National Programme for Tuberculosis Control and Chest Diseases

Ministry of Health, Nutrition & Indigenous Medicine

Sri Lanka

Standard Operating Procedures for contact tracing and screening of TB patients

All symptomatic and asymptomatic contacts of a TB patient should be referred to the chest clinic for investigations.

Any person who has been exposed to an index case of TB is considered as a contact.

Close contact could be either household or non-household
<u>Household contacts</u> - A person who shared the same enclosed living space for one or more nights or for frequent or extended periods during the day with the index case during the 3 months before the commencement of the current treatment episode
<u>Non-household contact</u> - A person who is not in the household but shared an enclosed space, such as a social gathering place, workplace or facility, for extended periods during the day with the index case during the 3 months before the commencement of the current treatment episode.

The rationale of investigating contacts of index cases <5 years of age is to find the source of the infection, not to find secondary cases from the child.

All contacts of a TB patient should be traced and registered in the 'TB Contact Register' maintained by the PHI of DCC. It should also be entered in the 'TB Investigation Register' (TB 19) by the range PHI of the relevant Medical Officer of Health.

All close contacts of all TB forms of patients should be screened for active TB. However, screening of the following categories of contacts should be **ensured**. Medical Officer looking after the contacts should pay special attention to these contacts during the screening process.

- Children less than 5years
- Elderly more than 60 years
- Patients with diabetes
- All HIV positive patients
- Immunocompromised individuals
- Patients on immune-suppressive drugs such as long-term steroid therapy
- Cancer patients on anti-cancer treatment
- Patients who have undergone transplant surgery
- People living under risk environments (e.g. slums, estates, internally displaced, migrants, homeless people)
- Current and former workers in workplaces with silica exposure
- Migrant population and returning refugees
- If the patient is an inmate of an institution in congregate settings all the contacts should be screened
  E.g.:
  - Prisoners
  - Inmates of elderly homes
  - Inmates of destitute homes
  - Inmates of rehabilitation centres for drug addiction

- Healthcare workers in high-risk settings such as MDR-TB wards and laboratories

Method of screening

A. Responsibilities of the Medical Officer

1. Obtaining information on contacts

Should obtain the information related to household and close contacts and need to update in the patient's file/ ePIMS.

2. Counselling of contacts

Regarding the importance of screening

3. Screening

Open a standard card for each contact

Clinical screening of the contacts should be done as follows:

- Clinical screening (history and examination/symptoms and signs) and Chest X-ray (all contacts)
- Sputum examination (Smear/GeneXpert)
- Appropriate biological specimen including smear, Xpert MTB/RIF and/or Culture as considered appropriate as per the guidelines.
- Maintain all the records in the standard card (results of the investigations)
- All the contacts who were diagnosed to have active TB through screening should be registered, started treatments, and routinely followed up.
- <5 years child contacts of bacteriologically confirmed patients should be given INAH prophylaxis for 06 months after excluding active TB.
- For all the other contacts, advise to attend the DCC if symptoms suggestive of TB appear at any time

B. Responsibilities of the Public Health Inspector of the chest clinic

- Maintain the contact register
- All the contacts listed in the patients' files should be entered in the contact register (automatically generated in the ePIMS).
- Crosscheck the contacts who have been investigated with the standard cards, get down all the contacts those who are not investigated.
- During routine home visits of TB patients, identify additional close/household contacts if any, not listed in the list (ie: small children looked after by grandparents for several hours per day)
- Closely collaborate with the range PHIs attached to Medical Officer of Health to trace the contacts and follow up of contacts
- Routine follow up of patients who are started on prophylaxis for treatment adherence and completion
- Ensure that all the other contacts were followed up by the range PHI 06 monthly intervals for 2 years for the appearance of symptoms suggestive of TB