

TO: ALL HEADS OF DIVISIONS / DIRECTORATES / CHIEF DIRECTORATES / HEADS OF INSTITUTIONS / REGIONS / DISTRICTS AND SUB-STRUCTURES

**CIRCULAR NO. H 49 /2022**

**UPDATED COVID TESTING AND SCREENING CRITERIA DURING THE 4<sup>TH</sup> INTER-WAVE PERIOD**

**1. PURPOSE**

To provide updated criteria for COVID-19 testing and screening during the fourth inter-wave period, which moves towards integrating COVID services with all other health services, in the most effective and efficient manner. The reduction in COVID-19 infections and the comparatively much lower level of hospitalisations and deaths associated with COVID, which we are now experiencing, makes this possible. This circular replaces the previous circulars in this regard i.e. Circulars H175/2020; H186/2020; H222/2020; H231/2020; H17/2021, H37/2021, H80/2021 and H205/2021.

**2. BACKGROUND**

**COVID Testing Criteria**

Initially during the COVID pandemic widespread testing was used in an attempt to mitigate transmission of the coronavirus, by isolating the patient and quarantining their close contacts. However, we simply did not possess, and do not possess, sufficient resources to do this quickly enough and comprehensively enough to significantly dampen COVID infections. Hence the focus of testing has mainly moved to provide a definitive diagnosis to direct the care of the patients with disease severe enough to require admission to hospital. In addition, for patients at risk of severe disease (the elderly and those with co-morbidities), their mortality is lowered if they are diagnosed early before they deteriorate and require admission. Hence testing them before they require admission and implementing a care plan that would rapidly detect clinical deterioration and facilitate early admission, is important. Conversely testing those with COVID symptoms who do not have severe disease (are not ill enough to be admitted to hospital) and are not at risk of developing severe disease (the young and those without co-morbidities), is of limited value, as confirming the diagnosis with a test will not affect their clinical management. Additionally, as the isolation period has been reduced to 7 days and as the COVID point prevalence is low and hence the probability of testing positive for COVID is low, coupled with the inability to conduct active contact tracing successfully, the value of testing those not at risk of developing severe disease is further lowered. Finally, testing patients for COVID is resource intensive in terms of staff time, facility space and high cost of the test and hence limiting testing allows these resources to be used for other useful activities.

The highest value in testing is obtained from testing patients who have COVID symptoms. Patients who have no symptoms suggestive of COVID have a much lower probability of testing positive and hence we do not test these patients. Previously we have been testing all asymptomatic patients before a surgical operation, however

the probability of them testing positive during an inter-wave period is very low and the peri-operative risk posed by asymptomatic COVID is much lower than that for symptomatic COVID, and hence it is not practically feasible to test these patients.

Patients with COVID symptoms who are not tested would not be required to isolate (as test positivity is low [3% – 7%] in the inter-wave period), but should instead follow the same transmission precautions as for asymptomatic COVID infected patients. These are to wear a mask whenever interacting with people, for 5 days, avoid social gatherings (3 or more people) for 5 days, avoid being with others socially in indoor spaces for 5 days, 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.

### **Type of COVID Test**

Antigen point of care tests are an important tool, as the results of the test are available much quicker than PCR tests (result available in 20 minutes as opposed to approximately 24 hours for PCR test) and they are much cheaper than PCR tests (approximately a quarter of the cost). The Antigen test has high specificity (>99%) and hence all those who test positive are treated as coronavirus positive. However, the Antigen test has a lower sensitivity (70% - 80%) in some contexts, although in other contexts it has higher sensitivity and up to 100% sensitivity in patients with high viral loads. It has low sensitivity when the coronavirus viral load is low and high sensitivity when the coronavirus viral load is high. This means that the Antigen Test will misdiagnose some patients who actually have COVID, indicating that they are uninfected (false negative). However, this is much more likely to occur when the patients are infected but have low infectiousness potential (low viral load), than when they have a high infectivity potential (high viral load). The implication of this is that the antigen test is very good at detecting those individuals who will spread the disease.

The number of false negatives are also affected by the pre-test probability of infection, which is itself linked to the prevailing point prevalence. The lower the point prevalence (and hence lower risk of spread of the coronavirus in the community) the lower will be the pre-test probability and the lower will be the number of false negatives. Hence during periods of low population point prevalence of COVID, such as the inter-wave period, the value and safety of antigen tests is enhanced. However, for some sub-groups, such as those admitted with severe disease, or symptomatic patients pre-operatively, the consequences of a false negative status might be more serious than for other subgroups, such as those with mild infection. For these small subgroups and those with a high pre-test probability of infection, follow-up PCR testing is required. Whereas for the majority of patients during a low population point prevalence of COVID, **follow-up PCR testing after a negative Antigen test, is not required, as false negatives are small in number.** This is very important, as it means that for the majority of patients suspected of having COVID during an inter-wave, an Antigen test to determine coronavirus infection is all that is required.

### **Screening**

While active screening for COVID exposure and symptoms has been widely used in the past, it is unclear how effective this has been. In particular patients might deny COVID symptoms if they perceive that they will as a result of disclosure, receive different care to what they initially presented themselves for and which they are most concerned about. Also, screening would have a low yield of “positive screens” during the inter-wave period and therefore the staff time utilised for screening could be more usefully deployed to perform other high yield tasks. The results of screening are being recorded but these lists are not being used for any useful



purpose and hence could be halted. Instead of active screening, passive screening could be implemented with patients attending health facilities being asked to inform a staff member if they have COVID symptoms. This could be done by asking people in groups in a queue or waiting room, via posters and pamphlets, and by individually asking patients when taking their medical history. Staff could self-screen and then go for testing if they screen positive.

### 3. POLICY POSITION

#### A. COVID Testing Criteria

The COVID Testing Criteria are modified to the following situations.

##### A.1. Provide a COVID test for:

1. People with coronavirus symptoms **AND** who are admitted to hospital
2. People with coronavirus symptoms **AND** who are at high risk of severe disease (those aged >40 years; those of any age who have one or more of the following co-morbidities: Diabetes, Obesity, Heart disease, Lung disease, Kidney disease, Cancer, Tuberculosis and poorly controlled HIV).
3. People with coronavirus symptoms **AND** who are awaiting surgery (should be tested 3 days or less before their operation).
4. Health Care Workers and Care Home Workers **WITH** coronavirus symptoms
5. Natural deaths who had coronavirus symptoms.
6. Those who previously tested positive for COVID but have developed new coronavirus symptoms, should only be tested 90 days after their first test (if they meet the criteria above).

**A.2.** Do **NOT** test those who are **COVID asymptomatic**. This includes health workers, care workers, patients awaiting surgery and patients admitted to hospital.

**A.3.** While the above criteria would cover the vast majority of circumstances, it is accepted that not all possible circumstances can be pro-actively provided for, and hence for unusual circumstances the attending clinician should exercise their clinical judgement around whether to provide a COVID test to a patient, or not, based on the specific clinical picture.

#### B. Managing patients with COVID symptoms who will NOT be tested

All patients who have coronavirus symptoms, but who do not fit the criteria above, and hence will not receive a COVID test, should be informed that they do **NOT need to isolate**. However, they should be advised to:

1. **Wear a mask** whenever interacting with people for the next 5 days
2. **Avoid social gatherings** (3 or more people) for 5 days
3. **Avoid** being with others **socially** in **indoor spaces** for 5 days
4. 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

#### C. Type of COVID Test to use

**C.1. Antigen testing** is mandated as the **first line test** for criteria 1, 2, 4 and 6, which covers the vast majority of patients.

1. **no further testing is required for Antigen negative test results**, except for the circumstances in the bullet below.



2. **Patients admitted to hospital** and patients whose particular clinical picture suggests a high probability of a false negative antigen test, **should have a follow-on PCR test done**, if the Antigen test is negative.

**C.2. PCR testing** should be done for patients tested for **criteria 3 and 5**.

**D. Screening**

- D.1. Active screening** (and recording of the screening result) of patients and staff on arrival at health facilities, **should be stopped**.
- D.2.** All patients and escorts should simply be advised, verbally (singly or in groups), via broadcasts and via signage, to report to clinical or administrative staff if they have symptoms suggestive of COVID. These patients are then tested if they meet the criteria above.
- D.3.** All staff should be asked to self-screen before reporting for duty and to obtain a COVID test if they have self-screened positive for COVID.

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