit and observe contacts daily. Supervisors should join contact follow-up teams for home visits on a rotating basis to ensure that home visits are done correctly. Quality checks may also include randomly calling some contacts to verify whether they were visited. Conduct regular meetings with all contact tracing teams to address any issues that might have an impact on the effective functioning of contact tracing. Other administrative strategies may be needed to address non-compliance and the management of uncooperative contacts.

### Discharge of contacts-

Contacts completing the 28-day follow-up period should be assessed on the last day. In the absence of any symptoms, the contacts should be informed that they have been discharged from follow-up and can resume normal activities and social interactions. The team should spend time with the contacts' neighbours and close associates to assure them that the discharged contacts no longer poses a risk of transmitting the disease. If an employer requests an official letter declaring the end of follow-up, this could be provided by the response team. The contacts should ensure that they are not re-exposed to symptomatic contacts or probable/confirmed cases of Covid-19.

### Recommended safety precautions for contact tracing teams-

The teams should abide by the following:

1. Avoid direct physical contact like shaking hands or hugging.
2. Maintain a comfortable distance (more than 1metre)) from the person.
3. Avoid entering the residence.
4. Avoid sitting on chairs offered to you.
5. Avoid touching or leaning against potentially contaminated objects.
6. Always have a good breakfast before home visits to resist the temptation of eating or drinking while visiting contacts.
7. Do not conduct home visits wearing personal protective equipment like masks, gloves, or gowns.
8. If you must take the contact's temperature:
  - (a) Put on disposable gloves.
  - (b)Have the contact turn around and take their temperature in the armpit.
  - (c) Avoid touching the patient and step back to wait for the thermometer.
9. If the contact is visibly ill, do not attempt to take their temperature, but notify your supervisor.
10. As part of the overall safety of the response team, all members of the contact tracing team should monitor their own temperature every morning.
11. Before leaving the site all people involved in Contact tracing should also spray Hydrochloride solution on their shoe sole.

#### Annex 1: Explain-

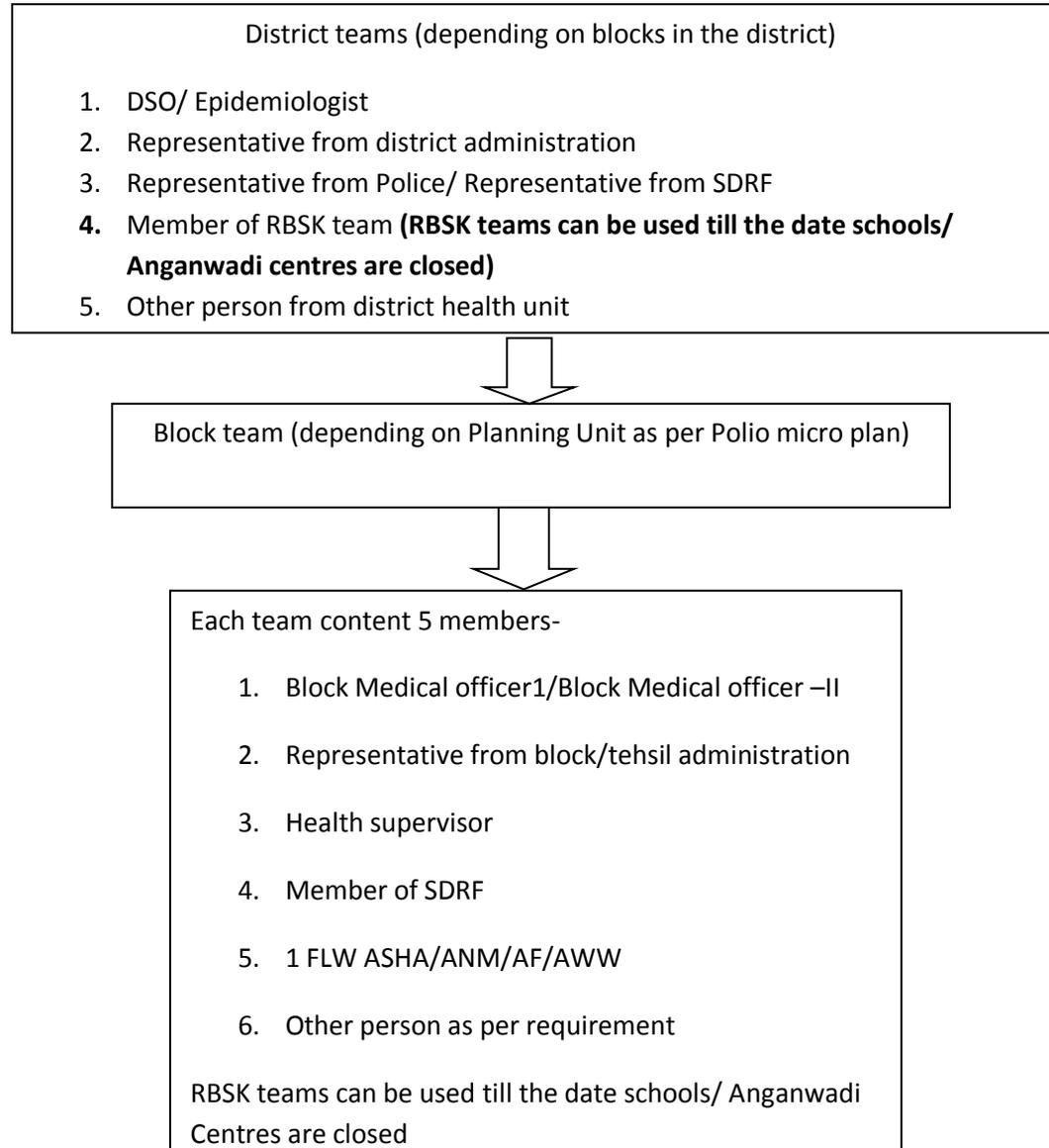
Districts should formed Districts & Block level teams to follow the above guidelines (see annex 1)

Each team content 5 members-

1. Block Medical officer1/Block Medical officer –II
2. Representative from block/tehsil administration
3. Health supervisor
4. Member of SDRF
5. 1 FLW ASHA/ANM/AF/AWW

**RBSK teams can be used till the date schools/ Anganwadi Centres are closed.**

## Annex 1: DISTRICT PLAN FOR FIELD INVESTIGATION – COVID -1





## Annex 2

### COVID-19 Case & Contact definition



#### Definition of “Case” (COVID-19):

1. A patient with acute respiratory illness {fever and at least one sign/symptom of respiratory disease (e.g., cough, shortness of breath)}, AND a history of travel to or residence in a country/area or territory reporting local transmission (See NCDC website for updated list) of COVID-19 disease during the 14 days prior to onset of symptoms;

**OR**

2. A patient/Health care worker with any acute respiratory illness AND having been in contact with a confirmed COVID-19 case in the last 14 days prior to onset of symptoms;

**OR**

3. A patient with severe acute respiratory infection {fever and at least one sign/symptom of respiratory disease (e.g. cough, shortness breath)}AND requiring hospitalization AND with no other etiology that fully explains the clinical presentation;

**OR**

4. A case for whom testing for COVID-19 is inconclusive.

**OR**

#### **Laboratory Confirmed case:**

5. A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

#### Updated definition of “Contact” (COVID-19):

##### **A ‘contact’ is a person who is involved in any of the following:**

- Providing direct care without proper personal protective equipment (PPE) for COVID-19 patients
- Staying in the same close environment of a COVID-19 patient (including workplace, classroom, household, gatherings).
- Traveling together in close proximity (1 m) with a symptomatic person who later tested positive for COVID-19.

##### **High Risk “Contact” are those who:**

- Touched body fluids of the patient (Respiratory tract secretions, blood, vomit, saliva, urine, faeces)
- Had direct physical contact with the body of the patient including physical examination without PPE.
- Touched or cleaned the linens, clothes, or dishes of the patient.
- Lives in the same household as the patient.
- Anyone in close proximity (within 3 ft) of the confirmed case without precautions.
- Passenger in close proximity (within 3 ft) of a conveyance with a symptomatic person who later tested positive for COVID-19 for more than 6 hours.

##### **Low Risk “Contact” are those who:**

- Shared the same space (Same class for school/worked in same room/similar and not having a high risk exposure to confirmed or suspect case of COVID-19).
- Travelled in same environment (bus/train/flight/any mode of transit) but not having a high-risk exposure.



## **Annex 4: Protocol for reducing risks of COVID19**

It is strongly recommended that patients and their contacts with symptoms are immediately evacuated to a health-care facility, ideally COVID-19 treatment centre. It is important to remember that:

1. COVID-19 respiratory pathogen, easily transmissible from person to person
2. Elderly and co-morbid are high risk Household members should avoid all direct physical contact with the patients and their body fluids;
3. Contact with materials contaminated by a patient's body fluids, such as clothing and bedding, can spread the disease to others.

To prevent infection, these recommendations should be followed:

1. The patient should restrict movement to one room in the household and avoid direct contact with other family members;
2. Maintain social distancing
3. Wash your hands frequently
4. Avoid touching eyes, nose and mouth
5. Practice respiratory hygiene
6. If you have fever, cough and difficulty breathing, seek medical care early
7. Avoid direct contact with the patient's clothes, bedding and other household items the patient has touched;.

Cleaning:

1. The caregiver should prepare a bleach solution to clean the room, clothes, bedding and other household items touched by the patient. To prepare the bleach solution, mix 1 part of concentrated bleach (5%) with 10 parts of water (fill a cup with the bleach, empty the cup into a bucket and refill the cup with water 10 times, adding the water to the bucket);
2. The bleach solution loses its effectiveness after 24 hours, so fresh solutions must be prepared every morning;

3. Gloves should be worn before entering the room;
4. Hands should be washed with soap and water or an alcohol-based hand rub solution (hand sanitizer), if available, before and after entering the patient's room and immediately after glove removal;
5. Never put bleach or bleach solution in the patient's or caregiver's mouth or eyes;

Essential items for home use are:

- 10 pairs of latex gloves (disposable);
- 5 face masks;
- Bleach solution of 2 litres diluted;
- 1 pair of heavy gloves;
- 2 buckets (bleach solution and waste);
- Soap for hand washing and an alcohol-based hand rub solution (hand sanitizer);
- Home-based care instructions.

### **Home-based care instructions for contacts with symptoms**

#### ***If you start to feel ill:***

1. **Seek medical care as soon as possible** (immediately inform healthworkers);

Or call at 24\*7 COVID-19 help line



# Annex 5: Reporting form for field teams

## REPORTING FORM FOR FIELD TEAMS

Variable		Date:
Team name:		
Team members:		
Villages assigned	No. of villages	
	No. of households	
	Names of villages	
Villages visited	No. of villages	
	No. of households	
	Names of villages	
Total cases under follow-up (list names)		
Total contacts under follow-up		
Contacts who have completed 28-day follow-up today		
Total cases followed up today		
Total contacts followed up today		
Contacts who developed symptoms		
Details of community alerts responded to		

**Remarks/other issues**

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# Annex 6: Covid-19 Alert Case Notification Form

## COVID19 CASE NOTIFICATION FORM AT THE CALL CENTRE

Phone call received by: \_\_\_\_\_

on (date)\_\_\_\_/\_\_\_\_/\_\_\_\_;at(time)\_\_\_\_:\_\_\_\_  a.m.  p.m.

The suspected Covid 19 case was reported by:

A Contact Tracing Team  Name:\_\_\_\_\_ Phone:\_\_\_\_\_

A Health Facility  Name:\_\_\_\_\_ Phone:\_\_\_\_\_

A Community Leader/member  Name:\_\_\_\_\_ Phone:\_\_\_\_\_

<b>Name of patient (case)</b>	
<b>Contact</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Status</b>	<input type="checkbox"/> Alive <input type="checkbox"/> Dead
<b>Symptoms</b>	<input type="checkbox"/> Fever <input type="checkbox"/> Cough <input type="checkbox"/> cold <input type="checkbox"/> Difficulty <input type="checkbox"/> in breathing <input type="checkbox"/> <input type="checkbox"/> Other symptoms:___
<b>Date of onset of illness</b>	

**The patient is currently in:**

Village/Street Address (Residential): \_\_\_\_\_

Sub-county: \_\_\_\_\_

District/State: \_\_\_\_\_

• Contact telephone number of case at home: \_\_\_\_\_

• Action taken: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_