

Standard Operating Procedure (SOP) for Contact Tracing for COVID-19



Pacific
Community
Communauté
du Pacifique

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World Health
Organization
Representative Office
for the South Pacific

Introduction

Contact tracing is the process of identifying, assessing, and managing people who have been exposed to a disease to prevent onward transmission. When systematically applied, contact tracing will break the chains of transmission of an infectious disease and is thus an essential public health tool for controlling infectious disease outbreaks.

This Standard Operating Procedure (SOP) is an updated version of the SOP issued on 1 July 2020. The revisions include information from the recent [WHO Interim Guidance on Public Health Surveillance for COVID-19 \(7 August 2020\)](#) which includes the revised definitions of a suspected, probable and confirmed case of COVID-19 that takes into consideration the increased knowledge on the clinical spectrum of signs and symptoms of the disease. Additionally, the revised case definitions consider situations where testing is not available. A contact is therefore defined below based on the revised definitions of probable and confirmed cases of COVID-19.

The SOP should be used in conjunction with relevant WHO Guidances and other documents (see reference list) and Contact Tracing algorithms for community and health care settings in countries with or without COVID-19 testing capability ([Annex 1](#)).

Aim and Scope of SOP

This SOP aims to provide guidance to Pacific island countries and areas on the management of persons who have had contact with a confirmed or probable COVID-19 case aligned to the recently updated case and contact definitions in the WHO Interim Guidance on Public Health Surveillance for COVID-19 (7 August 2020). As countries may vary according to transmission scenario, laboratory testing capability and the applications and databases used for contact tracing, this SOP should be altered to suit the country context and contact tracing arrangements.

Definitions in the Context of COVID-19

- A **contact** of a COVID-19 case is a person not currently presenting symptoms, who has, or may have been, in contact (detailed below) with a probable or confirmed COVID-19 case.
- **Quarantine** is the separation from the rest of the population, of healthy persons who may have been exposed to the virus, with the objective of monitoring their condition and ensuring early detection of symptoms. Quarantine may be undertaken at a designated government facility or at home.
- Quarantine differs from **isolation** which refers, in this context, to the separation of suspected, probable or confirmed cases from other people. Isolation may occur at home or at hospital if medical observation is required.
- In this context, **monitoring** refers to the process whereby identified contacts are followed up, over a defined period, to identify the development of COVID-19 symptoms in contacts. Monitoring may occur in-person or over the phone with public health contact tracing staff.
- A **high-risk setting** is a location where there is a risk for rapid spread and ongoing chains of infection. These include but are not limited to places where people reside in groups and workplace settings with potential for large scale increases in cases (such as correctional facilities, residential care facilities). Outbreak investigation and identification and management of contacts may differ in high-risk settings. Refer to specific protocols and guidelines.

- Suspected, probable and confirmed COVID-19 case definitions:

Suspected COVID-19 case (two suspected case definitions A or B):

- A.** A person who meets the clinical AND epidemiological criteria:

Clinical criteria:

1. Acute onset of fever AND cough;
OR
2. Acute onset of ANY THREE OR MORE of the following signs or symptoms: fever, cough, general weakness/fatigue, headache, myalgia, sore throat, coryza, dyspnea, anorexia/nausea/vomiting, diarrhoea, altered mental status.

AND

Epidemiological criteria:

1. Residing or working in an area with high risk of transmission of the virus: for example, closed residential settings and humanitarian settings, such as camp and camp-like settings of displaced persons, any time within the 14 days prior to symptom onset;
OR
 2. Residing in or travel to an area with community transmission anytime within the 14 days prior to symptom onset;
OR
 3. Working in health setting, including within health facilities and within households, anytime within the 14 days prior to symptom onset.
- B.** A patient with severe acute respiratory illness (SARI; acute respiratory infection with history of fever measured fever of $>38\text{ C}^{\circ}$; and cough; with onset within the last 10 days; and who requires hospitalization).

Probable COVID-19 case:

- A.** A patient who meets clinical criteria above AND is a contact of a probable or confirmed case, epidemiologically linked to a cluster of cases which has had at least one confirmed case identified within the cluster.
- B.** A suspected case (described above) with chest imaging showing findings suggestive of COVID-19 disease*

*Typical chest imaging findings suggestive of COVID-19 include the following:

- Chest radiography: hazy opacities, often rounded in morphology, with peripheral and lower lung distribution.
 - Chest CT: multiple bilateral ground glass opacities, often rounded in morphology, with peripheral and lower lung distribution.
 - Lung ultrasound: thickened pleural lines, B lines (multifocal, discrete, or confluent), consolidated patterns with or without air bronchograms.
- C.** A person with recent onset of anosmia (loss of smell) or ageusia (loss of taste) in the absence of any other identified cause.
- D.** Death, not otherwise explained, in an adult with respiratory distress preceding death AND who was a contact of a probable or confirmed case or epidemiologically linked to a cluster which has had at least one confirmed case identified with that cluster.

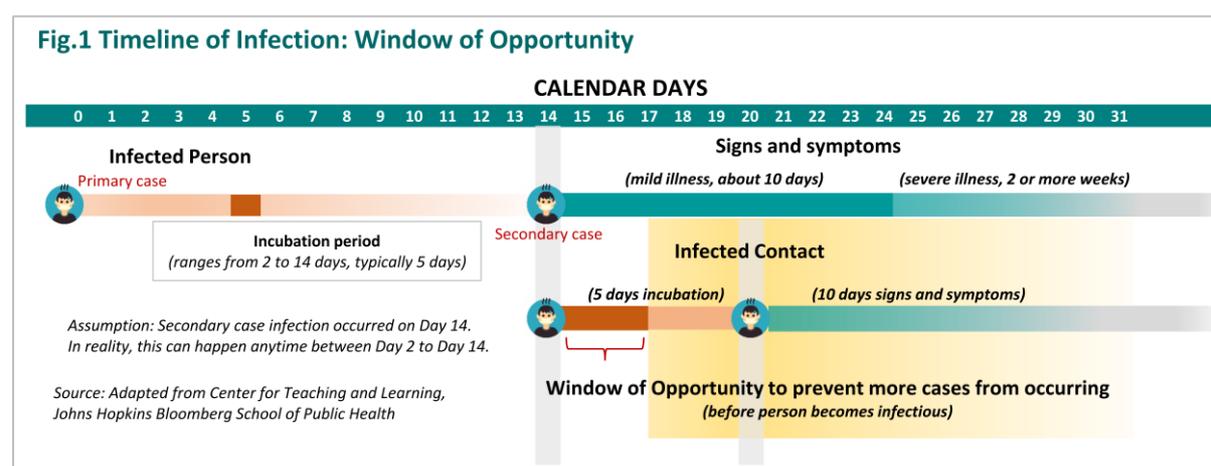
Confirmed COVID-19 case:

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

Contact Tracing and Management Process

Rapid detection and investigation of cases enables identification and management of contacts. Effective contact tracing means that interventions for the control of COVID-19 can be implemented to prevent further transmission including quarantine and monitoring of contacts, physical distancing, hand and respiratory hygiene, and PPE measures.

While contact tracing is a labour intensive process, it is recommended that contact tracing be initiated at the earliest possible time before an ill person becomes infectious, taking advantage of the window of opportunity to prevent more cases from occurring (Figure 1). Where possible, the use of information and communication technology is encouraged. It is also recommended that quarantine is undertaken for as long as resources and local conditions allow to slow down the spread of infection and reduce the burden on health services. Contact tracing should be conducted for all confirmed cases and probable cases.



Contact tracing and management involves the following processes:

- Defining contacts
- Identifying and listing contacts
- Informing contacts
- Contact management and follow-up
- Contact discharge

1. Defining Contacts

A contact who requires quarantine includes a person who experienced a defined exposure (listed below) to a probable or confirmed case during the period 2 days before and up to 14 days after the onset of symptoms (for symptomatic cases), and the period 2 days before and up to 14 days after the collection date of the sample testing positive (for test-positive asymptomatic cases).

- Face-to-face contact with a probable or confirmed case within 1 metre and for at least 15 minutes;
- Direct physical contact with a probable or confirmed case;
- Direct care for a patient with probable or confirmed COVID-19 disease without use of recommended personal protective equipment; OR
- Other situations as indicated by local risk assessments, ([Annex 2](#))

2. Identifying and Listing Contacts

2.1 Interview persons with probable or confirmed COVID-19 and complete the case investigation form. Ensure that the onset date, details of symptoms and results of laboratory tests are accurately recorded.

2.2 For COVID-19, contact tracing involves identifying upstream contacts, with an aim to detect the likely source of the infection, as well as downstream contacts who may have been infected by the case, with an aim to prevent onward transmission.

2.3 For **upstream contacts**:

- Ask the case about potential exposures prior to becoming symptomatic especially if they visited high-risk settings or were exposed to people exhibiting symptoms. The infection is likely to have been acquired 5-7 days prior to the case becoming symptomatic but up to 14 days prior to symptom onset, or in the case of contact of asymptomatic case 2 days before and up to 14 days after the collection date of the sample testing positive.
- Record locations and dates visited by the case as well as individuals who may have been the source of the infection or who may have experienced a common exposure to an infectious person.
- Individuals identified through this process must be followed up and, if symptomatic, tested and managed as suspected cases.
- In high-risk settings, risk assessment of asymptomatic upstream contacts should be undertaken to determine if specific management of asymptomatic contacts is required, e.g. quarantine, restriction, daily follow-up.
- Upstream contact tracing can identify undetected cases and other chains of transmission.

2.4 For **downstream contacts**:

- Take a detailed history from the case to exhaustively identify all social, familial, work, and health care worker who have had contact with the case from 2 days before symptom onset of the case and up to 14 days after their symptom onset, or in the case of contact of asymptomatic case 2 days before and up to 14 days after the collection date of the sample testing positive.
- [Annex 2](#) can assist identifying contacts in different settings.

2.5 For **all contacts**:

- Record details of the nominated contacts on the Contact Information and Monitoring sheet (attached) and in the Excel Contact Tracing line list.
- For Go.Data users, use the Go.Data Contact Tracing Form and Go.Data Excel line list. (Other applications such as SORMAS may also have specific forms.)
- Record demographic information, date, and type of exposure between the nominated contact and the case (and dates of common exposure for both case and contact if this is relevant).
- Consider the exposure of the nominated contact to the case and the likely timeline of events.
- Assess the risk of the exposure against the criteria for defining contacts and detailed examples in [Annex 2](#) and decide whether the person should be managed as a contact of the case.
- Using the most recent date when the contact was exposed to the case (remembering that this could be 2 days before symptom onset in the case or 2 days before the collection date of the sample testing positive for asymptomatic case) count forward 14 days from that date. This represents the quarantine period for the contact. Note that the quarantine may be prolonged if continuous exposure occurs or for family members of contacts who quarantine at home and later develop symptoms.

3. Informing Contacts

- 3.1 Communicate by telephone or in person with each identified contact and inform them that they may have been exposed to a case of COVID-19.
- 3.2 Confirm the information provided by the case to check if the nominated person meets the contact definition.
- 3.3 Confirm and complete details in the Contact Information and Monitoring Form ([Annex 3](#)).
- 3.4 Inform the contact about the following:
 - The process and rationale for contact tracing including why the contact is required to remain at home or at a designated setting for the defined period of quarantine.
 - The need for physical distancing and practicing appropriate personal hygiene.
 - Where they will be quarantined and how they will be cared for.
 - What symptoms to look out for during the quarantine period.
 - What to do if they experience symptoms.
- 3.5 Contacts must be provided with the telephone number (or other means of contact) of a health care worker who is to be contacted should symptoms develop.

4. Contact Management and Follow-up Process

- 4.1 A decision on where a contact is to be quarantined will depend on the local context as well as the circumstances of the person being quarantined. A home setting may be appropriate at times. A suitable facility for quarantining contacts such as a motel or similar may also be used particularly for those requiring close monitoring or where a home setting is unsuitable for quarantine or for groups such as travellers.
- 4.2 The local authorities should ensure that the quarantine setting is appropriate and that adequate food, water, and hygiene provisions can be made for the quarantine period, minimum Infection, Prevention and Control (IPC) measures can be implemented and minimum requirements for monitoring the health of quarantined persons can be met during the quarantine period.
- 4.3 For daily follow-up, phone or visit the contact (using appropriate PPE and physical distancing [at least 1 metre] as necessary) and enquire about symptoms and compliance with quarantine arrangements. This may also be possible via SMS or web-based platforms.
- 4.4 Record the contact's temperature either using the contact's thermometer or one provided at the commencement of quarantine.
- 4.5 Document information in the Contact Information and Monitoring Form ([Annex 3](#)). Remember to code the daily status of the contact, contact's temperature, the method of follow-up and add your initials to identify who performed follow-up on each day. (For technology users, applications such as Go.Data include a contact follow-up and data recording process).
- 4.6 Management of the contact may be modified by public health authorities, depending on factors such as exposure risk assessment and compliance of the contact with quarantine.
- 4.7 In certain circumstances quarantined individuals may be asked to self-monitor and report immediately by phone to health authorities should symptoms develop.
- 4.8 Where a contact does not comply with quarantine restrictions and is potentially exposed to infection, the period of quarantine must recommence and measures taken to ensure compliance.
- 4.9 If a contact cannot be reached or leaves the area, efforts must be made to find the contact. This may include asking relatives and friends or a contact tracing team in the other area to search for the contact.

5. Contact Discharge

- 5.1 If a contact completes the quarantine period without developing symptoms they can be discharged from quarantine and instructed to comply with existing community physical distancing and other control arrangements ([Annex 1](#)).
- 5.2 If the contact reports symptoms, the officer undertaking the follow-up must inform the supervisor who will ensure the symptomatic contact is isolated and, if available, tested for COVID-19. If testing is not available these cases must be isolated for 10 days after symptom onset plus at least 3 days since the end of fever and respiratory symptoms. Asymptomatic cases must isolate for 10 days after positive test result. As a probable or confirmed case, details should be recorded on the case report form or aggregated case list.
- 5.3 If the investigation leads to a person being re-classified as a non-contact, the contact may be discharged from quarantine.
- 5.4 If the investigation leads to the linked/source case being re-classified as a non-case (discarded case), the contact may be discharged from quarantine.

Healthcare workers*

For potentially exposed health care workers caring for a COVID-19 case, a detailed exposure risk assessment should be undertaken to assess the type of exposure and PPE use at the time of exposure.

- Any exposed staff member not wearing appropriate PPE at the time of exposure (as per contact definition) should stop working, undergo quarantine, and self-monitor for 14 days following last exposure.
- Staff who were exposed to a COVID-19 patient but are assessed as having worn appropriate PPE at the time of exposure may continue to work.
- Staff should report daily to a COVID-19 focal point in their workplace for any illness.
- Health care personnel exposed to a COVID-19 case outside of the health care setting will follow the same rules and monitoring principles as community contacts.

(*Extract from *Contact tracing in the context of COVID-19 Interim Guidance 10 May 2020*)

Community Engagement

It is recommended that public health authorities proactively engage with communities to provide information and reassurance about what contact tracing and management involves and how personal information will be protected from harmful disclosure. Effective community engagement will support voluntary compliance with contact quarantine arrangements and can counter potential challenges such as stigmatization of contacts and misinformation.

Pacific communities are diverse in nature and rural and remote settings, crowded and heavily populated settings and settings containing vulnerable people will present specific challenges. Engaging community support will be vital in addressing these challenges and implementing effective contact tracing and management procedures (see also *Engaging Communities in Contact tracing in the context of COVID-19 guidance*).

Monitoring Indicators

It is recommended that performance indicators should be compiled daily and used to monitor the performance of contact tracing activities. Examples are provided in Table 1.

Table 1: Daily Monitoring Indicators*

Indicator	Definition	Use
Proportion of contacts seen	# contacts seen / # contacts to follow (stratified by geographic region, type of contact, contact tracer)	<ul style="list-style-type: none"> • Monitor coverage • Identify areas with low coverage • Identify poor contact tracing performance
Proportion of contacts lost to follow up (arbitrarily defined as not seen for >2 days)	# contacts not seen for >2 consecutive days / 1 # contacts to follow (stratified by geographic region, type of contact)	<ul style="list-style-type: none"> • Identify areas with persistently low coverage and higher risk of spread • Identify individual contacts to be located (where resources allow)
Proportion of contacts who become suspect cases	# new suspect cases / # contacts to follow	<ul style="list-style-type: none"> • Monitor contact tracing quality (having no suspect cases among contacts may suggest that the monitoring is not rigorous enough)
Proportion of contacts who become confirmed cases	# new confirmed cases / # of contacts to follow	<ul style="list-style-type: none"> • Track outbreak dynamics
Proportion of new cases who are known contacts	# newly confirmed cases among contacts / # newly confirmed cases	<ul style="list-style-type: none"> • Track the quality and completeness of contact identification
Time from symptom onset to case confirmation	# hours/days between symptom onset in contact and case isolation/confirmation	<ul style="list-style-type: none"> • Track the performance of contact tracing to rapidly

(*Extract from WHO Guidance Contact tracing in the context of COVID-19 Interim Guidance 10 May 2020)

Issues to consider:

- Pre-positioning of quarantine kits, which include a thermometer, hand sanitiser, masks, and other necessary provisions.
- Establishment of Hotline or designated phones contactable 24/7 for persons who become symptomatic to call.
- Stocking and positioning PPE: required for staff that will be conducting contact tracing.
- Delivery of food and other essential items such as medication to people in quarantine
- Financial compensation for lost income.
- Letter or medical certificate for employers of contacts for the quarantine/isolation period.
- Psychosocial support: finding ways for people to communicate, connect and demonstrate concern with quarantined persons/household will make quarantine less stressful and encourage adherence.
- Healthy tips during quarantine for exercise and nutrition.

For information related to the identification, administration, infection control and cleaning of quarantine locations refer to:

World Health Organization. *Considerations for quarantine of individuals in the context of containment for coronavirus disease (COVID-19) Interim guidance 19 March 2020*

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>

Staffing for Contact Tracing

Without additional staff and support, public health teams in PICs will be rapidly overwhelmed by case investigation and contact management activities associated with COVID-19. Recent experience with measles outbreaks has highlighted these challenges. It is essential that early consideration is given to the identification and training of a surge workforce for public health to undertake contact tracing and other tasks.

In the initial stage when case numbers are small and the focus is on containment, medical and nursing staff from clinical and community services may be available to support case investigation and contact management activities conducted by public health. However, as the outbreak develops there will be a heavy demand on clinical services. Public health will require a surge workforce drawn from other sectors.

Additional staff may be identified to undertake the following:

- Data entry
- Regular (daily) follow-up of people in isolation or quarantine to ensure compliance and to monitor health status

Staff in the categories above should be identified and trained prior to the onset of the outbreak. Where possible experienced public health staff should act as team leaders for these additional staff. Interviews with cases and possible contacts should wherever possible be undertaken by experienced public health staff.

References

World Health Organization. Public Health Surveillance for COVID-19 Interim guidance 7 August 2020. Available: <https://www.who.int/publications/i/item/who-2019-nCoV-surveillanceguidance-2020.7>

World Health Organization. Contact tracing in the context of COVID-19 Interim Guidance 10 May 2020. Available: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>

World Health Organization. Considerations for quarantine of individuals in the context of containment for coronavirus disease (COVID-19) Interim guidance 19 March 2020. Available: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>

World Health Organization. Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts Interim guidance 17 March 2020. Available: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>

European Centre for Disease Prevention and Control. Public health management of persons having had contact with cases of novel coronavirus in the European Union, 25 February 2020. Stockholm: ECDC; 2020. Available: <https://www.ecdc.europa.eu/sites/default/files/documents/covid-19-public-health-management-contact-novel-coronavirus-cases-EU.pdf>

European Centre for Disease Prevention and Control. Resource estimation for contact tracing, quarantine and monitoring activities for COVID-19 cases in the EU/EEA. ECDC: Stockholm; 2020. Available: https://www.ecdc.europa.eu/sites/default/files/documents/COVID-19-resources-for-contact-tracing-2-March-2020_0.pdf

Communicable Disease Network Australia Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units. Available: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm>

This document has been developed in accordance with global guidance and contextualized to the Pacific context by the Epidemiology and Surveillance Cell of the COVID-19 Pacific Joint Incident Management Team

Annex 1
Interim Guidance for Contact Tracing

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Interim Guidance for Contact Tracing for COVID-19 in Health Care Setting

24 June 2020



Applicable where testing for COVID-19 is available.

Confirmed case is identified in health care setting

Identify contacts

*Note: contact with a **symptomatic (confirmed or probable) case** from 2 days before symptom onset of the case and up to 14 days after their symptom onset.*

*Note: contact with an **asymptomatic case** from 2 days before and up to 14 days after the collection date of the sample testing positive.*

Quarantine and monitor contacts for 14 days from time of last exposure to case

Test all HCW and patient contacts regardless of development of symptoms

Symptoms

Negative

Positive or Inconclusive for COVID-19

Isolate, test and treat as probable COVID-19 case
(Refer case management algorithm)

Continue to monitor for 14 days total

Symptomatic cases: 10 days after symptom onset plus at least 3 days without symptoms (without fever or respiratory symptoms)

Asymptomatic cases: 10 days after positive test

Monitoring can stop. Release from transmission precautions in hospital or home isolation.

Identify their contacts and repeat contact tracing cycle

Notes: Case definitions and other advice may change. Use flow chart in conjunction with relevant guidance. See Contact Management guidance for contact definition.

Interim Guidance for Contact Tracing for COVID-19 in Community and Health Care Settings

28 May 2020



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Applicable where testing for COVID-19 is NOT available.

Probable case is identified in the community or in a health care setting

Identify contacts

Note: contact with a probable case from 2 days before symptom onset of the case and up to 14 days after their symptom onset.

Quarantine and monitor contacts for 14 days from time of last exposure to case

No symptoms

Continue to monitor for 14 days total

Symptoms

Isolate and treat as probable COVID-19 case
(Refer case management algorithm)

10 days after symptom onset plus at least 3 days without symptoms
(without fever or respiratory symptoms)

Identify their contacts and repeat contact tracing cycle

Monitoring can stop. Release from transmission precautions in hospital or home isolation.

Notes: Case definitions and other advice may change. Use flow chart in conjunction with relevant guidance. See Contact Management guidance for contact definition.

Interim Guidance for Contact Tracing for COVID-19 in Community Setting

24 June 2020



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Applicable where testing for COVID-19 is available.

Confirmed case is identified in the community

Identify contacts

*Note: contact with a **symptomatic (confirmed or probable) case** from 2 days before symptom onset of the case and up to 14 days after their symptom onset.*

*Note: contact with an **asymptomatic case** from 2 days before and up to 14 days after the collection date of the sample testing positive.*

Quarantine and monitor contacts for 14 days from time of last exposure to case

No symptoms

Monitoring and quarantine can stop

Symptoms

Isolate, test and treat as probable COVID-19 case
(Refer case management algorithm)

Symptomatic cases: 10 days after symptom onset plus at least 3 days without symptoms (without fever or respiratory symptoms)

Asymptomatic cases: 10 days after positive test

Monitoring can stop. Release from transmission precautions in hospital or home isolation.

Identify their contacts and repeat contact tracing cycle

Notes: Case definitions and other advice may change. Use flow chart in conjunction with relevant guidance. See Contact Management guidance for contact definition.

Annex 2

Examples of identifying contacts in different settings

Setting	Specific contact by setting	Ways to identify contacts
Known/identifiable contacts		
Household and community/social contacts	<ul style="list-style-type: none"> • Face-to-face contact with a case within 1 metre and for >15 minutes • Direct physical contact with a COVID-19 patient • Providing direct care for a COVID-19 patient in the home without proper PPE • Anyone living in the household 	<ul style="list-style-type: none"> • Direct interview with the COVID-19 patient and/or their caregiver(s). This could be done in person or by telephone
Closed settings, such as long-term living facilities, and other high-risk congregational/closed settings (prisons, shelters, hostels)	<ul style="list-style-type: none"> • Face-to-face contact with a case within 1 metre and for >15 minutes • Direct physical contact with a COVID-19 patient • Providing direct care for a COVID-19 patient in the home without proper PPE • Sharing a room, meal, or other space with a confirmed patient • If contact events are difficult to assess, a wider definition may be used to ensure that all residents, especially high-risk residents, and staff are being monitored and screened 	<ul style="list-style-type: none"> • Direct interview with the COVID-19 patient and/or their caregiver • List of residents, visitors, and all staff members working during the relevant timeframe • Interview with coordinator or manager of facility
Known context, but contacts unknown		
Healthcare settings	<ul style="list-style-type: none"> • Health care workers: any staff in direct contact with a COVID-19 patient, where strict adherence to PPE has failed. • Contacts exposed during hospitalization: any patient hospitalized in the same room or sharing the same bathroom as a COVID-19 patient, visitors to the patient, or other patient in the same room; other situations as dictated by risk assessment • Contacts exposed during outpatient visits: Anyone in the waiting room or equivalent closed 	<ul style="list-style-type: none"> • Identify all staff who have been in direct contact with the COVID-19 patient or who may have been within 1 metre of the COVID-19 patient without PPE for >15 minutes without direct contact (e.g. chaplain) • Review the list of patients hospitalized in the same room or room sharing same bathroom • List of visitors who visited the patient or another patient in the same room during the relevant timeframe • Undertake a local risk assessment to determine whether any additional

	<p>environment at the same time as a COVID-19 should be listed as a contact</p> <ul style="list-style-type: none"> • Anyone within 1 metre of the COVID-19 patient in any part of the hospital for >15 minutes 	<p>exposures may be relevant, such as in common dining facilities</p>
Public or shared transport	<ul style="list-style-type: none"> • Anyone within 1 metre of the COVID-19 patient for >15 minutes • Direct physical contact with a COVID-19 patient • Anyone sitting within two rows of a COVID-19 patient for >15 minutes and any staff (e.g. train or airline crew) in direct contact with the case 	<ul style="list-style-type: none"> • Contact identification is generally possible only where there is allocated seating • Airlines/transport authorities should be contacted to obtain details of passengers and flight manifests • For public or shared transport where passenger lists or allocated seating is not available, a media release may be required to request passengers to self-identify. Media release may specify the date, time, pick-up location and arrival/destination, and stops along the way, requesting people self-identify as a potential contact
Other well-defined settings and gatherings (places of worship, workplaces, schools, private social events)	<ul style="list-style-type: none"> • Anyone within 1 metre of the COVID-19 patient for >15 minutes • Direct physical contact with a COVID-19 patient • When events are difficult to assess, the local risk assessment may consider anyone staying in the same close and confined environment as a COVID-19 patient as a contact 	<ul style="list-style-type: none"> • Undertake a local risk assessment and collaborate with organizers/leadership to notify potential contacts either actively or passively (for example, through ‘warn and inform’ messages to an audience of potential attendees) • Communication with focal points, such as faith leaders, about potential transmission events to raise awareness (‘warn and inform’) • For private social events, work from guest registration and booking lists • When necessary, consider media release specifying the event day and time, with request for people to self-identify as a potential contact

Source: Reproduced from World Health Organization. Contact tracing in the context of COVID-19 Interim Guidance 10 May 2020
<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>

Annex 3

Contact Information and Monitoring Form Template

Use a separate form for each contact. Keep the contact forms together with others associated with the same case. If using Go.Data do not complete this form. Use the Go.Data form and line list instead.

Date form completed: _____

Case Information (Record here the details of the case that the contact has been exposed to)					
Case ID No:		Case Surname:		First Name:	
Gender:	M/F	Age: (select one option)		Yrs (if ≥ 2)	Mnths (if < 2 yrs)
Date of onset of symptoms of the case: mm/dd/yy					
Date of positive test: mm/dd/yy (Asymptomatic cases only)					

Contact Information (Record here the details of the contact)					
Contact ID No:		Contact Surname:		First Name:	
Gender:	M/F	Age: (select one option)		Yrs (if ≥ 2)	Mnths (if < 2 yrs)
Address:					
Telephone:			Occupation:		
Date of last exposure to case: mm/dd/yy			Date at 14 days forward from this exposure mm/dd/yy		
Describe type and length of exposure and where: (e.g.: face to face, physical, health care, household)					
Link to cluster	Y/N	If yes, record cluster ID:			

Contact Follow-up (Record here details of daily follow-up)														
Instructions:														
1. Count 14 days since the last exposure of the contact to the case. Insert the dates against the 14 days in the table below. Put a line through any days prior to the identification of the contact for which monitoring did not occur e.g. first two days.														
2. In 'Method', monitor contacts each day either by Telephone "T", Face to face "F" or other "O". Record how monitoring was done each day.														
3. In 'Status', each day record whether: Contact was not able to be contacted "0"; Contact was contacted and asymptomatic "1"; Contact was symptomatic "2". (Advise supervisor of any "0" and "2" results)														
4. Record temperature of contact.														
5. Initial under each recording.														
	Days of Follow-up													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
Method (T, F, O)														
Status (0, 1, 2)														
Temperature														
Initial														

Quarantine Outcome (Record here the outcome of the quarantine period)	
Contact Discharged from Quarantine (D): <input type="checkbox"/>	Contact Developed Symptoms (S): <input type="checkbox"/>
Classified as non-contact (NC) <input checked="" type="checkbox"/>	Date of outcome: mm/dd/yy