Western Cape Government

OFFICE OF THE DDG: CHIEF OF OPERATIONS
REFERENCE: 16/4
ENQUIRIES: S Kariem

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

CASE AND CONTACT TRACING WITHIN AVAILABLE RESOURCES (i.e. MITIGATION)

A second wave of COVID infections is occurring in the Western Cape, and with it a recognition that community transmission is well established and widespread.

In addition, there is a severe shortage of staff, either because of illness, isolation and quarantine, or because of leave during this peak holiday season.

For these reasons there is a need to rationalise the public health response to COVID according to the following principles:

1. Do what is possible re case and contact tracing - within available resources
2. Recognise that the overall approach needs to shift to 'mitigation', meaning:
    a. Minimizing morbidity and associated mortality
    b. Avoiding an epidemic peak that overwhelms health-care services
    c. Keeping the effects on the economy within manageable levels
3. Workflow processes should be largely 'case-focused'– as opposed to 'case **and** contact' focused – and should be built around imparting diagnosis, ensuring cases know how to isolate, establishing the presence of risk factors, monitoring if identified as high risk, referring if ill etc
    a. You are not expected to call every known case for every day of their 10-day illness if resources do not allow for this
    b. If Outbreak teams are not able to make calls to all the cases on their line list, the following options can be used to prioritize who to call, depending on the capacity to make calls:
        i. Use the case prioritization line list on SPV to identify the at-risk cases (those with known co-morbidities) who should be called.

ii. In the Metro, diabetes can be excluded as a risk factor, seeing they are being managed through the Vector program.
iii. Prioritize public-sector tested cases
iv. Prioritize private-sector tested cases who live in disadvantaged areas
v. De-prioritize calling cases who are in hospital, as they are in care already
vi. If not able to use the SPV case prioritization list, cases can be prioritised using filters such as age (call the elderly ahead of the younger) and suburb.
vii. Prioritizing according to co-morbidities is not possible using this method.
viii. Prioritize cases who have been more recently diagnosed, as giving them the information to isolate will be of more use than calling someone at the end of their isolation period.

4. Systems for identifying, contacting and monitoring high-risk close contacts (eg elderly diabetics in the same house as the case) should be retained where resources allow.
5. Broader communication systems should be developed for enhancing community awareness around appropriate behaviour for quarantining and isolation– included in this could be mechanisms to aid the case in informing their contacts of their diagnosis. Standardised information can be given to patients on testing and/or on case calling so they can read what they need to know, rather than relying on a long phone call).
6. Simplifying access to tests in the community.
7. Known outbreaks in high-risk environments (old age homes, prisons etc) should continue to be responded to as timeously as possible. The role of mobile antigen testing should be enhanced in these situations.
8. The collection and submission of contact-tracing data should be de-prioritised (only maintained if resources and digital systems permit).

Yours Sincerely

DR S KARIEM
COO: Chief of Operations
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