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## National Guidelines for Public Health management of contacts of cases of COVID-19

V 9.7. 16.11.2021

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*This document summarises recommendations for contact management of cases of COVID-19. It is based on the current knowledge regarding COVID-19 and experiences with SARS-CoV and MERS-CoV. This guidance is suitable for a delay phase, when an increasing number of cases and their contacts have been identified in Ireland. It may change if and when we move to a mitigation phase.*

*Readers should not rely solely on the information contained within these guidelines. Guideline information is not intended to be a substitute for advice from other relevant sources including, but not limited to, the advice from a health professional. Clinical judgement and discretion will be required in the interpretation and application of these guidelines.*

*This guidance is under constant review based upon emerging evidence at national and international levels and national policy decisions.*

*These guidelines are aligned with the principles of Art 3 IHR.*

Version	Date	Changes from previous version	Drafted by
V.8.	02.04.2020	<ul style="list-style-type: none"> <li>• Change to infectious period for contact tracing purposes to 48 hours before symptom onset.</li> <li>• Change in contact management of probable, contact tracing to initiate following referral for testing.</li> <li>• Change in advice for close contacts to not leave the house unless absolutely necessary.</li> <li>• Change in information sources for close and casual contacts.</li> <li>• Change in advice to contacts regarding contacting their GP with symptoms instead of Public Health.</li> <li>• Note on current Government advice regarding physical distancing measures.</li> </ul>	HPSC
v.8.1	22.04.2020	<ul style="list-style-type: none"> <li>• Added tracing of asymptomatic cases</li> </ul>	HPSC
V.8.2	24.04.2020	<ul style="list-style-type: none"> <li>• Change to start period of contact tracing for asymptomatic cases</li> </ul>	HPSC
V8.3	14.05.2020	<ul style="list-style-type: none"> <li>• As per NPHET recommendation of 14/05/2020, all close contacts of a confirmed case should have a COVID test at DAY 0 and DAY 7 after last exposure to a confirmed case</li> <li>• As per NPHET recommendations of 14/05/2020, all close contacts (not just household contacts) should restrict their movements for 14 days after last exposure to a confirmed case</li> </ul>	HPSC
V8.4	20/05/2020	<ul style="list-style-type: none"> <li>• Adjusted the summary of changes table to include the following NPHET recommendation:</li> </ul> <p>As per NPHET recommendations on 14th May 2020, it is further recommended that where a test is taken on a suspected case the tester should request that the suspect case inform their household contacts and any other close contacts without delay and ask them to restrict their movements (i.e. stay at home) until the outcome of the test is known.</p>	HPSC
V8.5	18/06/2020	<ul style="list-style-type: none"> <li>• Removal of recommendation to commence contact tracing on suspected cases.</li> <li>• Removal of paragraph re testing in LTCF</li> <li>• Link to Government road map instead of specific details of phases in this document.</li> </ul>	HPSC
V8.6	19/10/2020	<ul style="list-style-type: none"> <li>• Change in infectious period for cases in the community from 14 days to 10 days</li> <li>• Link to Resilience and Recovery Plan instead of Government road map</li> </ul>	HPSC
V8.7	10.02.2021	<ul style="list-style-type: none"> <li>• Change in timing of testing of close contacts to day 0 and day 10, with ending of period of restricted</li> </ul>	

		movements if “not detected” result from day 10 test and remain asymptomatic	
V8.8		<ul style="list-style-type: none"> <li>• Term “vulnerable individuals” has been replaced by “people at higher risk”</li> <li>• Household contacts of confirmed cases are advised to wear a surgical mask</li> </ul>	
V8.9		<ul style="list-style-type: none"> <li>• Added caveat that guidance does not apply to variants of concern</li> </ul>	HPSC
V8.10	08/07/2021	<ul style="list-style-type: none"> <li>• Updated to reflect changes in relation to contact tracing for VOCs</li> <li>• Updated to reflect that the Delta variant is now predominant in Ireland. Added that Delta remains a VOC but as occurred with Alpha, usual contact tracing will apply for cases of Delta variant (i.e. as are currently implemented for non-VOC or Alpha cases.</li> </ul>	
V9.0	05/08/2021	<ul style="list-style-type: none"> <li>• Updated to reflect contact tracing for VOCs and non-VOCs</li> <li>• Updated to reflect the impact of vaccination on contact tracing</li> <li>• Updated to reflect international travellers and flight contact tracing</li> </ul>	
V9.1	16/08/2021	<ul style="list-style-type: none"> <li>• Document restructured</li> </ul>	
V9.2	10/09/2021	<ul style="list-style-type: none"> <li>• Update to wording on ‘Persons who are fully vaccinated’</li> </ul>	
V9.3	15/09/2021	<ul style="list-style-type: none"> <li>• Update to wording in section 6.1 ‘Management of all symptomatic close contacts’</li> <li>• Update to section 7 ‘ Management of close contacts of COVID-19 cases identified during air-travel’</li> </ul>	
V9.4	21/09/2021	<ul style="list-style-type: none"> <li>• Section 6.1 amended</li> <li>• Referred section 6.3 back to section 6.1 where a close contact becomes symptomatic</li> </ul>	
V9.5	01/10/2021	<ul style="list-style-type: none"> <li>• Added link to contact tracing guidance for under 13s</li> </ul>	
V9.6	28/10/2021	<ul style="list-style-type: none"> <li>• Updated information on vaccination status of immunocompromised people</li> <li>• Update information on heterologous vaccination</li> <li>• Updated information on the use of RADTs</li> </ul>	HPSC
V9.7	16/11/2021	<ul style="list-style-type: none"> <li>• Updated evidence on vaccine effectiveness and vaccine effectiveness on transmission</li> </ul>	HPSC

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## Table of Contents

Table of Contents .....	4
Preface.....	5
1.0 Summary of key points.....	6
3.0 Scope .....	7
4.0 Information on COVID-19.....	7
4.1 Vaccine effectiveness .....	8
4.2 Transmission of COVID-19.....	9
4.2.1 Vaccine effectiveness on transmission.....	10
4.2 Definition of contact tracing.....	11
4.3 Definition of fully vaccinated.....	13
5.0 Identification and initial management of close contacts of COVID-19 .....	15
5.1 Management of casual contacts .....	15
5.2 Management of all symptomatic close contacts.....	16
5.3 Management of asymptomatic close contacts .....	17
5.3.1 Management of asymptomatic close contacts who are not fully vaccinated.....	17
5.3.2 Management of asymptomatic close contacts who are fully vaccinated .....	18
5.3.3 Management of asymptomatic close contacts who had COVID-19 infection within the previous 9 months.....	19
5.4 Management of close contacts of COVID-19 Variants of Concern (VOCs).....	19
6.0 Management of close contacts of COVID-19 cases identified during air-travel .....	20
References.....	21

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## Preface

These guidelines have been updated to reflect the evolving situation in relation to the COVID-19 pandemic. This document outlines the measures that should be adopted for contact tracing of all COVID-19 cases. Delta remains a variant of concern and is now the predominant variant in Ireland. In this context, additional public health measures are now no longer required for probable or confirmed delta cases. Therefore, the contact tracing processes that are implemented for non-VOC and Alpha cases also apply to cases of the Delta variant.

Please see [here](#) for contact tracing guidance for those aged > 3 months to under 13 years of age.

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## 1.0 Summary of key points

- Advice for close contacts varies depending on a number of factors including setting, previous infection, vaccination status, and whether the contact(s) have been exposed to a confirmed case who has travelled from a [designated state](#).
- All **symptomatic close contacts** should book a test online or by contacting their GP by telephone. Symptomatic close contacts are advised to [self-isolate](#) (including not going to work) for 10 full days and are managed as per the current recommendations for suspected COVID-19 cases, with urgent testing for COVID-19 infection undertaken.
- **Asymptomatic close contacts** who are not fully vaccinated and who do not have a history of prior infection in the previous 9 months must restrict their movements pending the outcome of testing. They should be advised to get a RT-PCR test at day 0 and day 10 and advised to continue to [restrict their movements](#) until they receive a “not detected” test result from the Day 10 test. The Day 10 test is to be performed 10 full days after that last contact (where day 1 begins the day after the close contact’s last contact with the case).
- If either (day 0 or day 10) test is positive, the close contact becomes a case and must self-isolate.
- In the absence of a Day 10 test, close contacts who are not fully vaccinated must restrict their movements for **14 days**.
- For adult and child cases for whom it is not feasible to self-isolate (e.g. children under 13 years old or adults with care needs), all household contacts with ongoing unprotected exposure to the case should restrict their movements for 17 days from the onset of symptoms in the first case or from the date of the test if the case was asymptomatic. This is regardless of whether further cases are identified in the household.
- Asymptomatic close contacts who are fully vaccinated will receive a Rapid Antigen Detection Test (RADT) and will be requested to self-administer one antigen test as soon they get the test and repeat every second day until three antigen tests have been performed. Please see [section 5.3.2](#) for further information as RADTs are not recommended for all asymptomatic close contacts.
- Please see [here](#) for contact tracing guidance for those aged > 3 months to under 13 years of age.
- In all instances, close contacts should be reminded about the importance of good respiratory etiquette and hand hygiene practice and asked to adhere to the general public health measures and physical distancing advice that the Government of Ireland has issued for the general public.
- The period of self-isolation for confirmed cases of non-VOCs and Delta variant is **10 days**

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- Delta remains a variant of concern, but as it is now predominant in Ireland, additional public health measures are no longer required to be applied to probable or confirmed delta cases
  - As of the 8th September 2021, a decision has been taken to cease routine contact tracing of infectious cases notified during air travel. Flight contact tracing will occur where indicated by Departments of Public Health/MOH risk assessment.

## 2.0 Purpose

The purpose of this document is to provide public health guidance for contact management of cases of COVID-19. The purpose of identifying and managing the contacts of COVID-19 cases is to support early diagnosis and to interrupt onward transmission, through the rapid identification and management of secondary cases that may arise after transmission from primary cases.

## 3.0 Scope

This document provides information for contact management of all COVID-19 strains including the Alpha and Delta variants and for other Variants of Concern (VOCs) (i.e. Beta and Gamma).

## 4.0 Information on COVID-19

COVID-19 is an illness, identified in late 2019, caused by a virus called SARS-CoV-2. Internationally and in Ireland we continue to learn about how easily the virus spreads from person to person and how to control it.

It can take up to 14 days for symptoms of COVID-19 to show. Infection can spread from people before they develop symptoms. Some people with infection develop no symptoms, or have symptoms that are so mild that they take little notice of them, but they can still spread infection.

Prior to the development of effective vaccines the primary way to prevent the spread of the SARS-CoV-2 virus was by implementing a series of non-pharmaceutical interventions (NPIs), such as physical distancing, wearing of a face covering and frequent hand hygiene. Increasingly the importance of improving ventilation in reducing transmission, especially in closed environments, has been understood and implemented either through natural ventilation (i.e. opening windows and external doors) or by mechanical means (e.g. central air-conditioning unit).

Effective vaccines against COVID-19 are now available and a robust vaccination programme is underway in Ireland. This is an additional and important intervention to prevent the spread of the virus. However, precautions to prevent introduction and spread of the virus are still required even in the context of community

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vaccination because although the COVID-19 vaccines have been proven to reduce the spread of COVID-19 and reduce the risk of severe disease and or hospitalisation, they do not prevent all infection. Additionally, there is now some concern that the vaccines may be less effective against some virus variants.

Viruses constantly change and mutate due to evolution and adaptation processes. As a consequence, the emergence of new variants is to be expected. This could result in an increase in transmissibility, or virulence, or a decrease in the effectiveness of vaccines, treatments, diagnostic assays or other public health measures.

There were four COVID -19 virus variants (Alpha (B.1.1.7), Beta (B.1. 351 (501Y.V2), Gamma (variant P.1 (B.1.1.28.1)) and Delta (B.1.6.177.2 sub lineage) that have caused concern due to mutations that have led to increased transmissibility and deteriorating epidemiological situations. The Delta strain of SARS-CoV-2 is now dominant in Ireland and although Delta remains a Variant of Concern (VOC), standard contact tracing processes now apply for cases of Delta variant in the Irish context. Additional contact tracing measures are no longer applied to Delta cases but, these additional measures should continue to be applied for Beta (B.1. 351 (501Y.V2), Gamma (variant P.1 (B.1.1.28.1)) variants of concern.

As there remain gaps in the understanding of infectivity of COVID-19 cases and transmission modes, the definition of contacts and their public health management is based on similar coronaviruses such as SARS-CoV and MERS-CoV.

## 4.1 Vaccine effectiveness

All vaccines currently in use in Ireland are proven to be effective against SARS-CoV-2 infection, severe disease, hospitalisation and death. This does **not** mean that individuals are immune from SARS-CoV-2 once vaccinated and might still be able to transmit SARS-CoV-2 infection to susceptible contacts (1). The available evidence at this time regarding real world vaccine effectiveness and duration of protection shows that all vaccines authorised in the EU/EEA are currently highly protective against hospitalisation, severe disease and death for a variety of strains of COVID-19 (2).

However, studies from Israel and the US have reported declines in vaccine effectiveness in those aged 65 and older. This decline may be due to waning immunity in older persons coupled with relaxation of non-pharmaceutical interventions and the emergence of the Delta variant (3). A recent study from the New England Journal of Medicine indicates that immunity against the delta variant of SARS-CoV-2 waned in all age groups a few months after receipt of the second dose of vaccine (4).

Therefore, as of September 2021, the National Immunisation Advisory Committee are recommending:

- **Booster vaccines** for certain cohorts.



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- **Additional vaccination dose** for certain cohorts.

**Booster doses** are administered to a vaccinated population that has completed a primary vaccination series (currently one or two doses of COVID-19 vaccine, depending on the product). When with time the immunity and protection has fallen below a rate deemed sufficient in that population (5) The objective of a booster dose is to restore vaccine effectiveness from that deemed no longer sufficient.

**An additional vaccination dose** may be needed as part of an extended primary series for targeted populations where the immune response rate following the standard primary series is deemed insufficient. The objective of an additional dose in the primary series is to optimise and enhance the immune response to establish an sufficient level of effectiveness against disease. (5).

Waning of immunity and the need for booster doses of vaccine may differ between vaccine products, target populations, circulating SARS CoV-2 virus, in particular variants of concern (VoC), and intensity of exposure. **Therefore, while vaccinations are highly effective at preventing severe disease and hospitalisation, non-pharmaceutical interventions still remain an important public health measure to reduce incidence of disease.**

## 4.2 Transmission of COVID-19

The virus is spread mainly through the air from the respiratory tract (nose or mouth) of a person with the infection. The virus can reach the respiratory tract mucosa (eyes, nose and mouth) of a susceptible person in two ways:

1. Travelling directly through the air to the respiratory tract or
2. Indirectly as a result of contamination of hands or other surfaces and subsequent transfer to the respiratory mucosa.

The risk of transmission through the air is dependent on a number of factors and include, how much virus is being shed by the infectious person, how close the susceptible person is to the infectious person, how forcefully the infectious person is scattering particles (for example, when the infected person coughs, sneezes, talks, sings, shouts or laughs) and what barriers are in place (e.g. masks).

There is evidence that COVID-19 outbreaks are more commonly associated with crowded indoor spaces, and that poor ventilation may increase the risk of transmission in such settings by facilitating the spread of liquid respiratory particles over longer distances.

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#### 4.2.1 Vaccine effectiveness on transmission

The European Centre for Disease Control (ECDC) and Centers for Disease Control and Prevention (CDC) acknowledge that more evidence is needed to understand the effectiveness of COVID-19 vaccines in preventing transmission (6,7).

A limited number of prospective follow-up studies show reduced viral load and duration of virus shedding among those who have received a vaccine compared to those who have not. Viral load is thought to be a leading factor of SARS-CoV-2 transmission (8). However it is not currently known if these observed reductions in viral load and duration of shedding actually reduce transmission.

Most vaccine effectiveness studies have not been designed to measure transmission risk (following subsequent exposure) from vaccinated individuals to others. One study from Scotland, however, which did directly measure transmission risk, reported a 30% risk reduction for transmission of SARS-CoV-2 from vaccinated health care workers to their household close contacts as compared to transmission from unvaccinated health care workers. The authors of this study noted that given the potential for household close contacts to have been infected through a different route, the true risk reduction for transmission of SARS-CoV-2 in those who have been vaccinated is likely to be as high as 60% (9).

The highly transmissible Delta variant of SARS-CoV-2 is circulating in all EU/EEA countries. Delta breakthrough infections in those who are unvaccinated and vaccinated have been reported to be associated with similar viral burden, however levels of culturable virus and duration of viral shedding are reduced in the vaccinated with breakthrough infection. This suggests that transmission is reduced from vaccinated persons who have breakthrough infection (3).

A recent study published by Eurosurveillance found that vaccination confers protection against onward transmission of SARS-CoV-2 from vaccinated index cases, albeit somewhat less for the Delta than for the Alpha variant (10).

More evidence is needed to see how effective COVID-19 vaccines are at preventing transmission of the Delta variant. **Therefore, everyone, regardless of vaccination status, should follow the relevant non-pharmaceutical interventions including social distancing, face covering/mask wearing, hand hygiene, respiratory and good cough etiquette and optimising ventilation indoors to mitigate the spread of the disease.**

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## 4.2 Definition of contact tracing

Contact tracing is the process of identifying, assessing, and managing people who have been exposed to a disease to prevent onward transmission. When systematically applied, contact tracing will break the chains of transmission of COVID-19 and is an essential public health tool for controlling the virus (WHO, 2020).

Contact needs to have occurred during the infectious period. For the purposes of this guidance, given the current knowledge about COVID-19 transmission, the infectious period for contact tracing purposes (of unvaccinated symptomatic contacts) is defined as from 48 hours before symptom onset in the case, until the case is classified as no longer infectious (usually 10 full days from symptom onset AND 5 days fever free for cases in the community; 10 days from symptom onset AND 5 days fever free for residents in residential care facilities or cases who are hospitalized). Please note this doesn't apply to people who are discharged from hospital INTO another healthcare setting or RCF (they remain with 14 days self-isolation). The COVID-19 tests referred to in this document are Reverse Transcription Polymerase Chain Reaction (RT-PCR).

For the purpose of this guidance, contact tracing of truly asymptomatic cases in this context should be initiated from 24 hours prior to date of diagnosis (i.e. date of swab being taken). The infectious period for asymptomatic cases is 10 days from the positive test result date.

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### **Close contact definition**

- Any individual who has had face-to-face contact with a COVID-19 case within two metres for more than a total of 15 minutes over a 24-h period (even if not consecutive)
- Household contacts defined as living or sleeping in the same home, individuals in shared accommodation sharing kitchen or bathroom facilities and sexual partners.
- Healthcare workers, including laboratory workers, who have not worn appropriate PPE or had a breach in PPE during the following exposures to the case:
  - Direct contact with the case (as defined above), their body fluids or their laboratory specimen
  - Present in the same room when an aerosol generating procedure is undertaken on the case.
- Passengers on an aircraft sitting within two seats (in any direction) of the case, travel companions or persons providing care, and crew members serving in the section of the aircraft where the index case was seated.<sup>#</sup> If there is more than one case and they are sitting together then contact tracing is extended to two rows.
- For close contacts who have shared a closed environment with a case for longer than two hours, a risk assessment should be undertaken. This risk assessment may vary

### **Casual contact definition**

- Healthcare workers, not including laboratory workers, who have taken recommended infection control precautions, including the use of appropriate PPE, during the following exposures to the case:
  - Direct contact with the case (as defined above) or their body fluids
  - Present in the same room when an aerosol generating procedure is undertaken on the case.
- Any individual who has shared a closed space with a case for less than two hours.
- Passengers on an aircraft sitting beyond two seats (in any direction) of a case.

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## 4.3 Definition of fully vaccinated

### Persons who are fully vaccinated

include those who are:

- a. 7 days after receipt of the **second** Pfizer-BioNTech (Comirnaty®) dose (two dose vaccination course)
- b. 14 days after receipt of the second Spikevax® ( Covid-19 vaccine Moderna®) dose (two dose vaccination course)
- c. 15 days after receipt of the second AstraZeneca (Vaxzevria® or Covishield) dose (two dose vaccination course)
- d. 14 days after receipt of the Janssen (Janssen®) dose (one dose vaccination course)
- e. 14 days after receipt of an extended primary dose of vaccination (three dose vaccination course<sup>1</sup>). Please note this does not apply to those who have received:
  - i. a transplant (solid organ, bone marrow, haematopoietic stem cell) in the past 12 months
  - ii. systemic cytotoxic chemotherapy or other systemic cancer chemotherapy in the past 12 months.

Ideally the same vaccine should preferably be used for both doses of a primary vaccination course, however, in some instances a heterologous vaccination schedule can be delivered. Heterologous COVID-19 vaccination means getting two different COVID-19 vaccines e.g., getting the Vaxzevria® vaccine for the first dose followed by an mRNA vaccine Comirnaty® (Pfizer BioNTech) or Spikevax® (COVID-19 Vaccine Moderna) for the second dose. In these circumstances, these individuals are also considered fully vaccinated after their second dose (7 days after Comirnaty® and 14 days after Spikevax®).

The National Immunisation Advisory Committee (NIAC) advises that individuals may be offered an additional vaccine dose in addition to their primary vaccination course because evidence suggests that those who are severely immunocompromised do not have adequate protection following a primary COVID-19 vaccine course. This additional vaccine dose enhances their protection however if the person's immune system response to vaccination could be compromised due to either of the following conditions:

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<sup>1</sup> An additional mRNA vaccine dose should be given to those aged 12 and older who are immunocompromised, associated with a suboptimal response to vaccines who have completed their primary course, regardless of whether the primary course was an mRNA or an adenoviral vector vaccine. This is an extended primary vaccination course. The additional vaccine should be given after a minimum interval of two months following the last dose of an authorised COVID-19 vaccine

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- i. a transplant (solid organ, bone marrow, haematopoietic stem cell) in the past 12 months
  - ii. systemic cytotoxic chemotherapy or other systemic cancer chemotherapy in the past 12 months.

**They should be treated as an unvaccinated close contact, i.e. be offered two tests (on day 0 and day 10) and advised to restrict their movements ([Table 5a.2](#)).**

A booster dose may also be offered to a vaccinated population that has completed a primary vaccination series, when with time, the immunity and clinical protection has fallen below a rate deemed sufficient for that population (4).

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## 5.0 Identification and initial management of close contacts of COVID-19

The objective of contact tracing is to contain the disease and prevent secondary spread by identifying positive cases and their close contacts as soon as possible.

### *Identification of close contacts:*

- Community based close contacts are identified and monitored by the Contact Management Programme (CMP) and public health as appropriate, for example in complex situations.
- Healthcare workers with an occupational exposure in Ireland, including laboratory staff, are identified and monitored by Occupational Medicine. Please see [Occupational Health](#) guidance for further information.
- Hospital in-patient close contacts are identified and monitored by infection prevention and control (IPC) and clinical microbiology while receiving in-patient care and by Public Health following discharge.
- For guidance relating to [education](#), [childcare](#) and other non-healthcare settings, please see [here](#). For all other guidance relating to healthcare settings, please see [here](#).

### *For all close contacts:*

- Establish whether the close contact is symptomatic or not
- Determine whether the close contact is fully vaccinated, partially vaccinated or unvaccinated
- Determine whether the close contact has had laboratory confirmed COVID19 in the last 9 months
- Determine whether the person they were in contact with is:
  - A person under investigation (PUI) **or**
  - A probable or confirmed variant of concern (VOC), excluding delta and alpha variants for which standard contact tracing management processes apply

## 5.1 Management of casual contacts

Those identified as casual contacts should:

- be advised about their risk and the symptoms of COVID-19 and directed to further information on the HSE website.
- be advised to self-isolate if they develop any symptoms of COVID-19 and ring their GP without delay.

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be reminded about the importance of good respiratory hygiene, cough etiquette and hand hygiene practice and asked to adhere to the general public health measures and physical distancing advice that the Government of Ireland has issued for the general public.

## 5.2 Management of all symptomatic close contacts

For all contacts, if [symptoms](#) consistent with COVID-19 develop within the first 14 days following the last contact regardless of the close contacts vaccination status or prior COVID-19 infection, the individual should:

- Contact their GP by telephone without delay.
- Even if you are fully vaccinated or have had prior COVID-19 infection in the previous 9 months, be advised to [self-isolate](#) and get tested – if the test is not detected they can cease self-isolation once they are 48hrs symptom free.
- If not fully vaccinated, be advised to [self-isolate](#) and get tested as per the current recommendations for suspected COVID-19 cases i.e., tested on day 0 and day 10. exit RM if day 10 test result is “not detected” and you are symptom free for 48 hours. The Day 10 test is to be performed 10 full days after that last contact (where day 1 begins the day after the close contact’s last contact with the case. In the absence of a Day 10 test, close contacts who are not fully vaccinated must restrict their movements for 14 days.
- be reminded about the importance of good respiratory etiquette and hand hygiene practice and asked to adhere to the general public health measures and physical distancing advice that the Government of Ireland has issued for the general public.
- If acute symptoms persist, following a day 10 “not detected” RT-PCR test, please contact your GP.



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## 5.3 Management of asymptomatic close contacts

### 5.3.1 Management of asymptomatic close contacts who are not fully vaccinated

- All persons identified as having had contact with a confirmed case during the infectious period even if they are asymptomatic should be assessed to see if they should be classified as a close or casual contact.
- Contact should be made with the close contact(s) on a regular basis to ask about development of relevant symptoms until receipt of a “not detected” result from a Day 10 test, or, for 14 days after the last possible exposure to a case in the absence of a Day 10 test. The Day 10 test is to be performed 10 full days after that last contact (where day 1 begins the day after the close contact’s last contact with the case). If the Day 0 and 10 tests are too close together only one test is necessary.
  - The lead team undertaking the contact management can make an operational decision as how best to manage this, such as use of telephone calls, text messages or emails on a regular basis. The Day 10 test is to be performed 10 full days after that last contact
- Close contacts should be advised about their risk, and the [symptoms](#) of COVID-19 and provided with COVID-19 Close Contact information which is found [here](#).
- Close contacts must restrict their movements pending the outcome of testing.
- If the Day 0 test is positive, there is no further test required – the contact becomes a case.
- Close contacts may end the period of [restricted movements](#) on receipt of a “not detected” test result from the Day 10 test, so long as they remain asymptomatic.
- Close contacts should be reminded about the importance of good respiratory etiquette and hand hygiene practice and asked to adhere to the general public health measures and physical distancing advice that the Government of Ireland has issued for the general public.
- Household contacts should be provided with information on restricting movement found [here](#).
- Household contacts of confirmed cases are advised to wear a surgical mask.
- Elderly close contacts, close contacts who are immunocompromised or those taking anti-pyretic analgesia may not present with fever and the importance of reporting other symptoms should be highlighted to them.
- For adult and child cases for whom it is not feasible to self-isolate (e.g. children under 13 years old or adults with care needs), all household contacts with ongoing unprotected exposure to the case should restrict their movements for 17 days from the onset of symptoms of the first case or from the date of the test if the case was asymptomatic. This is regardless of whether further cases are identified in the household.

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### 5.3.2 Management of asymptomatic close contacts who are fully vaccinated

These recommendations apply to fully vaccinated asymptomatic close contacts only.

- All asymptomatic fully vaccinated close contacts aged 13 years will be sent Rapid Antigen Detection Tests (RADTs) and will be requested to perform one antigen test as soon they get the test and repeat every second day until three antigen tests have been performed.
- All asymptomatic fully vaccinated healthcare workers who are identified as close contacts **within the community** will be requested to self-administer one antigen test as soon they get the test and repeat every second day until three antigen tests have been performed. Please note healthcare workers who are identified as a close contact through **exposure in the workplace** are under supervision of the relevant healthcare setting and should get local advice within that healthcare setting.
- All asymptomatic fully vaccinated close contacts will not be required to restrict their movements while awaiting the delivery of these tests.
- If the result of the RADT is positive, close contacts are advised to self-isolate and book a RT-PCR test. All **unvaccinated** household contacts must restrict their movements during this time.
- If the result of the close contacts RT-PCR test is 'not detected', no further ADTs is recommended and the close contact can exit self-isolation. Any household contacts who were restricting movements can also exit restriction of movements.
- RADTs can be also considered for use where there are community outbreaks or outbreaks among vulnerable populations. The use of RADTs will be informed based on a Public Health Risk Assessment (PHRA).
- The following groups are exempt from RADTs:
  - Asymptomatic children including children aged 13 years of age who are identified as a close contact in primary education setting. [Please see here for advice on children who are identified as close contacts aged > 3 months to under 13 years.](#)
  - Asymptomatic children identified in Special Educational Needs, respite care or equivalent settings, aged between 3months and 18 years, they will follow specific advice as per PHRA.
  - Asymptomatic close contacts who have had confirmed COVID-19 infection within the previous 9 months, regardless of vaccination status, are not recommended to undertake ADTs.
  - All asymptomatic healthcare workers who are identified as a close contact through exposure in the workplace are under supervision of the relevant healthcare setting and should get local advice within that healthcare setting.
  - ADTs are not recommended for residents who are asymptomatic close contacts in Residential Care Facilities\* (RCF) as these residents are under enhanced clinical supervision. These

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residents will be managed and advised as per Public Health Risk Assessment (PHRA) and clinical teams.

- RADTs are not recommended for in-patients who are asymptomatic close contacts in hospitals as these patients are under enhanced clinical supervision. These in-patients will be managed and advised as per Public Health Risk Assessment (PHRA) and clinical teams.

### 5.3.3 Management of asymptomatic close contacts who had COVID-19 infection within the previous 9 months

- If the close contact develops symptoms of COVID-19, they need to immediately [self-isolate](#) and be referred for a COVID-19 test.
- **Asymptomatic** close contacts who have had **confirmed** COVID-19 infection within the previous 9 months, regardless of vaccination status (unvaccinated, partially vaccinated, fully vaccinated), do not need to restrict their movements and are not recommended to undertake ADTs.

## 5.4 Management of close contacts of COVID-19 Variants of Concern (VOCs)

The approach to management of all cases of COVID-19 is now broadly the same, whether they are due to VOC or not (see section 6.0). Although additional contact tracing measures are no longer applied to Alpha and Delta cases, additional contact tracing measures should continue to be applied for Beta (B.1. 351 (501Y.V2)), Gamma (variant P.1 (B.1.1.28.1)) variants of concern and any future identified VOCs.

The additional contact tracing measures required for Beta and Gamma VOC are as follows:

- Source investigation should be undertaken for any Beta or Gamma case detected as directed by the relevant Department of Public Health.
- There should be a focus on supporting those who need to [self-isolate](#) or [restrict their movements](#) to aid compliance with recommended public health measures for Beta and Gamma cases
- Following a risk assessment, an outbreak control team may be established where appropriate
- In addition, close contacts known contact with a case of COVID-19 in which the case is a Person Under Investigation, probable or confirmed variant of concern **excluding Alpha and Delta**. In this situation the close contact should be managed as a close contact of a VOC.

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## 6.0 Management of close contacts of COVID-19 cases identified during air-travel

As of the 8<sup>th</sup> September 2021, a decision has been taken to **cease routine contact tracing** of infectious cases notified during air travel.

Flight contact tracing **will occur where indicated by Departments of Public Health/MOH risk assessment**. This risk assessment can include –

- More than ten unrelated COVID-19 confirmed cases on a flight (i.e. not travelling as a family/group)
- Confirmation of one or more non-prevalent VOC/VOI
- Other Public Health concerns (i.e. number of cases/exposure of highly vulnerable groups/high symptom burden or poor outcome of passengers)

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