Guidelines for Public Health Services on Cluster Control for Pandemic Influenza

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MINISTRY OF HEALTH
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Contents

1 Background

1.1 Purpose

These guidelines describe the public health interventions that may be used by Public Health Units (PHUs) in the cluster control phase of pandemic influenza.

The aims of cluster control in a pandemic are to:

- control or eliminate the disease after introduction to New Zealand (in conjunction with rigorous border management)
- slow the transmission of the disease
- obtain epidemiological information to characterise the spread of the infection to inform the pandemic management response.

Key decisions

Key decisions for cluster control are concerned with:

- when to implement cluster control measures
- implementation of social distancing measures:
  - mass gatherings cancellation
  - school closure (including early childhood education centres)
  - workplace closure
  - restriction of movement
- use of antivirals for prophylaxis.

1.2 Case definition

The case definition for pandemic influenza will change as information on the pandemic evolves. Refer to the Ministry of Health website for the latest case definition (www.moh.govt.nz).

1.3 Laboratory test for diagnosis

All PHUs should be aware of local arrangements for obtaining and processing laboratory samples from people suspected of having pandemic influenza.

Refer to the *National Laboratory Guidelines for Pandemic Influenza* (www.moh.govt.nz/moh.nsf/indexmh/national-laboratory-guidelines-for-pandemic-influenza).

Preferred specimens of choice are throat swabs or nasopharyngeal swabs. Samples should be collected during the first three days after onset of clinical symptoms, but may be taken up to a week after the onset of illness.

The test of choice during cluster control is real-time polymerase chain reaction (PCR). Specimens must be **rapidly** sent to one of the five PCR referral laboratories in Auckland, Hamilton, Wellington (Wellington Hospital or ESR) or Christchurch, via transport systems usually used. Positive PCR samples will be sent to the WHO Collaborative Centre in Melbourne (CSL) for confirmation.

1.4 Incubation period and period of communicability

Seasonal influenza has the following characteristics.

- **Incubation period** is commonly 1–3 days.
- **Infectious period**: There is limited evidence that adults are infectious up to one day before most symptoms start, through to about Day 5 of the illness. Children generally remain infectious for up to seven days after symptoms start. For children aged 12 years or younger, infectivity can persist for 21 days after the onset of illness. Infectivity is usually highest during the early symptomatic phase.

As information on the pandemic evolves, the incubation period and infectious period may be found to differ from normal seasonal influenza periods. Refer to the Ministry of Health website for the latest epidemiological information on the pandemic strain (www.moh.govt.nz).

1.5 Mode of transmission

The most common way for the influenza virus to spread is as droplets of respiratory fluid from infected people talking, coughing or sneezing. It can also be spread from contaminated surfaces (where the influenza virus can last for several hours) and from hand-to-face contact.

1.6 Notification procedure

The suspected diagnosis of infection with a novel influenza virus (such as Highly Pathogenic Avian Influenza (HPAI)) must be notified immediately by the attending medical practitioner to the Medical Officer of Health. HPAI is currently a section B notifiable infectious disease and is in the list of notifiable conditions in the Public Health Bill.

Pandemic influenza is not currently a notifiable condition. However, there is potential for it to become notifiable with rapid amendment to the schedule to the Health Act 1956 (or Public Health Act when this comes into force).

Other health care workers are encouraged to discuss with the Medical Officer of Health any suspected cases.

The Medical Officer of Health will notify the Ministry of Health of any initial suspected cases by contacting [XXXXXXXXX].

2 Cluster Control Measures

2.1 When to implement cluster control measures

Cluster control operations will be started as soon as a suspected case (with symptoms **and** related epidemiological data) is identified in New Zealand. A confirmed cluster will be treated as a major health emergency. Updates on the international and national situations will be regularly sent from the Ministry of Health to District Health Boards (DHBs) and PHUs through the nominated DHB single point of contact.

Border management operations will continue during the cluster control phase. In the unlikely event that a case is found in New Zealand without a history of travel to a country known to be affected by pandemic influenza, cluster control operations will start immediately.

2.2 Limitations on cluster control operations

Public health services need to be prepared to take rapid action when a suspected case of pandemic influenza is notified. This action will involve identifying whether there is a cluster of cases (>1 linked cases) and attempting to control disease spread.

However, intensive and prolonged cluster control may not be warranted if the first indication of a pandemic arriving in the country is a large outbreak or several outbreaks (perhaps totalling 20–30 cases, which would indicate a similar number of second- and third-generation contacts already incubating infection and an escalating number of contacts). In this case, immediate activation of the Pandemic Management Phase is recommended (see New Zealand Influenza Pandemic Action Plan, www.moh.govt.nz/moh.nsf/indexmh/nz-influenza-pandemic-action-plan-2006).

The main limitations on cluster control are expected to be:

1. the behaviour and spread of the virus before cases are identified, and the difficulties in controlling the spread
2. the availability of staff with skills to undertake control measures.

DHBs will need to plan for rapid redeployment of staff to assist public health control activities and the plan should include where the resources will come from within the health sector (PHU, DHB). Other sectors may be able to contribute (eg, police, local government). High-intensity responses may not be sustainable for more than a few weeks. However, if border management is rigorous and there is a limited number of imported cases, control efforts could be continued for many months.

2.3 Social distancing

There is inevitably a tension between promoting social distancing and promoting community support. The key message of social distancing ('avoid unnecessary contact with others') is at odds with the key message of community support ('check on other members of your community and provide support if necessary'). There is the potential for people to respond to social distancing messages in a disproportionate manner by interpreting avoiding **unnecessary** contact as a declaration to avoid **all** contact. It will also be important that social distancing messages are explicit: people who have close personal contact with those infected with influenza (such as family members) will not necessarily become infected themselves, although they will be treated and managed as contacts for the purposes of cluster control.

Measures to increase social distancing in a pandemic are important. These measures include providing messages to the public about avoiding crowded spaces, and the infection control messages: 'if you are coughing and/or sneezing, avoid mixing with other people'.

Public gatherings are likely to be a means of transmission during the early stages of a pandemic. Although it is likely the public will avoid mixing during a pandemic, compulsory cancellation of public gatherings may be instituted in certain circumstances. In other circumstances, employers and businesses may decide to close, or postpone or cancel events in the interests of staff health.

International plans and World Health Organization (WHO) recommendations all advocate social distancing measures (such as school closures and cancellation of mass gatherings) as part of pandemic control interventions. They also recommend that decisions should be based on information available at the time.

There is some evidence that closure of schools could reduce the impact of an influenza pandemic, with a lesser level of evidence regarding the effect of the cancellation of public gatherings. The literature suggests that in countries where early childhood centres are common, transmission in this setting is a major factor in the early spread of the annual influenza epidemic.

School closure and/or cancellation of mass gatherings should not be recommended lightly. Any benefit has to exceed possible negative effects – including, for example, loss of members of the health care workforce because they must take leave to care for children.

The Medical Officer of Health may use powers under sections 70(1)(la) and (m) of the Health Act 1956 to close schools and cancel mass gatherings if special powers have been authorised. These powers may be used for the purpose of preventing the outbreak or spread of an infectious disease:

1. with the authority in writing by the Minister of Health
2. during a state of emergency declared under the Civil Defence Emergency Management Act 2002
3. while an epidemic notice under the Epidemic Preparedness Act 2006 is in force.

2.3.1 Closure of education institutions to students and children

In yearly influenza epidemics, preschool and school aged children are a significant source of influenza spread, because of close contact in preschools and schools, poor hygiene, and lack of immunity to viral strains. Children spread the infection in the home environment to other family members, and may shed influenza virus for up to 21 days, whereas adults usually stop shedding virus after five days.

Closures of schools (including early childhood centres and schools up to and including secondary schools) in an affected area during the cluster control phase may contribute to the effectiveness of pandemic control measures. Decisions by Medical Officers of Health to close schools to children will be influenced by the epidemiology of the virus (eg, the age groups affected by the pandemic virus), whether there is high morbidity and mortality associated with the pandemic virus, and local circumstances.

Although early childhood centres, schools and tertiary institutions may be closed to children and students, the premises would not necessarily be closed in a quarantine sense. For example, staff may continue to go to work to deliver essential and other services, or to carry out 'alternative duties' for their employer or another agency. (Section 70(1B) of the Health Act 1956 permits an order under 70(1)(la) or (m) to exempt people engaged in necessary work in the premises.)

Educational institution closures may not be effective if children mix in large groups in other settings. If parents choose to stay at home to care for children, this decision will impact on the workforce. This flow-on effect will need to be considered as part of planning for cluster control measures.

Mathematical modelling suggests that closing schools and early childhood centres could decrease disease spread and modestly decrease total population rates of cumulative clinical attack.

School closure would not, however, be recommended if clinical attack rates are relatively high for the elderly, and relatively low for children.

Boarding schools are a special category because, if disease does occur and attack rates are high, it would be necessary to discourage sick students from returning home if they would be returning to unaffected areas.

Criteria for school closure

Closure should start as early as possible during the period of local circulation of the virus, and may last up to 12 to 14 weeks to cover the peak of transmission. Closure can only occur if special powers have been authorised (Health Act 1956 section 70(1)(la and m)).

Consider closing schools if:

- the pandemic has high levels of morbidity and mortality (as indicated by information coming in from overseas)
- there is a high clinical attack rate in children (as is the case with seasonal influenza)

- the school's catchment area is rural rather than urban
- measures, such as parents/caregivers being able to remain at home to care for children, are in place so that the congregation of children in care programmes is less likely
- it will aid cluster control.

If a Medical Officer of Health is considering closure of one or more schools prior to any national decision, they should first discuss the situation:

1. with the Director of Public Health or delegate **or**
2. at the proposed regular teleconferences for Medical Officers and the National Health Co-ordination Centre.

2.3.2 Cancellation of mass gatherings

Gatherings with large numbers of people in confined spaces (such as large events in venues with audiences in close proximity) are more likely to contribute to disease transmission than, for example, local rugby club matches that are in the open air but not in a stadium. Cancellation by order of a Medical Officer of Health can only occur if special powers have been authorised (Health Act 1956 section 70(1)(m)).

Criteria for cancellation of mass gatherings

Mass gatherings should be considered for cancellation if they involve:

- large gatherings (eg, music concerts and professional sport gatherings with more than 500 persons attending)
- close physical contact because of, for example, seating arrangements
- high incentives for attendance that may counteract public health advice for social distancing, such as pre-booked events where ticket costs have already been incurred
- events where alcohol use is such that may reduce adherence to advice regarding social distancing
- indoor events that are more likely to facilitate transmission than outdoor events (unless effective air ventilation is in place)
- participants from geographically dispersed areas (eg, participants from overseas or from areas with disease are more likely to be sources of transmission)
- venues with inadequate hand-washing facilities
- venues whose standards of environmental cleaning (before and after use) are not high
- facilities that lack adequate duty of care for their own staff.

In addition, cancellation should be considered if it will aid cluster control.

If a Medical Officer of Health is considering cancellation of a mass gathering, they should first discuss the situation:

1. with the Director of Public Health or delegate **or**
2. at the proposed regular teleconferences for Medical Officers and the National Health Co-ordination Centre.

2.3.3 Isolation and quarantine

Compulsory or voluntary isolation of cases and quarantine of contacts are important measures to prevent or slow the spread of the pandemic virus at all phases of a pandemic response, particularly in the context of border and cluster control. Cases must be isolated until they are no longer infectious (see section 1.4 above) or until an alternative diagnosis has been made.

Early cases must be isolated and provided with medical attention, following local protocols. Contacts of cases will be advised about symptoms, actions they can take if symptoms develop and how to reduce spread (see section 6 below). They will be advised to stay at home in voluntary quarantine for several days, with the specific duration depending on the timing and incubation period of the illness.

Quarantine will be used in combination with post-exposure prophylaxis using antivirals for contacts at the cluster control phase. Modelling indicates that this combination of interventions will be more effective than quarantine on its own in controlling the potential spread of pandemic influenza, provided that antivirals are effective against the pandemic strain.

All contacts who live alone, as well as contacts who are unlikely to follow quarantine restrictions or receive any support at home, should be considered for facility quarantine to ensure that they are able to observe quarantine restrictions and receive adequate support. The Medical Officer of Health can requisition premises for this purpose under section 71(1) of the Health Act 1956 if special powers have been authorised.

Quarantine of groups of contacts

Where a group (eg, tour bus party) is considered to meet the definition of being close contacts of a probable case, then facilities may need to be provided for the duration of the quarantine period.

DHBs are responsible for identifying facilities, such as hotels, that can be used for this purpose. It is desirable to have arrangements in place with the owners of such premises.

The Ministry of Health has a Memorandum of Understanding (MoU) with the Hotel Council of New Zealand regarding the use of hotels for quarantine as part of emergency responses at the border. The MoU is intended as a guide for PHUs to arrive at local memoranda of understanding with hotels in their area for quarantining small groups of arrivals, and also for coming to arrangements with hotels for their use as quarantine facilities for larger groups – a measure known as ‘enhanced quarantine’.

A template has been developed for local arrangements to encourage compliance with the national MoU. The template could be amended for use as part of community response planning if required. Community use would not fall into the category of 'enhanced quarantine' as described in the MoU template.

See 'Memorandum of Understanding' template.

Failing such prior arrangements and as a matter of last resort, the Medical Officer of Health can requisition premises for this purpose under section 71(1) of the Health Act 1956 if special powers have been authorised.

3 Use of Antivirals

Provision of effective antiviral medication to people with pandemic influenza, and for post-exposure prophylaxis of contacts, may reduce the likelihood of spread. Antivirals, if effective against the pandemic virus, will be used early in a pandemic as part of the efforts to contain or eliminate any initial clusters by providing:

- treatment for any cases or suspected cases
- post-exposure prophylaxis or early treatment for close contacts of cases or suspected cases, including health care workers and other essential workers.

If or when the pandemic becomes more widespread in New Zealand, antivirals will be reserved for the treatment of cases and any other purposes that fit with prioritisation criteria advised by the Ministry of Health.

In the cluster control phase, antivirals will be used alongside other public health measures, such as social distancing, to eliminate the cluster/s.

The scale of effort and amount of national reserve put into cluster control efforts will be influenced by the nature and epidemiology of the disease, the timing and availability of any vaccine programme, and the size, location and number of known clusters. National reserve has been pre-positioned in each DHB for initial control activity.

3.1 Antiviral usage – cluster control phase

Activation

In the cluster control phases, antiviral usage will be activated by laboratory confirmation that human pandemic strain case/s have been found on the landside of the New Zealand border.

Provision

National reserve medication will be provided to assist with cluster control operations. It is anticipated that national reserve medication will be provided free of charge to people meeting criteria for provision. Cluster control is likely to be provided through PHUs. Medication is expected to be used for:

- treatment of any cases or suspected cases
- post-exposure prophylaxis of contacts of cases or suspected cases
- any other person identified for treatment or post-exposure prophylaxis by the Medical Officer of Health in charge, or by clinical staff to whom the Medical Officer of Health has delegated responsibility.

Notes

- Once a probable case is identified in New Zealand, treatment, contact tracing and post-exposure prophylaxis/early treatment will be initiated for all contacts. Laboratory confirmation may be required unless the index of suspicion is sufficiently high. See section 6 below.

- National Reserve medication will be released to the appropriate DHB incident controllers for use in accordance with the guidelines.
- Cluster control operations are expected to be local, or confined to a relatively small area, and may be carried out simultaneously in a number of separate localities.
- As relatively few individuals will be involved, cluster control operations need not be constrained by antiviral resource issues.

See:

- *National Reserve of Antiviral Medication*
- *Sector Distribution Notes*
- Appendix I: Antiviral Medication Interim Guidelines, in the *New Zealand Influenza Pandemic Action Plan*.

4 Restriction of Movement

The ability of communities to slow the entry of the virus by restricting entry or exit will depend on local geography and associated logistics. In the current context, in which free mobility and ubiquitous car and train transport are expected, movement controls are likely to be less acceptable than they were in the 1918 pandemic. In addition, prolonged cessation of travel into a geographic region may be difficult for economic and other reasons. Essential goods and services will need to pass through any internal borders.

Attempts to restrict movement may only be practicable for geographically distinct communities (eg, Great Barrier Island, Chatham Islands, the West Coast region and the Tairawhiti region). Movement restrictions may be introduced in order to attempt to slow the introduction of pandemic influenza through the assessment of incoming or outgoing travellers and, if necessary, mandatory isolation of any people showing symptoms, along with quarantine of their contacts.

Section 70(1)(g) of the Health Act 1956 enables a Medical Officer of Health to forbid persons, crafts or things from leaving any port or place that is supposed to be infected with any infectious disease.

Such measures are only likely to be considered during cluster control and in exceptional circumstances (eg, when infection results in high mortality rates).

If a Medical Officer of Health is considering restrictions on movement, they should first discuss the situation:

1. with the Director of Public Health or delegate **or**
2. at the proposed regular teleconferences for Medical Officers and the National Health Co-ordination Centre.

5 Protocol for Case Management

5.1 Investigation

As soon as they receive notification of a suspected case, PHUs should commence a case investigation using the EpiSURV case report form.

5.2 Response procedure

The following measures should be taken in response to identification of a suspected case.

1. Isolate symptomatic person, sending them to the designated health care facility. Ensure the facility is advised that a case is being transported to them.
2. Implement infection control procedures.
   - Probable cases should be cared for in respiratory isolation or in a single room. Use both contact and airborne precautions.
   - For adults, infection control precautions should be continued for [7][1] days after illness onset. For infants and children aged 12 years and under, continue precautions for [21] days after illness onset.
   - Patients should be advised of the nature of the infection and its mode of transmission. Provide information about infection control.
3. Provide antiviral treatment **as soon as possible**.[2]
4. Ensure that laboratory confirmation is being obtained and ask the laboratory to notify the Medical Officer of Health as soon as the results are available.
5. Complete the web-based EpiSURV case report form, with travel and exposure history. Confirm onset date and symptoms of the illness.
6. Identify a list of potential contacts from case or other sources.
7. Initiate contact tracing and enter details using [contact tracing software on SURVINZ].
8. Follow up laboratory results, and ensure appropriate infection control precautions are being followed.

Note: If interviews with suspected cases are conducted face-to-face, the person conducting the interview must have a thorough understanding of infection control practices and be competent in using appropriate personal protective equipment.

[1] Time periods in [brackets] are based on seasonal influenza and may change, depending on the epidemiology of the pandemic virus.

[2] In contrast to seasonal influenza, Tamiflu treatment may be warranted for patients who present late with pandemic influenza because viral replication may be more prolonged than with seasonal influenza.

6 Management of Contacts

6.1 Definition

The definition of a contact includes people who, during the infectious period of a suspected or confirmed case, were:

- household members of the case
- close workplace contacts of the case, including people sharing an office or cubicle area or whose work brought them into close physical proximity (sitting within one metre for at least [15 minutes]) with the case, but not people who share general office space
- members of the case's class or child care group (up to and including tertiary education) with whom most of the day is spent and who spent at least [15 minutes] within one metre of the case; this definition includes the teacher or child care supervisor
- identified by the case as being household members or workplace contacts who have been in close physical contact (hugging, kissing, sitting within one metre for at least 15 minutes) with the case.

In air travel context, a 'contact' is defined as:

- Phase 4[3] – passengers seated in the same row as the case and two rows in front or behind the case; crew that have had prolonged interaction with ill person
- Phase 5[4] – passengers and crew travelling on the aircraft (ie, the entire plane).

6.2 Laboratory investigation of contacts

Obtaining samples from asymptomatic contacts for laboratory testing is not recommended.

6.3 Management of contacts of a suspected or probable case

6.3.1 Contacts of the very first suspected case in New Zealand

For the very first suspected case (ie, before pandemic influenza has been associated with local transmission in New Zealand), contacts should be identified and advised to enter voluntary home quarantine. Advise these contacts that you will be in touch with them within 24 hours to tell them whether the suspected case has been confirmed.

[3] Phase 4 involves small cluster(s) with limited human-to-human transmission but spread is highly localised, suggesting that the virus is not well adapted to humans.

[4] Phase 5 involves larger cluster(s) but human-to-human spread is still localised, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible.

If the ‘first’ case has recently arrived from overseas, passenger locator cards relating to the flight or voyage will be required to locate contacts. If the arrival was during a period when passenger locator cards were not required, the usual contact tracing procedures relating to requesting the New Zealand passenger arrival cards will have to be employed, possibly enhanced by media requests for fellow passengers to contact their local PHU.

The welfare needs of these people should be assessed.

Laboratory confirmation should be received before any antivirals are given to contacts, unless the index of suspicion is extremely high.

[Enter details on the contact management system attached to SURVINZ.]

6.3.2 Contacts of suspected or probable cases following transmission of pandemic influenza in New Zealand

Once pandemic influenza has been found in New Zealand, contact tracing of any suspected or probable cases should begin immediately.

[Enter details on the contact management system attached to SURVINZ.]

Contacts of a suspected or probable case should be quarantined voluntarily at home while awaiting laboratory results.

- If definite diagnosis of something non-pandemic is made, contacts may be released from quarantine.
- If the case is confirmed, contacts should remain in voluntary quarantine for [7] days following their last contact with the case.
  - See ‘Management of contacts of a confirmed case’ below.

All contacts of a suspected case are to be given antivirals, as per the Antiviral Medication Interim Guidelines. Provide antiviral prophylaxis **within 48 hours** of last contact with the suspected case.

All contacts of a suspected or probable case should be given an information sheet containing the following information:

- that they will be phoned as soon as the case is confirmed as positive or negative for pandemic influenza
- symptoms to look out for
- actions to take if symptoms develop
- the importance of social distancing
- restrictions on activities
- advice on reducing spread of infection through hand hygiene plus following cough and sneeze etiquette
- social support arrangements.

See ‘Information for People Who Have Been in Contact with a Suspected or Probable Case of Pandemic Influenza’.

6.4 Management of contacts of a confirmed case

Contact tracing is necessary for confirmed cases during the cluster control phase of a pandemic in New Zealand. The Ministry of Health will advise when the transition to pandemic management occurs and contact tracing is no longer necessary.

[Enter details on the contact management system attached to SURVINZ.]

Close contacts of a confirmed case should enter voluntary quarantine for [7] days following their last contact with the case and be closely monitored for development of symptoms.

- If symptoms develop, PHUs should arrange for a medical assessment at a designated facility.
- Quarantine may cease once [7] full days have elapsed since last exposure and the contact has not developed symptoms.

PHUs should ensure that contacts are followed up on a [daily][5] basis to:

- determine whether the contact has developed any symptoms or side-effects and needs a health assessment
- ensure that the contact is observing quarantine restrictions (including by not coming into contact with anyone in a way that meets the definition of close contact, ie, being within one metre for at least [15 minutes])
- ensure that the contact is taking any antivirals as directed
- determine whether the contact needs welfare support.

All contacts of a confirmed case are to be given antivirals, as per the Antiviral Medical Interim Guidelines. Provide antiviral prophylaxis **within 48 hours** of time of last contact with the case.

All contacts should be given an information sheet containing the following information:

- symptoms to look out for
- the importance of staying at home and of social distancing
- advice on hand hygiene plus cough and sneeze etiquette
- actions to take if symptoms develop

[5] Alternatively, specify the interval that can be managed with resources available, eg, every two days.

- that a health worker will be in [daily] contact with them during the isolation period to monitor their health
- infection control procedures – that they should take particular care with hand hygiene and avoid extended periods of time in the same room as other household members.

See ‘Information for People Who Have Been in Contact with a Suspected or Probable Case of Pandemic Influenza’.

7 Monitoring People in Quarantine – Instructions for Public Health Units

PHUs should arrange for appropriately trained health workers to make [daily] contact with a person in quarantine to assess the following:

- Assess symptom status.
- Temperature recording: most people should be able to take their own temperature (twice daily) and provide the information to public health staff over the phone or even by e-mail. They should report immediately to public health staff if they develop a fever (> 38°C).
- Ascertain if the person is fully following the quarantine requirements (including not coming into contact with anyone in a way that meets the definition of close contact, ie, being within one metre for at least [15 minutes]). If they are not, then the importance of these requirements needs to be reinforced.
- Ascertain if the person needs assistance with normal daily living activities and requirements.

7.1 Enforcement

Where a person refuses options for quarantine, or absconds from quarantine, public health staff need to be actively engaged in informing the person of the importance of quarantine and assisting them to fulfil these requirements. Failure of these approaches, and as a matter of last resort, it may be necessary for the Medical Officer of Health to use their powers under the Heath Act 1956.

- Sections 79 and 70(1)(f) can be used to isolate or quarantine a person
- Sections 70(1)(e), (ea) and (fa) require person/s to report for and have a medical examination and/or testing
- Section 71A lists the powers of members of the police to assist Medical Officers of Health in relation to infectious diseases
- Section 72 lists the offences for not complying with a Medical Officer of Health or people assisting the Medical Officer of Health