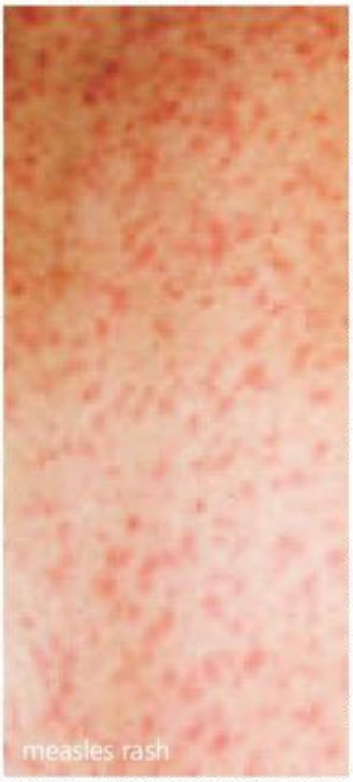
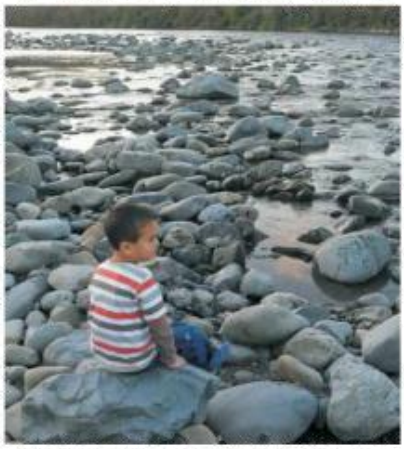




Regional Public Health
Better Health For The Greater Wellington Region

2017 Public Health Disease Notification Manual

for primary care health practitioners

August 2017

Purpose

This manual is to help primary health care practitioners meet the legal duty to notify. Notification forms and links are on Health Pathways, under Public health/Notifiable diseases and the Regional Public Health (RPH) website, under Health professionals/Notifiable diseases. The RPH website also has information on specific diseases (www.rph.org.nz/public-health-topics/illness-and-disease/). National policy is in the Ministry of Health's Communicable Disease Control Manual.

Introduction

On 4 January 2017 the Health (Protection) Amendment Act 2016 came into force. It updates the Health Act 1956 and repeals the Tuberculosis Act 1948 to improve surveillance and management of notifiable diseases. All health practitioners now have to notify the medical officer of health upon 'reasonable suspicion' of a notifiable disease, if this is in their scope of practice.

The Act makes three sexually transmitted infections (syphilis, gonorrhoea, HIV/AIDS) notifiable, but without personally identifying information. Since notification is anonymous, the diagnosing clinician responsible for initial contact tracing for these STIs.

Why notify?

Disease notification enables (1) surveillance to monitor trends, associated risk factors, and enable early identification of potential outbreaks; and (2) prevention of spread by identifying sources and contacts.

Why do I need to notify after laboratory notification?

For most notifiable diseases, a laboratory test provides the initial notifications (see Table 1). But you are still required to notify to provide contact details, context and clinical information for RPH follow-up. STIs are the exception: you do **not** need to notify STI cases that the laboratory has notified.

Table 1. Top 15 notified diseases to RPH 2013-2016 with source of notification

Disease	Number of notifications	Notification source			
		GP	Hosp	Lab	Other
Campylobacteriosis	2602	12%	2%	83%	2%
Giardiasis	741	4%	0%	95%	1%
Pertussis	685	44%	2%	50%	3%
Salmonellosis	352	5%	4%	88%	2%
Gastroenteritis - unknown cause	342	6%	2%	0%	92%
Yersiniosis	329	4%	2%	94%	0%
Cryptosporidiosis	327	4%	1%	94%	2%
Gastroenteritis - with cause	318	78%	5%	6%	10%
Latent tuberculosis infection	263	1%	27%	3%	69%
Invasive pneumococcal disease	178	0%	1%	99%	1%
Tuberculosis disease - new case	130	6%	71%	17%	6%
Lead absorption	73	4%	1%	78%	16%
Dengue fever	62	5%	6%	85%	3%
Rheumatic fever - initial attack	46	9%	74%	4%	13%
Shigellosis	45	13%	13%	69%	4%

Which diseases are notifiable?

Annex A lists notifiable diseases in alphabetic order. The MoH website lists the diseases under the three categories of infectious notifiable diseases:

- **Section A** diseases: enteric infections (eg, campylobacter, giardia), legionellosis and amoebic meningoencephalitis. These diseases are notified to the territorial authority (TA), as well as the medical officer of health (MOH). RPH notifies the TA.
- **Section B** diseases: other infectious diseases that are only notified to the MOH. These include vaccine-preventable diseases (eg, pertussis, measles) and rare diseases (eg, anthrax, avian influenza, Creutzfeldt-Jakob disease, Middle East Respiratory Syndrome, rabies, viral haemorrhagic fevers).
- **Section C** diseases: syphilis, gonorrhoea, HIV and AIDS. These are notified **without** identifying personal information. Anonymity is to prevent people avoiding diagnosis and treatment, due to fear of stigma and discrimination.

There are also non-infectious notifiable diseases: poisoning from hazardous substance, high blood lead, decompression sickness, and parasites (cysticercosis, taeniasis, trichinosis).
NOTE: **Notification of hazardous substances** and high blood lead is through separate BPAC form (see www.rph.org.nz/health-professionals/notifiable-diseases/ *)*

Additional notification

At times, the Ministry of Health or the medical officer of health may request that a specific disease not listed in the schedule be notified for disease control purposes.

Contact tracing: new clinician responsibility for STIs

The purpose of contact tracing is to identify people at risk of getting disease to prevent further spread. Treatment or early diagnosis of disease in the contacts, as well as advice to limit contact during risk periods will limit further spread of infectious disease. Contact tracing can also identify the source of the infection.

For most notifiable diseases, RPH will undertake the follow-up, including contact tracing. But the clinician is expected to undertake contact tracing for STIs, since RPH is not provided with case details. This role builds on current clinical care, where the patient is advised to tell any sexual partners to seek medical advice and testing. The New Zealand Sexual Health Society guidelines on partner notification (that includes a link to the Australasian Contact Tracing Guidelines) provides evidence-based guidance for clinicians. There is also a British resource.

The Act also establishes 'formal' contact tracing, with additional powers that the medical officer of health can nominate you to undertake. If so, you will need to be trained to comply with the processes and obligations set out in the Act.

Disease notification process

Forms for report and investigation are nationally defined for each disease and available from ESR. There is also a generic RPH form (Annex D) that you can use for any disease, except the STIs and AIDS where no identifiable information is to be included (Annex E). You can phone or fax the notification to RPH:

Phone:	(04) 570 9267 during office hours (8am to 5pm, Monday to Friday).
	(04) 570 9007 after hours; ask for on-call medical officer of health
Fax:	(04) 570 9373
Electronic:	<being developed by ESR>

What information is needed about the notified cases?

RPH needs contact details (phone and email) for follow-up and confirmation that they are expecting RPH follow-up because they have been advised about the notification. This is why you still need to notify a case after the laboratory notification, as the test results do not provide these details.

In addition, it is vital to share any information you have about possible sources/exposures of the case and risks of further transmission based on their occupation or other factors. This information helps RPH to identify possible clusters and prioritise follow-up.

Urgent notification

Annex A highlights the diseases that require **urgent phone notification**; the list is also on the RPH website. **Any potential outbreak needs to be urgently reported**. An outbreak is defined as two or more cases linked to a common source.

Other reasons for urgent reporting are:

1. limited time to offer contacts protection (eg, measles, meningococcal disease);
2. possible common source potential (eg, toxic shellfish poisoning, chemical poisoning)
    - including for diseases that are not notifiable (eg, skin infection following tattoo) ;
3. infected person is at increased risk of spreading it (eg, food worker, caregiver) especially for gastroenteritis or respiratory illness;
4. unusual presentation (eg, arboviral infection with no travel history); or
5. rare but important (eg, botulinism, cholera, MERS, plague, polio, rabies).

For these diseases, please **notify based on clinical suspicion** at the same time as arranging the diagnostic test. If in doubt, please phone to check, using the phone numbers above.

Patient consent

Patient consent to notification is not needed, but it is good practice to discuss it with the patient/whānau and to advise that public health may contact the patient or family member. Public health follow-up can be compromised if the person does not expect this follow-up. As noted above, this is one reason why you still need to notify a case that has been notified by the laboratory.

Anonymous notification

For section C disease (STIs and AIDS), the notification does not include the person's name, but instead uses code (first two letters of surname followed by first letter of first name). Personally identifying information is not to be included; but the medical officer of health can request it.

Notifications for STIs are usually made by the laboratory upon a positive test result. The health practitioner who requested the test does **not** need to notify upon receipt of the test result – in contrast to other notifiable diseases.

A questionnaire for the notifier to complete on the case's risk and protective factors is under development.

Relevant legislation

- Health Act 1956, Sections 70 – 87 A and associated regulations
- Health (Infectious and Notifiable Diseases) Regulations 2016
- Hazardous Substances and New Organisms Act 1996 Section 143

In addition, the International Health Regulations 2005 requires notification of some diseases (eg, cholera and polio) to the World Health Organization. For some infections that acquired overseas, the relevant national health authorities may be notified. Both of these functions are done by RPH.

Annex A: List of notifiable diseases

Urgent notification

Phone 04 570 9267

After hours until 10pm (including weekends and public holidays) contact the on-call health protection officer or medical officer of health (MOH) on 04 570 9007. Overnight in exceptional circumstances or urgency call the on-call MOH.

- Acute gastroenteritis[1]
- Amnesic shellfish poisoning
- Anthrax
- Avian influenza (highly pathogenic)
- Botulism
- Cholera
- Diarrhoeic shellfish poisoning
- Diphtheria
- Ebola
- *Haemophilus influenzae* type b (invasive disease)
- Hepatitis A[2]
- Hepatitis B[2] (acute disease only)
- Highly pathogenic avian influenza (HPAI)
- Lassa fever (viral haemorrhagic fever)
- Marburg virus disease
- Measles[3]
- Meningococcal disease
- Meningoencephalitis – primary amoebic
- Middle East Respiratory Syndrome (MERS)
- Neisseria meningitidis invasive disease or conjunctivitis
- Neurotoxic shellfish poisoning
- Non-seasonal influenza (capable of person to person transmission)
- Paralytic shellfish poisoning
- Paratyphoid fever
- Plague
- Poliomyelitis
- Rabies and other lyssaviruses
- Scombroid
- Severe Acute Respiratory Syndrome (SARS)
- Shiga toxin producing or verotoxigenic Escherichia coli (STEC/VTEC) infection
- Shigellosis
- Toxic shellfish poisoning - unspecified
- Tuberculosis: new case, relapse or reactivation
- Typhoid fever or paratyphoid fever
- Verotoxigenic or Shiga toxin producing *Escherichia coli,* (VTEC/STEC) infection
- Viral haemorrhagic fevers
- Yellow fever
- Zika

Non-urgent notification

Fax generic case report form to 04 570 9373

During office hours you can also phone the communicable disease notification line on (04) 570 9267 with the name, DOB, NHI and contact details of the ill person.

- Arboviral disease e.g. Dengue fever[4] Chikungunya
- Barmah Forest virus infection
- Brucellosis
- Campylobacteriosis
- Congenital rubella
- Creutzfeld-Jakob Disease and other spongiform encephalopathies
- *Cronobacter* species *(*Enterobacter sakazakii invasive disease)
- Cryptosporidiosis
- Cysticercosis
- Decompression sickness
- Dengue fever[4]
- Giardiasis
- Hepatitis C
- Hepatitis (viral) not otherwise specified e.g. hepatitis E
- Hydatid disease
- Invasive pneumococcal disease
- Japanese encephalitis
- Kunjin
- Lead absorption > 0.48 µ mol/l (10µ/dl)
- Legionellosis
- Leprosy
- Leptospirosis
- Listeriosis
- Malaria
- Mumps[3]
- Murine typhus
- Murray Valley encephalitis
- Pertussis[3]
- Poisoning from chemical contamination of the environment
- Primary amoebic meningoencephalitis
- Q fever
- Rheumatic fever - initial attack or recurrence
- Rickettsial disease
- Ross River virus infection[4]
- Rubella - not congenital or congenital[3]
- Salmonellosis
- Taeniasis
- Tetanus
- Trichinellosis
- Typhus
- Yersiniosis

Section C diseases

Diseases notifiable without identifying information of person. Notification usually provided by laboratory.

- AIDS (Acquired Immunodeficiency Syndrome)
- Gonorrhoea
- HIV (Human Immunodeficiency Virus)
- Syphilis

1. Acute gastroenteritis notifiable if suspected outbreak or linked to common source or person in high risk category e.g. food worker, caregiver, etc. (check list of high risk category) or chemical, bacterial or toxic food poisoning e.g. ciguatera, scombroid
2. Notification must include a faxed copy of serology confirming acute hepatitis and LFTs
3. Notify on suspicion and send confirmatory serology (IgM) for measles/mumps/rubella or nasopharyngeal swab result for measles or pertussis to RPH when available.
4. Acute Dengue fever or Ross River virus notifiable by telephone if there is NO recent overseas travel; if there is recent overseas travel, notify by fax.

Annex B: Exclusion and clearance criteria for cases and contacts

Notification aims to prevent spread, by limiting potential exposures from cases and/or contacts. The periods of exclusion and clearance are detailed below. In most situations RPH organises the clearance testing for both cases and contacts. RPH will advise you when a person with a high risk occupation or child attending and has been cleared to return to work or early childhood centre (ECC)/school. Occasionally RPH may ask primary care for support to undertake this or if special circumstances exist.

The medical officer of health can also consider whether it is necessary to use exclusion provisions in s92I (for cases) or s92J (for high risk contacts) of the Health Act and from early childhood centres using the Education (Early Childhood Centres) Regulations 1998.

Enteric infections

Exclusion from work, school or an early childhood service is advised for **all** enteric infections until 48 hours have passed without symptoms. For specific enteric infections, additional microbiological clearance is needed for cases or contacts. Table B1 shows clearance for cases and close contacts in each of these groups:

Food or product handlers	Group A
People working in health care or early childhood facilities.	Group B
Children attending early childhood services.	Group B
Other adults or children at higher risk due to illness or disability.	Group B
Children attending school.	Group C

Table B1. Exclusion and clearance criteria for enteric infections

Pathogen	Group(s)	Exclusion ends after 48 hours symptom-free AND:	Exclusion for close contacts
Campylobacter	A, B		Not required
Cryptosporidium	A, B	Avoid swimming in public pools until 14 days with no symptoms	
Giardia	A, B		
Yersinia	A, B		
Rotavirus	A, B		
Norovirus	A, B		
Salmonella	B		
	A	Two consecutive negative stools at least 48 hours apart	One negative stool for group A contacts
S. typhi and paratyphi	A, B, C		One negative stool for contacts in groups A or B
Shigella	A, B		
VTEC/STEC	A, B		

Notes:

(1) The clearance criteria can be varied for a specific case by the medical officer of health
(2) For S. typhi and paratyphi all close contacts need a stool test
(3) For Salmonella, inappropriate antibiotics can lead to positive stools and infection risk for long periods;

Hepatitis A

Cases in risk groups A, B, or C (see above), should stay away from school or work for at least one week after onset of jaundice or symptoms. There is no restriction on contacts who are well; those with symptoms of hepatitis should be investigated.

Hepatitis B

Cases who may infect others during their work (eg, health care workers) need to avoid exposure-prone procedures and adopt universal precautions. Contacts have similar restrictions until test results are known.

Meningococcal invasive disease

Droplet precautions are needed for cases until 24 hours after the start of ceftriaxone, rifampicin or ciprofloxacin. Contacts are those exposed to the case's respiratory droplets from the case during the 7 days before onset of illness to 24 hours after onset of effective treatment from 7 days. Only close contacts need chemoprophylaxis and immunisation if the strain is vaccine-preventable (A, C, Y, W135).

Measles, mumps, rubella

Cases need to avoid contact during their infectious period: measles until 5 days after rash onset; mumps until 5 from onset of glandular swelling; rubella until fully recovered or 7 days after rash onset. This means not going to work, school or ECC. They need to stay home and avoid contact with those who are not immune. For rubella, cases should avoid contact with women of childbearing age.
Measles contacts born from 1969 and without documented immunity (from infection or two doses of vaccine) are advised to avoid attending school, ECC, and community gatherings; and to avoid contact with susceptible individuals until 14 days after their last exposure to the infectious case. Susceptible contacts who get a first dose of measles vaccine within 72 hours of exposure, are still subject to these restriction – unless they can demonstrate immunity.
For mumps contacts, exclusion for 25 days after the last exposure is only used if other susceptible individuals are at work, school or ECC. For rubella contacts there are no restrictions; the focus is on pregnant women to identify infection and offer protection through vaccine.

Pertussis

Cases are excluded from work, education, or other institutions or work until they have received at least 5 days of appropriate antibiotics or 3 weeks from onset date of paroxysms of cough, whichever comes first.
All contacts are to be advised to avoid work, school or other institution if they become symptomatic. In some cases, the medical officer of health could place additional restrictions to prevent spread.
Chemoprophylaxis is of uncertain benefit and only recommended for high priority contacts: children aged under one year; those who have contact with them, pregnant women, and those at high risk of severe illness or complications (for example chronic respiratory conditions, congenital heart disease or immunodeficiency). Offer vaccine to any high priority contacts vaccine who are not fully immunised.

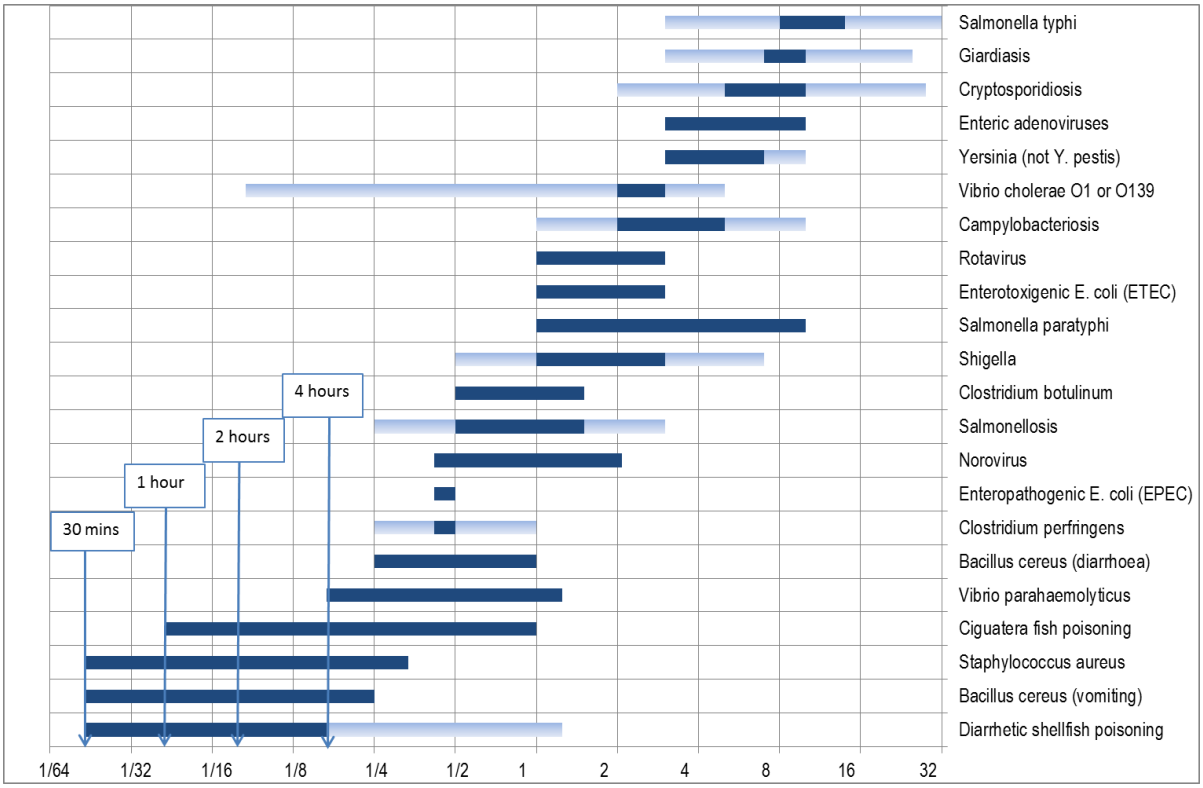
Tuberculosis

Cases with active pulmonary or laryngeal TB in a health facility need isolation and airborne precautions until non-infectious. Cases who do not warrant hospitalisation and who will comply with infection control precautions may be isolated at home, after discussion with the medical officer of health. Contacts have no restrictions unless they have symptoms of pulmonary TB, when they should restrict social interaction until an urgent chest x-ray is available.

Annex C: Incubation and infectious periods for enteric infections

Figure C1. Incubation period (days in log scale) for enteric infections

(Darker shade shows usual range, light shade possible range)



Source: Table 2.2 of Ministry's Communicable Disease Control Manual. Data for crypto, DSP, and Yersinia adjusted based on other sources.

Table C1. Communicable period for enteric disease with person-to-person transmission

Infection	Period of communicability
Enteric adenoviruses	Highest risk in the first few days of symptoms; up to months
Giardiasis	Up to months
Norovirus	During symptoms and until 48 hours after diarrhoea ceases
Rotavirus	During symptoms and until approximately 8 days after onset of symptoms. Up to 30 days after onset of symptoms in immunocompromised patients
Shigellosis	Up to 4 weeks after infection. Asymptomatic carriage may also occur. Rarely, faecal shedding may persist for months

Annex D: Generic case report form

Health practitioner notice of notifiable disease

Section 74, Health Act 1956

Regional Public Health
Better Health For The Greater Wellington Region

Instructions on use: This form is for notification of diseases listed in sections A and B of Part 1 of Schedule 1 of the Act.

Name of notifier:	Date:
Organisation:	Phone:
Disease being notified:	

CASE IDENTIFICATION		
Name of case:		NHI:
Current address:		Phone (home):
Email:		Phone (other):
Date of birth: / /	Sex: ☐ Male ☐ Female ☐ Indeterminate	
Caregiver's name if case is <16 years:		
Ethnicity (tick all that apply):	☐ NZ European ☐ Māori ☐ Samoan ☐ Cook Island ☐ Niuean ☐ Chinese ☐ Indian ☐ Tongan ☐ Other (please specify):	
Current occupation:		
Place of work/school/preschool:		
High priority occupation:	☐ Food worker ☐ Healthcare worker ☐ Early childhood worker/attendee ☐ High risk due to illness/disability	

PLEASE ADVISE PATIENT OF DIAGNOSIS BEFORE NOTIFYING REGIONAL PUBLIC HEALTH

CLINICAL SYMPTOMS
Illness onset date: / /
Hospitalised? ☐ Yes ☐ No ☐ Unknown Hospital name:
Diagnosis based on: ☐ Clinical findings ☐ Lab test ☐ Contact with confirmed case
Symptoms:
If vaccine preventable (e.g. pertussis/measles), dates and doses of vaccines given:
Any other information on the patient's situation, occupation, travel, or other activities that may be relevant for identifying the source or potential spread of the disease:

PATIENT MANAGEMENT
☐ Antibiotic, if given specify:
☐ Case advised of exclusion if required, details:
☐ Other comment:

Notify RPH within 24 hours by fax 04 570 9373

Annex E: Non-identified case report form (for STIs and AIDS)

Health practitioner notice of notifiable disease (non-identified basis)

Section 74(1) and (3A), Health Act 1956

Regional Public Health
Better Health For The Greater Wellington Region

Instructions on use: This form is for notification of diseases listed in section C of Part 1 of Schedule 1 of the Act; specifically AIDS and syphilis (if clinical diagnosis only). The name, address and other contact details of the patient **MUST NOT** be included in this form. However, a medical officer of health may require disclosure of those matters if necessary under section 74 (3B) of the Act.

HIV, gonorrhoea and syphilis (confirmed by a laboratory test) are notified directly by the laboratory. The clinician does not need to notify these positive laboratory results but will be asked to complete an electronic questionnaire (currently under development) about the person's risk and protective factors for the infection.

Name of notifier:	Date: / /
Organisation:	Phone:
Email:	Fax:
Disease being notified: ☐ AIDS ☐ Syphilis (clinical diagnosis without laboratory confirmation)	

PATIENT DETAILS - DO NOT COLLECT OR RECORD THE PATIENT'S FULL NAME. RECORD INITIALS ONLY	
First two letters of surname:	First letter of first name:
DHB district of usual address:	NHI (if known):
Date of birth: / /	Date of death (if applicable): / /
Sex: ☐ Male ☐ Female ☐ Indeterminate	
Ethnicity (tick all that apply): ☐ NZ European ☐ Māori ☐ Samoan ☐ Cook Island ☐ Niuean ☐ Chinese ☐ Indian ☐ Tongan ☐ Other (please specify):	

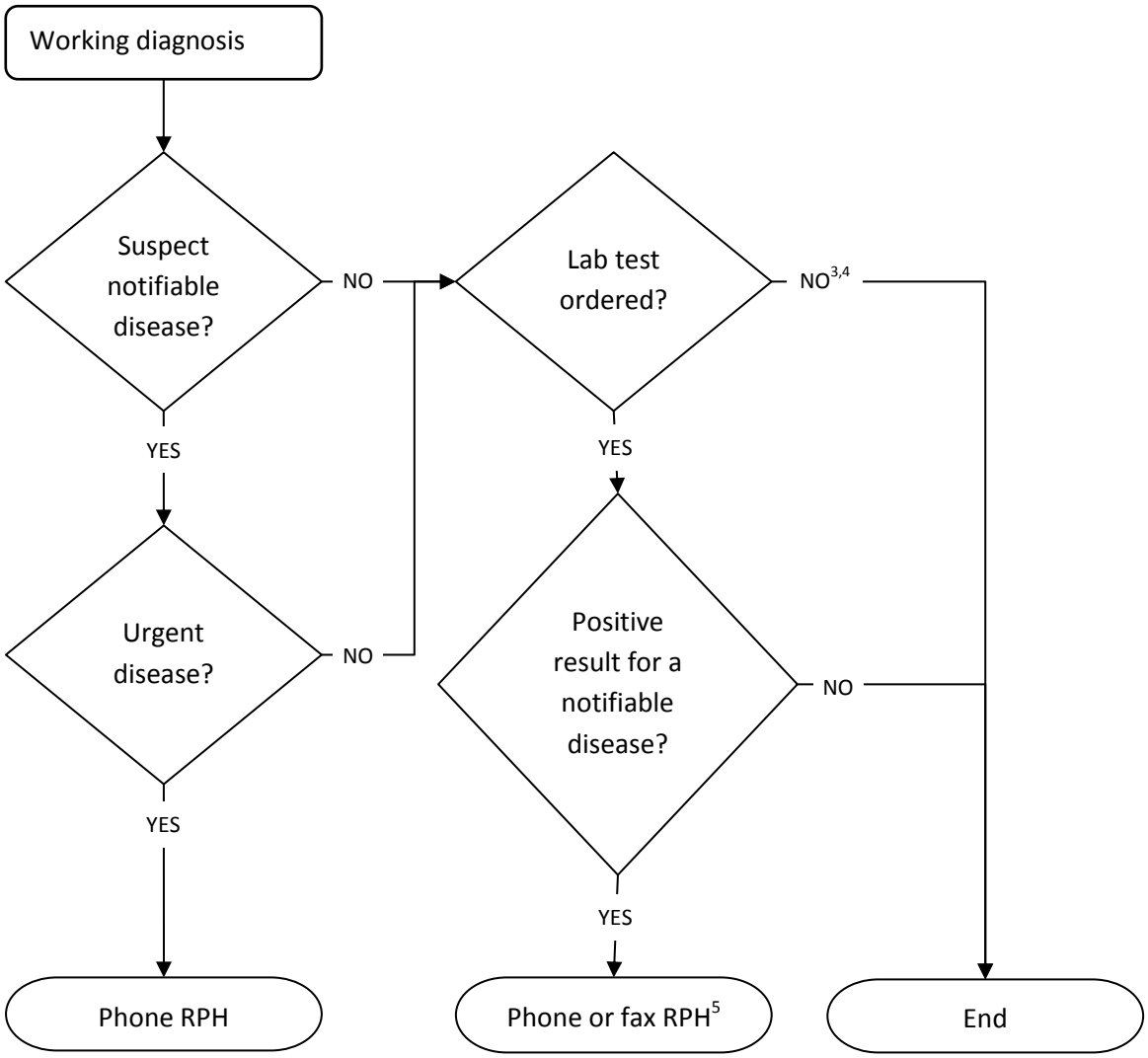
CLINICAL SYMPTOMS				
Illness onset date (approximate): / /				
Hospitalised?	☐ Yes	☐ No	☐ Unknown	Hospital name:
Previous –ve lab test?	☐ Yes	☐ No	Date: / /	Test:
Person under specialist care?	☐ Yes	☐ No	Specialist/clinic:	
Travel (if infection likely to have occurred overseas): Where:				When:
Any other information relevant to the risk of the patient having acquired the disease (for example, sexual behaviours or activity, or sex of partner or partners, if known):				

CONTACT TRACING / PARTNER NOTIFICATION

Contact tracing/partner notification guidance can be found at http://nzshs.org/docman/guidelines/principles-of-sexual-health-care/144-partner-notification-guideline/file

Notify RPH within 48 hours by fax 04 570 9373

Annex F: Notifiable disease report process



Notes:

1. Advise patient of notification and that RPH will contact them for follow-up, if needed.
2. Advise patient of any exclusion advice (available at rph.org.nz/health-professionals/notifiable-diseases/exclusion-and-clearance-criteria)
3. Not all notifiable diseases have confirmatory lab test e.g. tetanus, botulism, clinical syphilis - please notify upon clinical diagnosis.
4. A lab test is not need always needed to confirm the diagnosis, when there is a link to a confirmed case.
5. For the STIs (syphilis, gonorrhoea, HIV), a positive lab test is automatically notified, there is no need for the clinician to notify. For cases reported on suspicion, there is no need to report again if lab test confirms the diagnosis.
6. The End button is only for the notification process, normal case management continues.