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CIRCULAR NO. H 20/2022

UPDATED POLICY ON COVID ISOLATION, QUARANTINE AND CONTACT TRACING

Purpose

To update and finalise the provincial policy on isolation, quarantine and contact tracing for COVID contained in Circular H03/2022. This policy now supersedes that contained in H03/2022 and is fully aligned to the Guidelines from the National Department of Health of 17 February 2022 (attached).

Background

The updated Disaster Management Regulations of 1 February 2022 reduced isolation periods for symptomatic and asymptomatic COVID patients and Guidelines provided by the National Department of Health on 17 Feb 2022, provided further clarity on how to implement isolation, quarantine and contact tracing, in various scenarios. There has been a large social, economic and educational cost incurred in implementing strict isolation, quarantine and contact tracing procedures throughout the COVID-19 pandemic. However, the benefit derived from these strict procedures has been less than that hoped for at a community level, with little effect on mitigating the COVID-19 pandemic in the country. These measures had not been implemented widely and comprehensively enough to achieve sufficient mitigation of the impact of COVID-19 and also to justify the financial impact of implementing these measures.

In addition to this at periodic intervals (during waves) very high numbers of essential workers with mild COVID-19 infections and their close contact colleagues, are in isolation or quarantine and hence not available to provide essential services, including comprehensive health care. The absence of a large percentage of the essential worker complement hugely impacts the ability to provide adequate essential services to the population and demoralises the depleted ranks of staff left to continue with service provision.

During the latest and 4th wave of COVID-19 infections, the proportion of people developing severe disease and dying due to COVID-19 has dropped dramatically, due mainly to a rising percentage of people who have been vaccinated and to a large percentage of people having contracted COVID-19 previously, both of which protect against severe disease and death. Given this combination of high cost associated with isolation, quarantine and contact tracing, with limited benefit, as well as the adverse effect on health care staffing levels and the effective lessening of the severity of COVID infection, it is appropriate to review these practices and retain in a refined manner, a mixture of the most beneficial aspects combined with the lowest cost activities.

The regulations do not require those with **asymptomatic** COVID infection to isolate and at a population perspective this is reasonable, as those with asymptomatic COVID have a lower level of transmission, most people with asymptomatic COVID would not be identified. In addition, the time duration since onset of the infection for

asymptomatic patients is unknown and these people may already have passed the infectious period (people are most infectious 2 days before to 5 days after onset of COVID symptoms).

However, even though they do not have to isolate, asymptomatic COVID infected people can transmit COVID to others and hence should be advised to at least engage in COVID avoidance practises with a low cost and high benefit ratio, such as, observe strict mask wearing, avoid **social** gatherings for 5 days, avoid **socially** meeting with others in indoor spaces for 5 days and specifically avoid **socially** interacting with those who are at risk of developing severe COVID disease (the elderly [>60 years] and those with co-morbidities [diabetes, lung disease, heart disease, kidney disease, cancer, uncontrolled HIV, immunocompromised], for 5 days since testing.

Unfortunately, avoidance of others in workplaces and educational settings would have a much higher cost and noting that in those settings there would be many more undiagnosed asymptomatic people with COVID than diagnosed asymptomatic people, it would be pragmatic to allow them to be present while upholding strict mask wearing and encouraging the best possible ventilation in these settings. However, in confined congregate settings where there are many people at high risk of severe disease and where mingling time would be prolonged, such as health facilities and care homes, extra precautions should be taken. If asymptomatic COVID infected people need to be admitted to hospital for some other ill health condition, then it would be pragmatic to place them in a COVID ward for 5 days. Similarly, if they need to be placed in a care home, or old age home, or prison, then it would be pragmatic to isolate them for 5 days. Asymptomatic COVID infected staff at health facilities and care homes should, as a precaution against infecting the vulnerable, stay away from the workplace for 5 days. It should be noted that asymptomatic COVID positive people would be a small group, as in general people without COVID symptoms are not tested for COVID.

The regulations prescribe 7 days of isolation for those with symptomatic COVID. Isolating **symptomatic** COVID patients for 7 days is reasonable, as transmission of the coronavirus after day 8 is rare when the infected person has **mild disease** (does not require hospitalisation for COVID pneumonia). However longer isolation for those with **severe disease** (hospitalised with COVID pneumonia) would be required and it would be prudent to continue their isolation for 7 days from the date on which they no longer require oxygen therapy. Note that this extended isolation does not apply to those patients with mild symptomatic COVID infection, who are admitted to hospital for other pathologies (coincidentally admitted COVID patients). These coincidental symptomatic admitted patients should be isolated in COVID wards for 7 days.

Quarantine was instituted early on in the pandemic as an added pre-cautionary measure in an attempt to contain and/or mitigate the pandemic. It is precautionary in that people exposed to coronavirus are not infectious unless and until they become infected with COVID. Up to that point they are not a risk to others and would only become infectious if they themselves develop COVID, noting that transmission occurs from two days before the onset of symptoms.

Importantly, quarantine affects large numbers of people and therefore has a high social, economic and educational cost, but derives very little benefit. Close contacts of people with COVID should instead of quarantining, rather closely watch out for COVID symptoms (cough, sore throat, weakness, tiredness, headache, fever, muscle pain, diarrhoea, runny nose, blocked nose, phlegmy throat, or loss of taste and smell) and isolate if any symptoms appear. In some instances, people would experience ongoing exposure to those COVID infected, which would mainly be to those who are asymptomatic (since these people are not isolating), but also to symptomatic COVID infected where full isolation is impractical (e.g. caregiver of symptomatic infected child, or members of a household with limited ability to isolate). This ongoing exposure is typically in the latter period of the COVID infection. Exposure to those COVID infected is however in many cases ongoing, as transmission commences before symptoms occur and before a diagnosis of

COVID is made. Hence these people differ from others only in the time-period that their ongoing exposure takes place and given that the most infectious time-period is early on (just before and just after onset of symptoms) their exposure risk is probably low. They should therefore also not quarantine, but rather closely watch out for symptoms.

Active Contact Tracing was an activity undertaken to actively and extensively search for close contacts of those with COVID infection, in order to encourage them to quarantine. Since quarantine is no longer contemplated, *active contact tracing naturally falls away*. However, people exposed to the coronavirus should still be informed of this and exhorted to watch out for symptoms, as described above. Informing people of their exposure to coronavirus can be achieved passively, simply by the attending clinician telling patients with COVID (or their caregivers), to alert those who have been in contact with them while they were infected, to watch out for COVID symptoms. Contacts should then isolate if they develop symptoms. Alternatively **passive informing** can be done by sending an SMS to the person with COVID, asking them to alert their contacts.

Clusters of COVID cases (3 or more people COVID infected in a group within the same time-period) have previously been managed by attempts to contain the outbreak by isolating those infected, quarantining those exposed within the group and actively searching for other contacts. While a lot of time and energy has been expended on attempting to contain outbreaks, the effectiveness of these activities is doubtful as invariably they occur too late and after many in the group have already been exposed. They could however be valuable when an outbreak occurs within a setting where there are vulnerable people, such as in a health facility and a care home. Since quarantining and active contact tracing is being stopped, there is no need for an outbreak investigation or for dispersing the group, except if the outbreak is within a vulnerable population. Those COVID infected in a cluster should be isolated and those exposed should closely watch out for symptoms and isolate as soon as they occur.

Policy Position

1. Isolation for Asymptomatic COVID infection

- 1.a. People with **asymptomatic** COVID infection do **not** need to isolate, however they should be advised to:
 - Wear a mask whenever interacting with people, for the next 5 days from the date of the test
 - Avoid **social** gatherings (3 or more people) for 5 days from date of test
 - Avoid being with others **socially** in indoor spaces, for 5 days from date of test
 - Specifically avoid **socially** interacting with the elderly (>60 years) and anyone with co-morbidities (diabetes, lung disease, heart disease, kidney disease, cancer, uncontrolled HIV, immunocompromised), for 5 days from date of test.
- 1.b. A special scenario is people with **asymptomatic** COVID infection who are *admitted to hospital, or a congregate setting with people at risk of severe diseases, such as a care home*. They should be isolated in a separate room, or in a COVID ward, for 5 days from the date of the test.
- 1.c. Asymptomatic COVID infected staff at health facilities and care homes, should stay away from the workplace for 5 days from the date of the test. Where possible to do so, they should work remotely from home.

2. Isolation for Mild Symptomatic COVID infection

Those with **symptomatic** COVID infection who have **mild disease** (they do not require hospitalisation for COVID pneumonia) should isolate for 7 days from the date of start of symptoms.

3. Isolation for Severe Symptomatic COVID infection

Those with **symptomatic** COVID infection who have **severe disease** (they have been admitted to hospital for COVID pneumonia) should continue to isolate for 7 days from the date on which they no longer require oxygen therapy.

4. Quarantine

- 4.a. All quarantine should be stopped. This applies to everyone including health care workers.
- 4.b. An exception to this is where a cluster of COVID cases (3 or more people COVID infected in a group within the same time-period) occurs in a health facility or care home.
- 4.c. Those with ongoing exposure to asymptomatic COVID infected persons (since these people are not isolating) or to symptomatic COVID infected persons (e.g. caregiver of symptomatic infected child) do not need to quarantine.
- 4.d. Those who had exposure to COVID should closely watch out for COVID symptoms and isolate if any symptoms appear.

5. Contact Tracing

- 5.a. **Active contact tracing** should be stopped.
- 5.b. An exception is where a cluster of COVID cases (3 or more people COVID infected in a group within the same time-period) occurs in a health facility or care home.
- 5.c. **Passive contact informing** by alerting (either by a clinician or an SMS) people with COVID to inform others that they have been exposed to the coronavirus and should watch out for COVID symptoms, should continue.

6. Outbreak Investigation and Containment

Investigations and containment activities (quarantine and active contact tracing) of a cluster of COVID cases (3 or more people COVID infected in a group within the same time-period) should be limited to **health facilities and care homes**.

7. Complex scenarios for Isolation, Quarantine and Contact Tracing

While the above guidelines on isolation, quarantine and contact tracing covers most scenarios, there might be some unique complex scenarios not covered by the above, and in those unique situations the clinician/s involved should use their discretion on how to proceed, by balancing the safest option against the socio-economic cost.

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