STANDARD OPERATING PROCEDURE FOR CONTACT TRACING IN RESPONSE TO DETECTION OF MPOX IN SOUTH AFRICA

1. INTRODUCTION

A multi-country outbreak of mpox in humans has been reported in several regions that are not endemic for mpox virus. The situation is quickly evolving with cases being recorded in several European countries, the United States of America, Canada and Australia. At present, the outbreak is linked to international travel but community-based spread has also been noted in some areas. The source and linkage of cases are still under investigation.

2. PURPOSE

The aim of this document / Standard Operating Procedure (SOP) is to guide personnel in conducting contact tracing of individuals that have come into contact (see contact definition below) with a suspected, probable or confirmed mpox case (see case definitions below).

This document may be updated as additional information about the epidemiology of the current multi-country outbreak becomes available

3. OBJECTIVE

To identify, trace and monitor contact of mpox cases in order to ensure that appropriate public health measures are instituted to contain spread

4. CASE DEFINITIONS – *may be adjusted as additional information about the outbreak becomes available*

Suspected case: Any person presenting with an unexplained acute rash

AND

1) one or more of the following signs and symptoms:
    - Headche
    - Acute onset of fever (>38.5°C)
    - Lymphadenopathy (swollen lymph nodes)
    - Myalgia (muscle pain/body aches)
    - Backache

AND

2) for which the following differential diagnoses are excluded: chickenpox, measles, bacterial skin infections, syphilis, molluscum contagiosum, allergic reactions and other locally relevant common cause of papular or vesicular rash

N.B. it is not necessary to obtain negative laboratory results for differential diagnoses listed above in order to classify a case as suspected

Probable case: A person meeting the suspected case definition **AND** one or more of the following:

- An **epidemiological link*** to a probable or laboratory-confirmed case of mpox in the 21 days prior to symptom onset
- Travel history to a **mpox endemic country**** in the 21 days prior to symptom onset
- Had multiple or anonymous sexual partners in the 21 days prior to symptom onset
- A positive result of an orthopoxvirus serological assay, in the absence of smallpox vaccination or other known exposure to orthopoxviruses
- Hospitalised due to the illness

**Face-to-face exposure without appropriate PPE; direct physical contact with skin or skin lesions including sexual contact; contact with contaminated materials such as clothing, bedding or utensils*

***Cameroon, Central African Republic, Congo, Democratic Republic of the Congo, Gabon, Ghana, Ivory Coast, Liberia, Nigeria, Sierra Leone, South Sudan*

Confirmed case: A person meeting the suspected or probable case definition AND is laboratory-confirmed for mpox virus by detection of unique sequences of viral DNA either by real-time polymerase chain reaction (PCR) and/or sequencing

5. CONTACT DEFINITION - *may be adjusted as additional epidemiological information about the outbreak becomes available*

A person who had come into contact with a suspected, probable or laboratory-confirmed mpox case since onset of symptoms and has had one or more of the following exposures.

- Face-to-face contact or was in a closed environment with a case **without appropriate personal protective equipment (PPE)** - this includes, amongst others,
    - persons living in the same household as a case,
    - people working closely/in the same environment as a case (e.g. colleagues, classmates etc.).
    - healthcare workers or other person providing direct care
- Direct physical contact including sexual contact
- Direct contact with contaminated materials such as clothing, bedding etc.

6. WHEN TO INITIATE CONTACT TRACING FOR MPOX

- Identification of contacts should commence as soon as a suspected case is identified (i.e. during case investigation) and contacts should be recorded in a contact listing form (Appendix A)
- Contact listing form should be completed at the time of sample collection and completion of the case investigation form (Appendix B) by the person interviewing the suspected case (e.g. facility infection prevention and control (IPC) focal point, attending clinician).
    - If the contact listing form cannot be completed at this time, the district communicable disease control coordinator (CDCC) or equivalent (for districts without CDCC) will be responsible for ensuring that the form is completed when notified of the suspected case
- Contact monitoring (follow-up) should be done by completing the daily symptom monitoring tool (Appendix C). Monitoring should start immediately; however, if laboratory results come back negative, contacts should be dropped from further follow-up.
    - Monitoring of contacts may switch from immediate follow-up once a suspected case is identified to follow-up after laboratory confirmation depending on the number of contacts to be followed up should number of cases increase

7. MONITORING OF CONTACTS

- Contacts should be monitored by any of the three options below using the symptom monitoring tool. Options to use can be guided by availability of resources within districts/provinces.
    - *Self-monitoring* (passive monitoring)
        - Contacts should be provided with necessary information such as signs and symptoms, transmission, permitted activities etc. and what to do should symptoms develop
        - Where possible contacts should be provided with thermometers for daily temperature check – at least twice daily
        - If symptoms develop, contact should notify the officer designated to observe/monitor the contact or visit a healthcare facility so that necessary public health measures can be instituted
    - *Telephonic monitoring* (active monitoring)
        - Designated officer is responsible for at least once a day to see if the person under observation has self-reported signs/symptoms
        - If signs/symptoms have been reported, the designated officer should follow the necessary public health measures
    - *Face-to-face monitoring* (direct monitoring)
        - A designated officer to physically visit the person being monitored to examine for signs/symptoms of illness
- Monitoring to be done at least daily for the onset of signs/symptoms for a period of 21 days from last contact/exposure with a probable or confirmed case

- If a contact develops initial signs and symptoms (e.g. fever) other than rash, contact should be isolated and closely monitored for rash development
  - If rash develops, isolation is continued and contact is assessed as a suspected case as per the guidelines

8. DATA MANAGEMENT

Data should be managed at respective levels. All case lists, contact line lists and symptom monitoring forms with completed demographic information should be forwarded from one level to the other on a daily basis.

Situational Reports to be shared with all stakeholders.

9. ROLES AND RESPONSIBILITIES AT DIFFERENT LEVELS

9.1 District and Sub-District level

District CDCC or equivalent should coordinate the following:

- Activation of the district outbreak response team and establishment of contact tracing teams with clear roles and responsibilities
  - To increase capacity of contact tracing teams, a multidisciplinary team including but not limited to surveillance officers, environmental health practitoners, community health workers, IPC, health promoters, community/school health nurses etc. should be constituted
- Each contact tracing team must have a focal person who shall liase with the district CDCC or equivalent and supervise team activities
  - Team activities to include the following:
    - Investigate suspected cases and rumours reported
    - Record details of all contacts identified on the contact listing form (Annexure A)
    - Monitor all contacts for onset of signs and symptoms as per the monitoring tool (Appendix C)
    - If contact develops signs and symptoms inform the district CDCC or equivalent so that necessary public health measures are instituted and relevant stakeholders are informed
    - Submit contact monitoring tools to the district CDCC or equivalent for submission to the provincial CDCC on a daily basis
- Training of contact tracing teams on the identification of contacts, completion of contact listing form and monitoring of contacts
- Assign a designated officer/s to ensure daily symptom monitoring is/are completed
- Data management of all line lists (collate, data cleaning etc.) within the district
- Submit the district line lists to the provincial CDCC/team (see Table below) on a daily basis
- Completion of the contact demographic section on the contact monitoring form in order to update the contact line list

9.2 Provincial level

Provincial CDCC to cordinate the following:

- Ensure that all districts receive the contact tracing SOP, contact listing form, contact symptom monitoring tool and relevant guidelines/documents related to mpox
- Training of contact tracing teams on the identification of contacts, completion of contact listing form and monitoring of contacts
- Data management of line lists (collate, data cleaning etc.) from all districts
- Submission of provincial line lists to the National Team (NDoH and NICD – see Table below) on a daily basis
- Relevant Provincial Outbreak Response Team members (CDC, Environmentl Health, Infection Control etc.) provide support to the district contact tracing teams when need arise

9.3 National level

The National Team to coordinate the following:

- Develop contact listing form, contact monitoring tool and contact tracing SOP
- Provide approved contact listing form, symptom monitoring tool, SOP and other relevant documents to all provinces for distribution
- Provide support to all provinces and give regular updates and feedback to provinces
- Data management of national line list

Table 1: Contact details of the National Team members

Institution	Name/Department	Email address	Telephone number
National Department of Health	Tsakani Furumele	Tsakani.Furumele@health.gov.za	082 419 9686
	Lusizo Ratya	Lusizo.Ratya@health.gov.za	082 703 2784
	Wayne Ramkrishna	Wayne.Ramkrishna@health.gov.za	082 317 4687
National Institute for Communicable Diseases	Outbreak Response Unit	outbreak@nicd.ac.za	
	Laboratory	jacquelinew@nicd.ac.za naazneenm@nicd.ac.za	011 386 6376 082 903 9131

Email address for reports submission: see Table below for respective provinces and National Team

NICD hotline number (for healthcare professional only): 0800 212 552

Table 2: Contact details (email address and telephone) of stakeholders involved in coordinating outbreak response in provinces.

Provincial Communicable Disease Control Directorate			
Eastern Cape	Thomas Dlamini Nosiphiwo Mgobo	thomas.dlamini@echealth.gov.za nosiphiwo.mgobo@echealth.gov.za	083 378 0189 060 579 9027
Free State	Dikeledi Baleni	balenid@fshealth.gov.za	083 757 8217
Gauteng	Refilwe Mokgetle Tebogo Matjokotja	refilwe.mokgetle@gauteng.gov.za Tebogo.Matjokotja@gauteng.gov.za	082 4862934 082 373 1197
KwaZulu-Natal	Premi Govender Babongile Mhlongo	premi.govender@kznhealth.gov.za babongile.mhlongo@kznhealth.gov.za	071 609 2505 060 982 3333
Limpopo	Marlene Freda Ngobeni Mashudu P. Mudau	Marlene.Ngobeni@dhsd.limpopo.gov.za fredangobeni@gmail.com Prudance.Mudau@dhsd.limpopo.gov.za	079 491 1909 071 678 3864
Mpumalanga	Mandla Zwane Hluphi Mpangane	MandlaZw@mpuhealth.gov.za hluphim@mpuhealth.gov.za	082 229 8893 076 522 8511
North West	Khumbudzo Booi Magogodi Seema G Tsele	KBooi@nwpg.gov.za mseema@nwpg.gov.za gtsele@nwpg.gov.za	066 045 2156 0694169068
Northern Cape	Gloria Hottie Martin Son	hottieg@webmail.co.za martinson775@gmail.com	072 391 3345 053 830 0529 071 474 4571
Western Cape	Charlene A. Lawrence Hilary Goeiman	Charlene.Lawrence@westerncape.gov.za Hilary.Goeiman@westerncape.gov.za	072 356 5146 021 483 9964 / 3156 021 815 8741 083 333 1320

Annexure A: Mpox contact listing form

Appendix B: Mpox case investigation form

Annexure C: Mpox contact monitoring tool

References / other useful resources

https://www.who.int/publications/i/item/WHO-MPX-surveillance-2022.1?s=08