Contact Tracing for COVID-19 Guidance

This document has been developed to assist National Societies in deciding if and how they may wish to assist their government's strategy for contact tracing as part of their response plan for COVID-19. Given the complexity of COVID-19, its global scope, national priorities and National Society capacities, contact tracing may be one option to include in the response plan. This document provides guidance on the deciding whether assisting with contact tracing is appropriate, as well as considerations to include within contact tracing initiatives.

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Contact tracing: Who, What and Why

Contact tracing is the process of identifying, assessing, and managing people who have been exposed to COVID-19 to prevent onward transmission. People who may have been exposed to COVID-19 are systematically followed 14 days from the date of the most recent exposure. Please note that 14 days is suggested by WHO, but some governments may have their own requirements. Please ensure your National Society follows the requirements of the National government and health officials.

This process allows for the rapid identification of people who become symptomatic by following those most likely to develop symptoms (close contacts). Identifying people at the onset of symptoms and isolating them reduces exposure to other persons, preventing subsequent infections. Prompt isolation and admission of the symptomatic person to a health or treatment facility decreases the delay to supportive treatment, which may improve the likelihood of survival.

Contact tracing compared to other forms of public health surveillance:

There are many ways to include various forms of surveillance and detection within NS activities, and contact tracing is only one of them.

Process	Purpose	Who	How
Contact Tracing	The identification and follow-up of persons who may have come into close contact with an infected person with COVID-19	Trained VHWs or CHWs (NS volunteers when requested) typically with special request, support and training from National or local government	Close contacts to be isolated and monitored for 14 days following potential exposure. This entails: 1. Finding people who meet the definition of a close contact, and 2. Following-up on whether contacts develop symptoms (daily by phone if possible)
Active Case Finding	Systematic searching and screening for COVID-19 within targeted groups or locations believed to be at risk	Epidemiologists, CHWs or others based on the health system capacity	Requires rapid diagnostic testing capabilities and human resources, may include checkpoints, door-to-door, or searching within hospitals wards for people who may have been misdiagnosed

Point of Entry Screening	Screenings that are put in place at points of entry or points of control to assess whether symptoms are present in travelers	Government officials (HWs, army, police, etc.), based on mandate can also be RCRC NS	Based on National government requirements. Typically screening for symptoms aligned with WHO or National case definition
CBS	Immediate reporting of observed health risks that meet the COVID-19 criteria as trained during health promotion activities that match selected criteria	Trained CBS volunteers within the NS	Volunteers can report health risks matching COVID-19
Reporting Hotline	Communication network allowing community members to call and report if they believe COVID-19 is an issue in their community and provide information on symptoms for follow-up	Community members, health facility workers, RCRC Volunteers (population/ community)	Requires a national or local hotline established and maintained with referral connections

Who is a contact?

The WHO definition of "who a contact is" described below should be used and/or modified based on MoH specific requirements if they differ.

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 metre 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; OR
4. Other situations as indicated by local risk assessments.

Note: for confirmed asymptomatic cases, the period of contact is measured as the 2 days before through 14 days after the date on which the sample was taken which led to confirmation.

General considerations for contact tracing[1]:

Contact tracing relies on active participation and cooperation from the affected communities in order to be effective. To develop a relationship of trust, every effort should be made to engage communities, explain the purpose and process clearly and answer any questions or concerns people may have. Communities should have the confidence to cooperate with teams that are conducting contact tracing.

Contact tracing is best undertaken in settings where appropriate, accurate and culturally sensitive two-way communication and messaging exist. Enrolment of contacts relies on a community's willingness to be followed; they may be more or less willing to be followed based on their understanding of COVID-19, the potential stigma[2] associated with being a contact (from peers, family, or the community), and how they feel overall about COVID-19. People also may not want to be identified or found if prohibitions from work or school are likely, and they may not want to report other contacts because of this stigma and potential retaliation. Public misinterpretations and perceptions of contact lists as a list of people who are likely to die may lead to community resistance and impede contact tracing. Therefore, the health communication and messaging as well as psycho-social support provided to the community are critical. The following measures may enhance community engagement and avoid stigma:

- Engage and educate community leaders regarding COVID-19 infection, transmission, and the steps communities can take to combat it, including the importance of contact tracing.
- Engage religious centres, such as churches and mosques, to provide accurate messaging to the community (if open and sanctioned by MoH) including explaining why contact tracing benefits the whole community.
- Use early health communication and education efforts, if possible, before the first introduction of COVID-19.
- Listen and respond to community feedback, including any fears and concerns people have about contact tracing, and make sure these are logged, analyzed and responded to.
- Use early psychosocial support to overcome the fear associated with COVID-19.
- Educate the media on the importance of confidentiality for cases and contacts.
- There are a number of risk communication and community engagement (RCCE) tools which can help with the above actions, including training resources, feedback tools, a community worker and stigma guide. You can access all of these tools here.

Successful contact tracing requires skills in the assessment of COVID-19 symptoms, interviewing techniques and counselling. Volunteers need to be flexible and empathic with cases, contacts and their families in order to build trust and good community relations.

The implementation of contact tracing activities may vary with the burden of disease and the local context. The number of cases and contacts traced daily may cover wide geographical areas and extend into defined pockets such as densely populated urban areas, posing logistical challenges to locating and tracing all those who have been in contact with a case. In such instances, comprehensive and systematic

[1] Modified from: Emergency Guideline: Implementation and Management of contact tracing for Ebola virus disease (WHO, CDC)

[2] For additional guidance on how to handle stigma related to COVID-19 see "A Guide to preventing and addressing social stigma" developed by IFRC, UNICEF and WHO.

contact tracing activities need to be enhanced through robust community engagement and intensified social mobilization.

Before RCVs engage in contact tracing with local or national authorities, it is important to review any existing volunteer statements or agreements to ensure they include a clause prohibiting disclosure of personal, confidential or other sensitive information. A signature record should exist for all volunteers participating in contact tracing. It should be made clear in training that disclosure of personal, confidential or other sensitive information, especially with respect to CT work puts individuals' safety at risk and is therefore strictly forbidden. Additionally, it should be made clear from government officials whether RCVs may be exposed to any liability during the process of CT. Volunteers should also be informed that they may be required to sign additional confidentiality statements if working directly with the MOH or government authorities.

Case definition for COVID-19

The suggested case definition from WHO[3] described below should be compared and adjusted in each country to match MoH requirements (if it exists).

A **suspected case** is:

A. 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 location reporting community transmission of COVID-19 disease during the 14 days prior to symptom onset;

OR

B. A patient with any acute respiratory illness AND who has been in contact with a confirmed or probable COVID-19 case (see the definition of contact below) in the 14 days prior to the onset of symptoms

OR

C. A patient with severe acute respiratory infection (that is, fever and at least one sign or symptom of respiratory disease, for example, cough or shortness breath AND requiring hospitalization) AND in the absence of an alternative diagnosis that fully explains the clinical presentation.

A **Probable case** is:

A. A suspect case for whom testing for the COVID-19 virus is inconclusive;
   OR

[3] Please note that the Global Surveillance for human infection with coronavirus disease website states last update on 27 February, 2020, however the downloadable PDF continues to have the most updated information – as of this document was updated on 20 March 2020. Before starting contact tracing activities, please ensure you have the up to date case definition from your Ministry of Health or WHO.

B. A suspect case for whom testing could not be performed for any reason.

A **Confirmed case** is:

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

Implementation of contact tracing for COVID-19

Contact tracers work to identify all social, familial, work, and health care worker contacts who have had contact with a confirmed case from 2 days before symptom onset of the case and up to 14 days after their symptom onset or for as long as symptoms persist if more than 14 days.[i] Create a line list, including demographic information, date of first and last common exposure or date of contact with the confirmed or probable case, and date of onset if fever or respiratory symptoms develop. The common exposures and type of contact with the confirmed or probable case should be thoroughly documented for any contacts who become infected with COVID-19, as per national MoH guidance and procedures.

For contacts of a suspected COVID-19 case, at a minimum, RCVs need to encourage respiratory and hand hygiene and may encourage – depending on the epidemiological context and resources available, as well as national MoH policy – self-monitoring for symptoms, social distancing, or quarantine.

Suggested Methods

To better determine the scope and need for contact tracing for COVID-19 please ensure you discuss with your MoH focal point. The MoH will have specific protocols that align with WHO guidance and suggested methods below but adapted to meet the needs within their specific context. Volunteer safety is essential and should be addressed in the MoH protocol. Some suggestions are listed below along with general logistics and HR resource considerations.

General Set-up and Logistics Requirements

Category	Suggested Considerations	Yes/ Feasible	No/ Not currently feasible
Contact Tracing Planning/ Processes	1. Contact tracing protocol planned with partners/ MoH, relevant stakeholders 2. Roles and responsibilities for RCVs clearly defined 3. RCCE and PSS strategy considered in planning process 4. Review Volunteer confidentiality agreements and ensure they are appropriate and up to date for the context of Contact Tracing		
Suggested Human Resources	1 District (or equivalent) Officer per area 1 Volunteer supervisor per 20-30 volunteers (Supervisors may by MoH staff, CHWs, or part of RCRC) 1 Volunteer per 20-30 contacts		
Logistics Considerations	Transport/ Community Access if needed in local context Security situation in locations of interest • Volunteers able to move within communities and conduct activities, OR Contact reachable by phone • Supervision visits possible • Contact tracing is accepted by the community Paper-based contact tracing system: • Printed forms for volunteers • Reporting books for supervisors Digital App-based Technologies • Smartphones and network available for supervisors based on contact tracing plan Hygiene • All volunteers conducting contact tracing should have access to hand sanitizer and/ or handwashing		

Recommended Trainings	Volunteer training per location • Location supervisor to lead • Recommended not to exceed 25 2-4 days for Volunteer training on contact tracing, including RCCE. Refresher trainings as needed		
Monitoring, Evaluation & Feedback Mechanism	• Core indicators considered and can be captured given expected resources • Community Feedback mechanism included to capture and analyse peoples' perceptions, fears, questions and suggestions about contact tracing and COVID-19 more generally. If feedback is also being collect through other activities such as social mobilization, this should be included here with one feedback system overall for the National Society.		

Volunteer Safety

If possible, it is suggested to conduct contact tracing by phone. This allows for the maximum amount of protection from potential transmission as well as personal privacy. However, in many contexts follow-up by phone is not possible. If follow-up in person is required, the below recommendations are suggested as best practice.

All volunteers, in contexts at every level of transmission should have access to hand sanitizer after every in-person visit. It is recommended that **volunteers keep a 1-2 metre distance** from community members during discussions and **no physical contact** should take place. If possible, discussions should take place outside, through a window or in an open space and between a healthy member of the family/ community member and volunteer rather than the ill person themselves.

If contact tracing is conducted by CHVs who have been trained to provide additional health support, they should follow any additional PPE measures that pertain to those activities and government requirements.

Volunteers conducting contact tracing activities do not need to wear PPE. Wearing face masks or gloves is not recommended, as it contributes to fear in communities, leads to a false sense of security, and is unnecessary due to physical distance precautions. However, if MoH guidance is to wear PPE for contact tracing, please adhere to their guidance and make sure to receive PPE stocks from MoH supply lines.

Dos and Don’ts of Contact Tracing

DO

- Practice physical distancing and call when possible to complete contact tracing
- Be empathetic, listen and respond to the concerns of those you are contacting and use your knowledge on RCCE, PSS and other support measures from volunteer trainings
- Take note of community feedback using IFRC RCCE guidance and tools. Speak to your National Society RCCE and CEA focal point.
- Wash your hands with soap and water, or use hand sanitizer after each visit
- Reach out to your supervisor if you are uncertain or feel unsafe at any time.
- Follow all security procedures put in place by the National Society and the Government.

DON’T

- Stigmatize people or make them feel ashamed for needing to be followed
- Share discuss the names or information of contacts outside of the CT efforts
- Enter homes while conducting contact tracing activities, volunteers SHOULD speak with people outside or through a window, maintaining a 1-2 metre distance.
- Do not touch or be closer than 1 metre with anyone.
- Get frustrated, Volunteers SHOULD be patient and listen to concerns and provide correct information to counter misinformation or rumours.

Suggested Indicators for Monitoring and Evaluating your contact tracing implementation

Suggested Indicator	Calculations/ Details	Purpose
% of targeted number of contacts visited/ contacted per day	Daily # of contacts visited, or contacted / Target # of contacts visited/ contacted	Monitoring
% of suspected or confirmed cases in target areas referred and captured through RCV contact tracing activities	# of confirmed cases referred though RCV contact tracing to authorities / Total # of cases confirmed by authorities in target areas	Impact
% of trained volunteers active in contact tracing activities	# of trained volunteers submitting reports as required/ # of trained volunteers in contact tracing	Program monitoring
Total Number of Trainers (ToT/ Master trainers) trained in contact tracing and Total number of Volunteers trained in contact tracing	*No calculation required*	Needed for program monitoring calculations and follow-up

ADDITIONAL TOOLS & GUIDANCE

1. IFRC GO for the latest guidance on Coronavirus disease (COVID-19) including community health guidance
2. Social Stigma Associated with COVID-19: A guide to preventing and addressing social stigma. (IFRC, WHO, UNICEF)
3. WHO Considerations in the investigation of cases and clusters of COVID-19
4. WHO Early detection and Identification of COVID-19
5. All RCCE tools and training, including for feedback collection and analysis, can be access through the matrix of resources.