Contact Tracing for Sexually Transmitted Infections

Centre for Disease Control 2014
Acknowledgements

This document has been prepared by Centre for Disease Control, Department of Health Northern Territory

<table>
<thead>
<tr>
<th>Target Audience:</th>
<th>Clinical employees in jurisdiction</th>
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<tr>
<td>Jurisdiction:</td>
<td>Northern Territory</td>
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<tr>
<td>Jurisdiction Exclusion:</td>
<td>Not Applicable</td>
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<td>Director Centre for Disease Control</td>
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Contact Tracing for Sexually Transmitted Infections

Policy Statement

Notifying known sexual partners of people diagnosed with a sexually transmitted infection is an essential component of reducing disease transmission. The following policy is to inform NT service providers of the contact tracing and prioritisation process in the Northern Territory.

Policy Purpose

To guide clinical staff performing contact tracing for people diagnosed with a sexually transmitted infection or blood borne virus in the Northern Territory.

Procedure/ Guideline

Background

Contact tracing is the process of notifying and offering treatment to the sexual partners of people diagnosed with a sexually transmitted infection (STI). It is a well-recognized and important component of sexual health care that has been shown to reduce the re-infection rate of people with sexually transmitted infections (STIs). It is also likely to reduce the prevalence of infection in the community.

Several factors contribute to the efficiency (how much benefit is expected from allocating clinical resources) of performing contact tracing.

Contact tracing is more efficient:

- Where there is lower prevalence of an infection
- When there is less screening occurring in a population
- When reaching those partners most likely to transmit to others i.e. more efficient when reaching people with many partners
- When it doesn’t take much time to treat each contact.

Clinical staff have ethical and legal responsibilities associated with contact tracing. When a person is diagnosed with an STI, staff must:

- Provide sexual health information and treatment according to approved clinical guidelines
- Discuss contact tracing options and action appropriate to the situation for informing known sexual partners.

Contact tracing is best performed as a voluntary process and a rigorous approach to confidentiality must be taken. Staff should consider the potential risk of harm to the presenting patient and be aware that, in some circumstances, contact tracing may not be appropriate if the risk of harm outweighs the likely benefit.

Anecdotally, in remote areas of the Northern Territory (NT) contact tracing is sometimes considered a major resource burden for sexual health programs. This is because healthcare staff usually notify partners; there is limited use of patient self-notification of partners, contract notification (where an agreement is made with patient to notify partner within a certain time period, after which healthcare staff contact the partner) or of notification via non-face-to-face methods such as telephone and SMS. Additionally, there is limited prioritisation according to STI, patient and partner characteristics.
Management of contact tracing

Overview

- Prioritise sexual partners of the presenting patient to identify those who will benefit most from treatment, especially regular partners, partners of pregnant women and recent partners.
- Contact tracing attempts should be time-limited in most situations as the benefit decreases with time.
- Use less resource intensive methods of contact tracing such as telephone, self-notification and contract notification where appropriate.
- Prioritisation should be guided by local context and capacity (see below).
- Contact tracing referrals between services must contain sufficient information to allow the receiving service to prioritise the contact tracing effort.
- Developing contact tracing templates and integration with clinical records is encouraged for clinical and CQI purposes.
- Contact tracing for chlamydia, gonorrhoea, and trichomonas should not considered an absolute necessity following community wide STI screening events where greater than 80% of the population is tested, as most contacts were tested during the screening event. In current practice this criteria is rarely met.

Contact tracing process / prioritisation

1) Discuss with patient, the options of self-notification, healthcare provider notification or making a contract for notification.

2) Contact tracing priorities will vary according to local context and capacity. The SHBBV unit suggests that NT healthcare practitioners prioritise contact tracing efforts in the following order:
   - Priority 1: a) all regular sexual partners of pregnant women   
     b) all partners of people with infectious syphilis or HIV
   - Priority 2: all regular sexual partners of people with chlamydia or gonorrhoea
   - Priority 3: any casual sexual partners of people with chlamydia or gonorrhoea
   - Priority 4: any sexual partners of people with trichomonas

3) When possible make a follow-up consultation with the presenting patient for providing results and to confirm that sexual partners have been advised, assessed and treated adequately.

As patients need to know about the implications of infection, mode of transmission and prevention and treatment options; current and accurate knowledge of the disease/s is essential. Refer to CARPA STM for information and treatment guidelines. Policies, disease fact sheets and further guidelines can be found on the SHBBV unit website. Alternatively contact local Sexual Health Unit staff for advice.

Important points to discuss with the patient:

- Reassure that the process is confidential
- Provide an explanation of the duty of staff concerning contact tracing
- Give specific advice about which sexual partners need to be advised and what information must be imparted.

Responsibility for contact tracing according to priority level (see above)

- Priority 1: The diagnosing health service should always ensure contact tracing occurs for these cases. The SHBBV unit should actively assist with this process.
- Priority 2 – 4: The diagnosing health service or the person themselves may take responsibility, dependent on capacity and local context. The SHBBV unit can provide advice on request.
Standard documentation
- Ensure that all aspects of the consultation are appropriately recorded using accurate, non-judgemental documentation
- Identifying information of sexual partners should not be included within the clinical record of the presenting patient
- Document a service encounter or diary event for the sexual health contact where possible on the contact’s electronic records i.e. Primary Care Information System (PCIS).

Referral to other services
- Is advised for Priority 1 and 2 patients
- Should be considered for Priority 3
- Ensure sufficient information to allow appropriate contact tracing i.e. patient gender, pregnancy status, disease exposure, regular or casual partner status
- Must ensure confidentiality is maintained in any communication provided to other health services
- Use of standard referral forms within organisations and integration with clinical record is encouraged – template available
- Ensure capacity to receive information for confirmation of appropriate management from the referral service.

Further information on specific infections

HIV
HIV is rare in the NT context, especially among the heterosexual population. Contact tracing is likely to be an important case finding activity and must be performed for all cases as soon as practical. SHBBV unit staff will proactively assist in this process and provide expert advice.

Syphilis
The incidence of infectious syphilis is far lower than for other bacterial STIs. Testing and treating sexual contacts of infectious syphilis will find more infectious cases than any routine screening. As the period of maximum infectiousness is one year, routine annual screening and treatment will fail to prevent the majority of transmission. To further reduce the current low incidence, active contact tracing of infectious syphilis cases needs to be prioritised and the resources of the SHBBV unit should be utilised when required to assist with this process. For syndromically managed cases of genital ulcer disease, contact tracing should be considered at initial consult. This will be most useful where primary syphilis is a likely diagnosis and other cases have been recently diagnosed in the community; however due to the rarity of this condition, awaiting confirmation of syphilis in presenting patients is an appropriate action. All contacts of known early syphilis should be treated presumptively at the time of testing without awaiting serology results.

Chlamydia and gonorrhoea
The prevalence of chlamydia is high in all remote areas of the NT, especially in young people. Gonorrhoea has a more variable prevalence but is likely to be above 5% in most areas. The likelihood of a sexual partner being infected is approximately 50%, with recent and frequent sexual partners most likely to be infected. In most areas of the NT screening sexual contacts of known cases would yield a significantly higher rate of infection than routine screening and would reduce the re-infection rate. Clinical guidelines recommend patients being treated syndromically for chlamydia and gonorrhoea associated conditions, such as urethral discharge and pelvic inflammatory disease, should have contact tracing initiated at the first visit. This is of particular importance for regular partners due to the risk of early re-infection.

The usefulness of this strategy would be directly related to:

1. The resources required to notify and treat one infected partner.
2. The prevalence of infection in the community.
Communities with a lower prevalence of STIs should allocate proportionally greater resources than communities with a higher prevalence to each contact tracing episode. This is because in low prevalence areas contact tracing requires less resources compared to screening and will have a far higher yield of positive results.

The benefit of contact tracing when performed as part of a community wide screening activity is likely to be minimal and should only occur where resources are abundant or the screening coverage is low (below 80%). Given the high prevalence of chlamydia and gonorrhoea in the NT, the allocation of SHBBV unit resources to actively perform routine contact tracing for chlamydia and gonorrhoea is not an effective use of resources.

As there is strong data suggesting treatment of regular ongoing sexual partners reduces re-infection rates, regular partners should be contacted regardless of community prevalence.

**Trichomonas**
Trichomonas is very common in remote areas of the NT. Infection among females is thought to be long standing, whereas infection among men may spontaneously resolve in many cases. There is limited data describing the prevalence of infection in male contacts of infected women. Due to these factors in remote areas contact tracing for trichomonas is of lower priority than that for other STIs. Ongoing regular partners should be contacted and treated due to the risk of re-infection. In urban populations where the prevalence of trichomonas is lower, the priority of contact tracing is equal to chlamydia and gonorrhoea.

**Hepatitis B**
Testing and vaccination of the sexual, household and needle sharing contacts of hepatitis B should be performed by the service diagnosing the case. CDC funds vaccination of most people who are at risk of infection. CDC staff will actively follow-up acute hepatitis B cases to ensure contact tracing is performed.
### Implementation, Review & Evaluation Responsibilities

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<th>Method</th>
<th>Responsibility</th>
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<td><strong>Implementation</strong></td>
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<tr>
<td>Document will be published through PROMPT, the Policy and Guidelines Centre and on the Centre for Disease Control’s webpage. All Sexual Health and Blood Borne Virus staff will be advised of guideline via email and at staff meetings.</td>
<td>Section Head</td>
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<tr>
<td><strong>Review</strong></td>
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<tr>
<td>Consultation with sexual health providers and primary care services will be performed in the year prior to review being due.</td>
<td>Sexual Health Physician</td>
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<td><strong>Evaluation</strong></td>
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<td>Evaluation will be continuous through the audit and quality improvement processes of the unit</td>
<td>Remote Sexual Health Program Managers, Clinic 34 Managers, Darwin and Alice Springs</td>
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### Key Associated Documents

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<tr>
<td>Preferred Term</td>
<td>Description</td>
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<tr>
<td>Contact tracing</td>
<td>The process of notifying a person’s sexual partners that they have been exposed to an infection. The process may be performed by a patient or another person, such as a healthcare practitioner</td>
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