Section 5
Border Health

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INTRODUCTION

PURPOSE AND SCOPE

This section of the *Environmental Health Protection Manual* sets out border health policy and regulatory requirements. The focus of such requirements is on preventing, detecting, assessing, controlling, and responding to public health risks at the border – including those from incoming aircraft and ships.

The two key public health risks covered by this section include public health risks from ill travellers/crew and those from vectors of public health significance (particularly exotic mosquitoes).

More specifically, this section covers:

- aviation quarantine, arrival and pratique, and health responses
- maritime quarantine, arrival and pratique, and heath responses
- other quarantine-related provisions
- ship sanitation certification
- core capacity requirements at points of entry
- annual border health returns
- pests of public health significance
- preparing for and responding to public health threats of international concern.

This section has combined and updated the previous *Biosecurity* and *Quarantine* chapters of the *Environmental Health Protection Manual* (formerly sections 5 and 15, respectively). These old sections should now be discarded and replaced with this section.

Much of the technical information from the former *Biosecurity* chapter has been removed and is now included in referenced guidance: *Medical Vectors – An Education Guide for Border Health and Integrated Pest Management*. Public health units have been provided with copies of this resource.

NZ BioSecure – Southern Monitoring Services. 2016. *Medical Vectors – An Education Guide for Border Health and Integrated Pest Management*. Available at: www.smsl.co.nz

This section seeks to:

- promote better understanding of the need for public health risk assessment and control at the border (including risks from infectious diseases, risk goods, and unwanted organisms such as exotic mosquitoes)
- assist public health units in assessing potential public health risks at the border and their compliance monitoring
- support decision-making on border health issues that may affect public health (including quarantine and biosecurity enforcement issues that have potential impact on public heath)
- describe the roles and responsibilities of those involved in risk assessment, surveillance, compliance monitoring and enforcement at the border
- identify sources of information that will assist in the assessment of risk to protect public health
- assist the practical interpretation and appropriate use of the legislation at the border such as the Health Act 1956, Biosecurity Act 1993, and supporting regulations
- set national expectations for surveillance and reporting at the border.

DEFINITIONS

Accredited person: a person accredited under section 103(7) of the Biosecurity Act 1993. For public health units, these are usually health assistants or technicians who work under the direction of an authorised person on routine activities relating to mosquito surveillance and other port health responses.

Authorised person: a person appointed by the Chief Technical Officer (Health) (CTO ((Health)) as an authorised person under section 103 of the Biosecurity Act 1993. For public health units, these are usually health protection officers or medical officers of health working to support the implementation of the Act – usually undertaking activities relating to mosquito surveillance and other port health responses.

Exotic mosquitoes: refers to mosquitoes not known to be established in New Zealand and that have public health significance.

Delimiting survey: a survey conducted to establish the boundaries of an area considered to be infested by or free from a pest. These surveys are usually carried out to determine the boundaries of an infestation rather than to define an area that is free from a pest. The initial detection site is used as a starting point to determine how the pest arrived, where it originated from and where it might have spread to. Determining where the pest might have spread will determine where the surveying and resources for managing the pest need to be focused.

Detection (of mosquitoes): when one or more adult mosquitoes or larvae have been found at or before the border or in association with recently arrived risk goods or travellers and laboratory identification has not yet confirmed that it is an exotic species, or laboratory identification confirms they are not exotic mosquitoes of public health significance.

Disinfection: the procedure whereby health measures are taken to control or kill infectious agents on a human or animal body surface or in or on baggage, cargo, containers, conveyances, goods and postal parcels by direct exposure to chemical or physical agents.

Disinsection: the procedure whereby health measures are taken to control or kill the insect vectors of human diseases present in baggage, cargo, containers, conveyances, goods and postal parcels.

Biosecurity Act 1993 ss.2 and 22

Import Health Standards: an import health standard is a document that specifies the requirements to be met in order to manage the risks associated with the importation of a risk good. A Chief Technical Officer may recommend the making, amendment or withdrawal of an import health standard. Because of concerns about exotic mosquitoes of public health significance, the Ministry of Health (MoH) has particular interest in the import health standards in relation to used tyres, used vehicles and machinery.

Incursion (of mosquitoes): confirmation of the post-border detection and breeding of exotic mosquitoes of public health significance not previously known to be established in New Zealand and not in direct association with recently arrived travellers or goods.

Infectious disease: any disease specified in Part 1 or Part 2 of Schedule 1 of the Health Act 1956.

Integrated pest management (IPM): IPM is an environmentally friendly, common sense approach to controlling pests. IPM is not a single pest control method but rather involves integrating multiple control methods based on site information obtained through inspection, monitoring and reports. IPM programmes take advantage of all appropriate pest management strategies, including the judicious use of pesticides. Preventive pesticide application is limited because the risk of pesticide exposure may outweigh the benefits of control, especially when non-chemical methods provide the same results.

Interception (of mosquitoes): the confirmation that adult mosquitoes or larvae detected at or before the New Zealand border, or in association with recently arrived travellers or goods such as at an MPI approved transitional facility, are exotic mosquitoes of public health significance.

Isolation: the separation of ill or contaminated persons or affected baggage, containers, conveyances, goods or postal parcels from others in such a manner as to prevent the spread of infection or contamination.

Point of entry: a passage for international entry or exit of travellers, baggage, cargo, containers, conveyances, goods and postal parcels as well as agencies and areas providing services to them on entry or exit. Points of entry are also ports and airports designated by the Ministry of Health under the Ministry's core capacity programme (see section 5.4).

Pratique: permission for a ship to enter a port, embark or disembark, discharge or load cargo or stores; permission for an aircraft, after landing, to embark or disembark, discharge or load cargo or stores.

Public Health Emergency of International Concern (PHEIC): an extraordinary event declared by the World Health Organization (WHO), which is determined, as provided in the International Health Regulations (IHR) 2005:

- to constitute a public health risk to other States through the international spread of disease and
- to potentially require a coordinated international response.

Quarantinable disease: a disease stated in Part 3 of Schedule 1 Health Act 1956. As at April 2018 these are: Avian influenza (capable of being transmitted between human beings), Cholera, Middle East Respiratory Syndrome, Non-seasonal influenza (capable of being transmitted between human beings), Plague, Viral haemorrhagic fevers (capable of being transmitted between human beings), Yellow fever.

Quarantine: the restriction of activities and/or separation from others of suspect persons (who are not ill) or of suspect baggage, containers, conveyances or goods in such a manner as to prevent the possible spread of infection or contamination.

Reservoir: an animal, plant or substance in which an infectious agent normally lives and whose presence may constitute a public health risk.

Surveillance: is an ongoing process that collects and records data from inspections and observations associated with pest occurrence or absence.

Transitional Facility: a facility that has been approved by MPI to receive containers and goods that may pose a biosecurity risk. Goods or containers may need to be inspected or treated at the facility before they can be 'cleared' for entry into New Zealand.

Vector: is an organism, often an insect, that carries a disease or a parasite from one animal or plant to another.

REFERENCES

A number of key border health reference documents are available from the following web sites:

- Ministry of Health's border health web page http://www.health.govt.nz (refer "Border health" under the "Our Work" tab
- World Health Organization's International Health Regulations web site http://www.who.int/ihr/ports_airports/en/

Specific references include:

Russell Prof R C and Ritchie Prof S A, Nov-Dec 2013. Review of New Zealand Mosquito Surveillance: Ports (Sea and Air) Mosquito Surveillance Review.

Heyman D L (ed). *Control of Communicable Diseases Manual,* 20th Ed.

Kay B & Russell R. 2013. *Mosquito Eradication. The story of killing Campto.* CSIRO publishing, Collingwood, Australia.

Ministry for Primary Industries, 2017. *Schedule of Aircraft Disinsection Procedures for Flights into Australia and New Zealand*. Wellington: Ministry for Primary Industries.

Ministry of Health. 2011. *Setting Fees and Charges: Guidelines for District Health Board Public Health Units.* Wellington: Ministry of Health.

Ministry of Health. 2012. *Communicable Disease Control Manual*. Wellington: Ministry of Health.

Ministry of Health. 1997. *Exclusion and Control of Exotic Mosquitoes of Public Health Significance: Report to the Minister for Biosecurity*. Wellington: Ministry of Health.

Ministry of Health. 2017. *New Zealand Influenza Pandemic Plan: A Framework for Action*. Wellington: Ministry of Health.

Ministry of Health. 2016. *Responding to Public Health Threats of International Concern at New Zealand Air and Sea Ports*. Wellington: Ministry of Health.

Mosquito Control Assoc. of Australia Inc. 2009. *Australian Mosquito Control Manual 3rd Edition*. Redland Bay Queensland: Australian Mosquito Control Association Inc.

NZ BioSecure – Southern Monitoring Services. 2016. *Medical Vectors – An Education Guide for Border Health and Integrated Pest Management*. Available at: www.smsl.co.nz

World Health Organization. 2009. *Guide to Hygiene and Sanitation in Aviation.* Geneva: World Health Organization.

World Health Organization. 2012. *Guide for Public Health Emergency Contingency Planning at Designated Points of Entry* http://www.who.int/ihr/publications/9789290615668/en/

World Health Organization. 2004. *Guide to Ship Sanitation*. Geneva: World Health Organization, http://www.who.int/water_sanitation_health/hygiene/ships/shipsanitation/en/

World Health Organization. 2011. *Handbook for the Inspection of Ships and Issuance of Ship Sanitation Certificates,* http://www.who.int/ihr/publications/handbook_ships_inspection/en/

World Health Organization. 2015. *Handbook for the Management of Public Health Events in Air Transport,* http://www.who.int/ihr/publications/9789241510165_eng/en/

World Health Organization. 2016. *Vector Surveillance and Control at Ports, Airports, and Ground Crossings.* Geneva: World Health Organization.

World Health Organization. 2016. *International Medical Guide for Ships.* 3rd Edition. Geneva: World Health Organization.

World Health Organization. 2005. *International Health Regulations 2005.* Geneva: World Health Organization.

For up to date information for the travel and transport sector there are two useful websites that border staff are encouraged to subscribe to. These provide information on current emergencies or threats and international guidance material:

- www.who.int/csr/don/en/
- https://extranet.who.int/pagnet/

LEGISLATION

New Zealand legislation (Acts and Regulations) is available at: http://www.legislation.govt.nz/

DOMESTIC LEGISLATION

- Health Act 1956 - mostly Part 4 (Quarantine), but also Part 3 (Infectious and Notifiable Diseases)
- Health (Quarantine) Regulations 1983.

Drafting note: The Ministry of Health is progressing an amendment to the Health (Quarantine) Regulations 1983, which, if passed, will impact on some of the procedures explained in the Border Health section of the Manual. The main implications of these proposals are on aircraft pratique (Procedure 5.0, which is still to be developed). There are also some other minor changes that have been flagged in other procedures. When this work is complete the Ministry will revise the necessary sections of the Environmental Health Protection Manual and reissue it to public health units.

- Health (Quarantine Inspection Places) Notice 2014
- Biosecurity Act 1993

Health Act 1956 ss.70-71

- Emergency legislation – two statutes may have relevance to border health in severe emergencies, by unlocking 'special powers' for medical officers of health contained in the Health Act 1956. These special powers are not routinely available to medical officers of health, without prior authorisation. They also do not apply to health protection officers.
    - The Epidemic Preparedness Act 2006 contains a mechanism to activate certain 'special' powers for medical officers of health to help manage serious epidemics of quarantinable diseases. Such powers can only be activated if the Prime Minister issues an epidemic notice.
    - The Civil Defence Emergency Management Act 2002 can also activate certain special powers for medical officers of health, but only if a state of emergency is declared under that Act. This Act may be a tool to help manage epidemics, but this would be a Government decision.

INTERNATIONAL HEALTH REGULATIONS 2005 (IHR 2005)

New Zealand has signed up to a global commitment under the IHR (2005) to plan for and respond to public health threats to the international community.

International Health Regulations 2005 Article 2

The purpose of the IHR (2005) is to prevent, protect against, control and provide a public health response to the international spread of disease that is appropriate to the public health risk, and which avoids unnecessary interference with international traffic and trade.

International Health Regulations 2005 Articles 5-18 and Annex 2

The IHR (2005):

- set up a global system to manage information and provide a public health response for events which may constitute a public health emergency of international concern (PHEIC). This includes a framework for countries to identify, assess, notify, verify and report events of potential concern to the WHO
- focus on rapid response and containment both at the *source* and controlling disease spread at *borders*
- cover existing and new diseases including emergencies caused by non-infectious disease agents (e.g., chemical spills)

- adopt a risk-based approach, with the term “public health risk” used in many of its provisions

International Health Regulations 2005 Articles 5, 13, and Part A of Annex 1

- set core *surveillance* and *response* capacities. Under the IHR countries are required to "detect, assess, notify and report events” in accordance with the IHR and to "respond promptly and effectively to public health risks"

International Health Regulations 2005 Articles 19-22 and Part B of Annex 1

- set core public health capacity requirements at international ports and airports (discussed in Procedure 5.4, below), including:
    - core capacities needed at all times at POEs; and
    - core capacities to respond to events that may constitute a PHEIC.

International Health Regulations 2005 Articles 23-41

- define a range of public health actions, measures, and documentation requirements for international travellers, goods, cargo and conveyances and the ports and airports that they use. These cover the provision of facilities, services, inspections, quarantine, treatment, and the range of control activities, etc.

International Health Regulations 2005 Articles 4, 47-66

- set out administrative and co-ordination requirements such as countries nominating National IHR Focal Points and WHO nominating IHR Contact Points.

ROLES AND RESPONSIBILITIES

Air Facilitation Committee: The Ministry of Transport is the lead agency for the convening of this national committee, which usually meets annually. There are also regional Airport Committees at all airports receiving international flights that meet with varying regularity. Public health units are encouraged to attend these meetings.

Board of Airline Representatives New Zealand Inc (BARNZ): An incorporated society comprising member airlines operating international and domestic services and some organisations that provide support to airlines.

Border Working Group: A group of government agencies that meets to consider cross-agency border issues and make strategic decisions on implementation of border control. The Group includes the New Zealand Customs Service, the Ministry of Primary Industries, the Ministry of Health, the Ministry of Transport, New Zealand Police, and Ministry of Business, Innovation and Employment.

Department of Conservation (DoC): The department that has an interest in any pests or diseases that are harmful or potentially harmful to indigenous flora and fauna or natural ecosystems (land, freshwater, marine) because such organisms may impact on the conservation values (lands, species, resources) for which DoC is responsible. DoC is accountable for:

- managing pests to protect significant sites and resources for which DoC is responsible
- controlling wild animals under the Wild Animal Control Act 1977
- DoC’s freshwater pest fish programmes under the Conservation Act 1987
- authorising the control of wildlife causing damage, under the Wildlife Act 1953.

DoC currently has accountability for freshwater pest fish programmes under the Conservation Act 1987. MPI and Fish and Game New Zealand also have some accountability for freshwater aquatic life.

Designated Officers: This is the term given to a medical officer of health or a health protection officer who has been designated by the Director-General of Health to administer statutory activities in relation to public health.

Health Officers: Health officers appointed as authorised persons under the Biosecurity Act 1993 may exercise, insofar as they relate to health, specific powers as conferred in that Act. The exercise of those powers is subject to:

- the authorised person having appropriate experience, technical competence and qualifications to be appointed
- the authorised person complying with instructions from the Chief Technical Officer (Health)
- the authorised person acting in good faith, with reasonable cause, and taking reasonable care at all times.

Authorised persons must produce their letter of appointment if they are exercising a power of entry, on every occasion they exercise that power (even on subsequent visits).

Maritime New Zealand: Maritime New Zealand is the national regulatory compliance and response agency for the safety, security and environmental protection of coastal and inland waterways. Health officials may work with Maritime New Zealand on regulation and compliance activities or in maritime incidents and emergencies.

Ministry of Health: The Ministry that has the statutory authority for ensuring that measures are in place to protect public health. It is responsible for providing advice to government on all matters relating to human health. The Ministry is also responsible for administering and implementing a variety of health-related legislation. The Ministry has an interest in organisms that may harm human health because of its responsibility to provide advice on all matters relating to public health and because any ongoing health effects from harmful organisms that become established will become a drain on the health system and require reprioritising resources away from other areas.

The primary role of the Ministry at the border relates to people coming into New Zealand as possible sources of infection, but human health port sanitation activities also include surveillance for and exclusion of rats and mosquitoes, which pose high human health risks. The Ministry is New Zealand's 'health administration' for the purposes of the International Health Regulations, which carries a high-level responsibility for the protection of human health at the border.

The Ministry is accountable for:

- port sanitation; surveillance for, and exclusion of, rats and mosquitoes that pose health risks to meet international health obligations (to be reviewed as part of the review of public health legislation)
- managing nuisance pests under the Health Act.

Management of the southern saltmarsh mosquito eradication programme and accountability for investigation and response for new incursions of mosquitoes that pose health risks shifted to MPI from 1

July 2006.

Ministry for Primary Industries (MPI): The lead agency for biosecurity and provides end-to-end and side-to-side policy advice, regulatory and operational services to deliver whole of Government biosecurity outcomes including primary production (agriculture, forestry, horticulture), marine, conservation and social (including health).

MPI is accountable for:

- ensuring that its biosecurity decisions take account of the full range of biosecurity outcomes, including economic, environmental and human health values
- enabling New Zealand's exports by giving assurances to other countries about the pest and disease status of New Zealand and our exported goods, or notifying trading partners and relevant statutory bodies about any change in our pest or disease status
- providing information about the potential invasiveness of exported species to importing countries
- managing risks associated with imported goods
- managing biosecurity risks at New Zealand's borders (except for surveillance for and exclusion of rats and mosquitoes that pose health risks)
- managing national-scale programmes for post-border surveillance, investigation, initial and ongoing responses
- marine biosecurity functions not otherwise carried out by other agencies, including pre-border, border incursion response and public awareness activities
- national leadership and coordination of pest management, including for the national pest plant accord
- national programmes and activities to improve public awareness, community participation and public support for biosecurity
- enforcing conditional release and containment of new organisms.

MPI has the lead role in implementing the Biosecurity Act 1993 in the terrestrial and fresh water environments for animal, plant and forestry pests and diseases affecting agriculture, horticulture, forestry, human health (except exotic mosquitoes) and indigenous flora and fauna, including:

- undertaking import risk analysis(es)
- negotiating import conditions and developing import health standards
- setting standards for border inspection and containment
- setting standards for surveillance and incursion responses
- developing operational biosecurity policy
- undertaking initial incursion responses
- enforcing the Biosecurity Act 1993.

In addition, MPI ensures other activities are carried out, including:

- border inspection and containment
- reference diagnostic capability for animal, forest and plant pests and diseases
- surveillance programmes for animal, forest and plant pests and diseases
- exotic pest and disease response capability
- approving transitional and containment facilities that manage

goods and containers arriving into New Zealand.

MPI Quarantine officers: Quarantine officers work to prevent harmful pests and diseases from entering New Zealand and monitor and manage the eradication of pests if they do get in. They lead New Zealand's biosecurity system at the front line – airports, ports, mail centres, and cargo facilities. Quarantine officers also inspect ships and yachts for the presence of mosquitoes and ensure aircraft disinsection is adequately carried out. If mosquitoes are detected at the border, the local public health unit is informed immediately and the specimens referred to the local public health unit or dispatched directly to New Zealand BioSecure for identification.

National Focal Point: The National IHR Focal Point (NFP) is a national centre, designated by each country which must be accessible at all times for communications with WHO IHR contact points. The NFP collates and disseminates information within their own country and externally to WHO and other countries. In New Zealand the NFP is the Office of the Director of Public Health in the Ministry of Health.

New Zealand Customs Service (Customs): The New Zealand Customs Service is the government agency with the job of ensuring the security of New Zealand's borders. It protects the economy from illegal imports and exports, promote New Zealand's international trade and collect revenues, investigate illegal activity and prosecute where necessary. They also make sure that lawful travellers and goods can move across our borders as smoothly and efficiently as possible.

Customs is responsible for developing the Joint Border Management System (JBMS), a new IT system for streamlining the clearance of goods and craft.

Customs Integrated and Targeted Operations Centre (ITOC) is located in Auckland. ITOC manages border data to determine risks presented by people, goods or craft and prioritise border activities. Border agencies such as MPI and Maritime New Zealand have a presence at ITOC.

Port and airport companies: Port and airport companies are the agencies responsible for ensuring that proper procedures are in place which comply with national and international statutory obligations. They are also obliged to deal with any nuisance conditions that may arise (such as potential mosquito habitats).

Public health units: Public health units provide technical and professional advice and support on public health issues relating to biosecurity and quarantine purposes, including:

- imported risk goods
- disease vector surveillance and control
- preparation and testing of contingency plans for emergency responses
- responding to reported sickness on board air/sea craft arriving in New Zealand
- ensuring airport and port environs are kept in a sanitary state
- rodent and vector control
- ensuring that water supplied to aircraft and international ships is potable and that sampling to ensure compliance with WHO

standards is carried out
- ensuring adequate sewage and refuse disposal facilities for aircraft and aircraft environs
- maintaining records and reporting on work undertaken
- liaison with the Ministry of Health, other providers, local government and others.

Public health units undertake a number of activities in relation to pests of public health concern, in particular exotic mosquitoes of public health significance including:

- providing sound technical and professional advice on public health issues relating to pests of public health significance, including work undertaken in relation to:
    - disease vector surveillance and control
    - preparation and testing of contingency plans for emergency response
    - maintaining records and reporting on work undertaken
    - liaison with the Ministry, other providers, local government and others
- vector surveillance of international sea and air ports
- response to complaints and interceptions
- initial response, and ongoing support, to incursions.

Public health units also participate in national, regional and local emergency arrangements and responses, as well as participating in and/or carrying out prompt, effective and efficient investigations of, and responses to, biosecurity and quarantine issues including:

- helping prepare health risk assessments in relation to threats and eradication or control actions
- participation in national, regional and local research, survey or pest management programmes
- participation in national, regional and local emergency or exigency arrangements and responses.

Public health units need to ensure that they form part of any emergency management plan at airports and ports so that they are able to respond in an efficient and appropriate way.

Regional Councils: A regional council is a type of local authority. Their responsibilities include some aspects that relate to border health, for example:

- harbour navigation and safety, oil spills and other marine pollution
- managing the effects of using freshwater, land, air and coastal waters
- developing regional policy statements and strategies and the issuing of consents
- developing and implementing a pest management plan and strategy.

Some district and city councils also have the powers of regional councils, these are referred to as unitary authorities.

Regional councils employ harbourmasters who manage waterways of ports and harbours. They make decisions regarding the manner and circumstances in which commercial vessels enter and leave their ports.

Their environmental role may include activities undertaken through the Resource Management Act or as part of the marine oil spill response system under the Maritime Transport Act.

Southern Monitoring Services Ltd (trading as New Zealand BioSecure (NZB)): The organisation that provides taxonomic identification, national mosquito database management, and advisory services to all public health units throughout New Zealand, for all aspects relating to exotic mosquitoes of public health significance. This includes the operation of biosecurity training, support for incursion and interception responses, supply of general sampling equipment, and the National Database.

NZB also carries out research and provides information and technical advice to the Ministry of Health, including GIS mapping of the national public health units' sampling efforts etc. Staff within public health units who are designing and implementing local mosquito surveillance plans may contact NZB for advice however as the budget for this service is limited, consultant services must be used judiciously.

Territorial Authorities (TA): TAs are responsible for providing a range of environmental health services including drinking water, sewerage and stormwater systems. TAs administer sections of the Health Act 1956, including those relating to inspection for nuisance conditions and taking action to have nuisance conditions abated if found. They may also assist the public health unit with information and may also assist in mitigating the risks to public health in their district in the event of an interception or incursion.

PROCEDURE 5.0 QUARANTINE AND PRATIQUE REQUIREMENTS FOR AIRCRAFT

5.0.0 Purpose

Aircraft arriving in New Zealand from overseas are subject to various entry requirements that are managed by a number of government agencies. A number of these requirements focus on the health of passengers and crew – with the primary aim of preventing the spread of diseases or other public health risks.

Pratique (granting of health clearance) is one such requirement and broadly involves the following process:

- incoming aircraft and people on board them, being liable to quarantine
- the person in control of an aircraft having an obligation to check the health status of those on board the aircraft prior to arrival in New Zealand
- the person in control of an aircraft being required to notify the health authorities about the health status on board the aircraft, including any health concerns
- public health units considering the information provided and making a decision on whether to grant or withhold pratique, and communicating their decision
- (if required) action to manage public health risks.

This core process is described in more detail in the sections below.

5.0.1 Aircraft liable to quarantine

The Health Act 1956 distinguishes between the liability to quarantine of *craft (aircraft and ships)* and the liability to quarantine of the *people* on such craft.

Health Act 1956 s.96(2)

Under the Health Act 1956 the liability to quarantine for incoming aircraft is defined broadly. Section 96 of the Act defines the initial liability to quarantine of craft as covering:

- every aircraft arriving in New Zealand from any place beyond New Zealand
- every aircraft arriving at any aerodrome in New Zealand from any 'infected place' in New Zealand (defined in the Act as a place that has been declared by the Minister on the grounds that it is infected with a quarantinable disease).

Health Act 1956 s.97(1)

Section 97 defines a person as liable to quarantine if he or she is on board, or disembarks from, a craft that is liable to quarantine.

Drafting note: The section on aircraft pratique is under development. The Ministry of Health is working on a proposed amendment to the Health Quarantine Regulations to modernise aviation pratique processes. When this work is complete the Ministry will revise the section this section of the Environmental Health Protection Manual and reissue it to public health units. For interim guidance on aviation pratique please refer to circular letters (Pratique process for unscheduled flights - MoH Circular letter Oct 2017).

PROCEDURE 5.1 SHIPS: QUARANTINE, PRATIQUE, HEALTH RESPONSES

5.1.0 Purpose

This procedure covers ships exempt from quarantine requirements, the maritime pratique (health clearance) process, and outlines actions and reporting for public health ship responses.

5.1.1 Ships and persons liable to quarantine

The Health Act 1956 distinguishes between the liability to quarantine of *craft* (ships and aircraft) and the liability to quarantine of *people* on such craft.

Health Act 1956 s.96(1)

The liability to quarantine for incoming *ships* is defined broadly as covering:

- every ship arriving in New Zealand from any port beyond New Zealand
- every ship arriving from an 'infected place' in New Zealand (defined in the Act as a place that has been declared by the Minister of Health on the grounds that it is infected with a QUARANTINABLE disease)
- every ship on which a QUARANTINABLE disease, or any disease reasonably believed or suspected to be a QUARANTINABLE disease, has broken out or been discovered.

Health Act 1956 s. 97(1)

A *person* is liable to quarantine if he or she is on board, or disembarks from, a craft that is liable to quarantine.

5.1.2 When liability for quarantine ceases

Health Act 1956 s.98(1)

A *ship* in New Zealand waters continues to be liable to quarantine until pratique (clearance) has been granted.

The pratique process is outlined below, but in most routine cases involves a health protection officer granting pratique via a message without having to meet the ship on arrival (e.g., by email, phone, radio, etc).

Health Act 1956 s.98(2)

Peoples' (i.e., crew and passengers) liability to quarantine continues until they are released from quarantine in accordance with regulations made under the Health Act 1956. However, to date, there have not been any such regulations made to provide for this.

Drafting note: The Ministry is currently working to resolve the current ambiguity around when a person's liability to quarantine ceases. This proposed change will require an amendment to the change Health (Quarantine Regulations) 1983, which has <u>not</u> yet been finalised. When the work is complete, the Ministry will revise the necessary sections of the Environmental Health Protection Manual and reissue it to public health units.

Health Act 1956 s.97(2)

However, regardless of whether the ship arrives at a port that is a Customs place or not the Health Act provides a further safeguard. If a medical officer of health believes or suspects on reasonable grounds that a person liable to quarantine is infected with a QUARANTINABLE disease or has been exposed to one within the 14 days before he or she arrived in New Zealand, then the liability of such a person to quarantine ends when the medical officer of health notifies the person that they are not currently or no longer infected with a QUARANTINABLE disease.

5.1.3 Ships exempt from quarantine requirements

Health (Quarantine) Regulations 1983 reg.21

The Health Act and regulations allow certain types of ships to be exempted from some quarantine requirements at the discretion of the Director-General of Health.

The Director-General of Health can exempt any ship or ships of any specified class from:

- section 96(1)(a) & (b) (liability of ships to quarantine)
- sections 99-102 (restrictions on ships when in quarantine; quarantine signal; inspections on ships liable to quarantine; ship declaration of health)
- section 105 (ships arriving from infected places)
- section 107 (granting of pratique) and
- any provisions of the Health (Quarantine) Regulations 1983.

Circular Memorandum 1983 and Health (Quarantine) Regulations reg. 21

Shipping and Seamen Act 1952 (now repealed)

The only exemptions that have been granted were made in 1983 by a memorandum issued by the Director-General of Health for:

- all yachts arriving at any New Zealand port (yachts are as defined in the Shipping and Seamen Act 1952).
- all ships belonging to the:
    - Royal New Zealand Navy
    - Royal Navy
    - Royal Australian Navy
    - United States Navy
    - Royal Canadian Navy.

The definition of yachts has not been replicated or replaced therefore the relevant definition remains in the now repealed Shipping and Seamen Act 1952. This states: *"Pleasure yacht" means a ship, however propelled, that is used exclusively for pleasure and does not carry passengers or cargo for hire or reward; but does not include a ship that is provided for the transport or entertainment of lodgers at any institution, hotel, private hotel, boarding-house, lodging house, guest house or other establishment; and does not include a ship that is used on a single voyage for pleasure if it is normally used or intended to be normally used as a fishing boat or for the carriage of passengers or cargo for hire or reward."*

Public health units should be aware of the role and activity of other border agencies such as MPI, NZ Customs, and NZ Defence in managing the risks from these craft.

Health Act 1956 ss.96(1)(a) & (b)

This exemption only applies to sections 96(1)(a) and (b) of the Health Act and some of the regulatory requirements in the Health (Quarantine) Regulations 1983 (summarised below).

The exemption from section 96(1)(a) and (b) means that yachts, and specific navy vessels, are not covered by these two 'liability to quarantine' provisions in the Health Act, and accordingly, in most cases, do not need to be granted pratique.

Health Act 1956 s.96(1)(c)

However, if a QUARANTINABLE disease is known or reasonably suspected to be on board any exempted yacht or navy vessel, then the ship is liable to quarantine. Accordingly, all health and quarantine provisions apply and ships must advise health authorities of their health status prior to arrival.

Memorandum of Understanding on biosecurity activities between MAF, Department of Conservation, and Ministry of Health, 31 October 2006.

All yachts, as defined in the Shipping and Seamen Act 1952, arriving in New Zealand are met on arrival by NZ Customs and inspected by MPI under the Memorandum of Understanding between the Ministry of Health and MPI to identify the presence of exotic mosquitoes (all life stages) or of actual or potential breeding sites. Any person arriving on board a yacht who suspects they may have an infectious disease is advised to contact Healthline or visit a doctor. MPI and Customs officials should be advised that if they become aware of any illness on any vessel they should advise the relevant medical officer of health or health protection officer.

https://www.customs.govt.nz/globalassets/documents/technical-lists-and-guides/yacht-pack.pdf

Navy vessels complete their own inspections to ensure any illness in incoming crew is appropriately managed and controlled.

https://www.customs.govt.nz/globalassets/documents/technical-lists-and-guides/yacht-pack.pdf

Exempted yachts and navy vessels also do not have to comply with the following regulations:

- regulation 10: Submitting notification of health status of the ship before arriving at the port
- regulation 11: Displaying a quarantine signal when in New Zealand waters (although NZ Customs do require yachts to displayed the Q flag)
- regulation 12: Submitting a maritime declaration of health
- regulation 17: Providing information regarding the status of their ship sanitation certificate.

Foreign vessels that have been initially granted pratique in New Zealand are also not liable for quarantine at subsequent New Zealand ports if they have only been 'at sea' in the intervening periods.

5.1.4 Notification requirements for incoming ships

The ship's master must submit documentation to satisfy New Zealand legal requirements for issuing pratique (quarantine/health clearance). This function may be undertaken through the ship's agent on behalf of the master.

Health (Quarantine) Regulations 1983 reg.10

The ship's master is required to:

- complete and submit the New Zealand Border Agencies' "*Advance Notice of Arrival*" form not less than 48 hours prior to the vessel's arrival
- submit (usually by email) a 'No Change of Health Status' report at least 12 hours and not earlier than 24 hours prior to ETA. A template form has been developed but the form is not legally required to be used (refer Appendix 1). A radio or emailed statement advising there has been no change in the health status of those on board is also legally accepted.

Advance Notice of Arrival form: http://www.customs.govt.nz/news/resources/forms/Documents/NZCS%20344.docx

Public health services need to establish their own arrangements and procedures with individual local shipping agents to assist in communication and responses. Shipping agents should be formally advised of any messages received that do not meet legal requirements.

The onus for ensuring the message is received by the public health service rests with the ship's master. For messages after hours, the on-call health protection officer is generally the point of contact.

Advance Notice of Arrival form see: http://www.customs.govt.nz/news/resources/forms/Documents/NZCS%20344.docx

The *Advance Notice of Arrival* must include the following information:

- last port of call and the date of departure from that port
- health conditions on board, including details of:
    - Any death (other than by accident) during the voyage or details of any symptoms of infectious diseases amongst crew or passengers during the voyage
    - Any diarrhoea or vomiting (apart from that associated with sea sickness)
    - Ship Sanitation/Ship Sanitation Exemption Certificate issue date and port of issue.

The *Advance Notice of Arrival* is a comprehensive document that provides information relevant to many aspects of border protection. It is sent directly by the master or through the shipping agent to the relevant public health unit for that port of arrival and the following border agencies:

- New Zealand Customs Service
- MPI Quarantine Service at the first port of arrival
- Maritime New Zealand (the first two pages only).

NZ Customs is developing an electronic platform, known as the Trade Single Window within the Joint Border Management System to be used by all border agencies. In future, all ships will be expected to submit the *Advance Notice of Arrival* form, No Change of Health Status declaration, and other relevant documentation through the Trade Single Window. The pratique process will be managed through this system once development has been completed.

5.1.5 Defining time of arrival

Health (Quarantine) Regulations 1983 reg.10

Health Act 1956 s.105

The Health (Quarantine) Regulations 1983 do not define “arrival” or “port of call”. However, “arrival” is “arrival at that port”. The Health Act 1956 also refers to arrival at a port. “Port” is defined in the regulations as “any … harbour or place in New Zealand at which a ship arrives for the first time on any occasion from a foreign place”.

The time of “arrival” is therefore consideredto be when a ship reaches the pilot station. The pilot station is the point at the harbour where the ship is considered to have entered the harbour and be under pilot instruction, i.e., where the pilot will board the ship. Therefore, pratique must be applied for at least 12 hours and not earlier than 24 hours before arrival at the pilot station.

This may differ from the definition of “arrival” in the Customs and Excise Act 1996, which includes arrival of the craft, whether lawfully or unlawfully in New Zealand whether or not the craft berths, moors, anchors, stops or otherwise arrives at any place in New Zealand.

5.1.6 Granting pratique

Health (Quarantine) Regulations 1983 reg.13(1) and 13(2)

Upon receipt of the Advance Notice of Arrival and the ‘No Change of Health Status’ message within the prescribed times, and provided the health protection officer or medical officer of health is satisfied there is no QUARANTINABLE disease or grave danger to public health from any INFECTIOUS disease on board the ship, then quarantine clearance (pratique) may be granted. Officers should contact the Ministry of Health immediately if they are concerned that a grave danger to public health from

any INFECTIOUS disease may exist on board an incoming vessel. Unexplained deaths of crew, passengers or animals on a ship are examples when grave danger to public health from an INFECTIOUS disease may exist and when Ministry of Health would need to be notified.

Regulation 13 refers to granting of pratique by radio only. In practice, modern ships now use other forms of communication and confirmation that pratique has been granted is usually confirmed by email. The confirmation message should include:

- date/time the communication was received/sent
- name of the person sending the message
- name of the vessel to which it relates
- a statement that pratique has been granted.

A ship with illness on board that is not a QUARANTINABLE disease, or does not constitute a grave danger to public health, should be granted pratique. The declaration of illness is a trigger for the medical officer of health to liaise with the incoming ship prior to arrival to determine whether any measures are required to manage potential public health risks. Measures could include advising and supporting infection control and contact tracing measures.

All pratique messages are to be replied to and records (electronic or hard copy) of key communications retained by the public health unit. As a minimum records should include the Advance Notice of Arrival, No Change of Health Status and the pratique confirmation message.

Advice that pratique has been granted must be given to the ship's master and agent. Copies should also be provided to other parties such as harbourmaster and/or pilot, NZ Customs and MPI as appropriate.

5.1.7 Maritime Declaration of Health

Health Act 1956 s.102(2)

International Health Regulations Article 37, Annex 8

http://www.health.govt.nz/our-work/border-health/maritime-border-control/maritime-declaration-health

The master of any ship arriving in New Zealand shall, on arrival, complete and deliver to the medical officer of health or health protection officer a Maritime Declaration of Health. In practice, this means that the Maritime Declaration of Health may be forwarded electronically by the master or the ship's agent, or collected by a health protection officer undertaking a ship sanitation inspection. Refer to the Ministry of Health website for a template form.

The Maritime Declaration of Health requires the ship's master to state whether or not the "ship/vessel has visited an affected area identified by the WHO". Should the WHO issue a standing recommendation regarding an affected area, the Ministry of Health would bring this to the attention of the maritime sector and public health units.

BUT if there is illness reported on the declaration it should have been declared on the Advance Notice of Arrival form and/or the 'No Change of Health Status' declaration, unless the onset of illness occurred after these declarations had been submitted. If the health protection officer believes the onset of illness was during the voyage and not reported earlier the master should be reminded of the reporting requirements and the illness report followed up accordingly.

International Health Regulations 2005 Annex 8

The symptoms for suspecting a disease of an INFECTIOUS nature (as specified in the Maritime Declaration of Health form) are:

(a) fever, persisting for several days or accompanied by (i) prostration; (ii) decreased consciousness; (iii) glandular swelling; (iv) jaundice; (v) cough or shortness of breath; (vi) unusual bleeding; or (vii) paralysis

(b) with or without fever: (i) any acute skin rash or eruption; (ii) severe vomiting (other than sea sickness); (iii) severe diarrhoea; or (iv) recurrent convulsions.

If the master declares an illness on board the ship, the health protection officer or medical officer of health should request that the Maritime Declaration of Health be completed. This includes completing the schedule for the Maritime Declaration of Health when an INFECTIOUS disease is suspected. This will provide information on the nature of the illness, travel history, onset of symptoms, any treatment given and other information to help guide the health protection officer or medical officer of health in risk assessment and further actions. When a ship is met on arrival the Maritime Declaration of Health must be submitted to the responding health protection officer.

5.1.8 No Change of Health Status message not received 12 – 24 hours before ship's arrival

If the No Change of Health Status report is not received within the required time frame, i.e., 12 to 24 hours before arrival, for example, due to communication difficulties, **and there is no reason to suspect that there could be illness on board the ship** the following are options for managing the situation:

(a) The vessel may be met on arrival (following the process outlined in section 5.1.9).

(b) Pratique may be issued. If the 'all healthy' or 'No Change of Health Status' message is received within 12 hours of the ETA, or there is other evidence that no QUARANTINABLE disease is present on the vessel, then the border health officer may issue pratique. However, the master and agent must be formally reminded of the legislative requirements and informed that in future, pratique may not be issued on arrival after the vessel has been met. If a decision is made not to meet the vessel on arrival, the justification for this decision must be documented.

(c) If there are continued instances from specific masters or agents of delays in No Change of Health Status reporting then the health protection officer must formally communicate the pratique requirements in the Health (Quarantine) Regulations 1983 and the consequences of repeated offending (that is meeting and issuing of pratique on arrival). This may create delays in being able to commence loading and unloading and bunkering operations as the ship remains under quarantine until pratique is issued.

5.1.9 Granting pratique on arrival

Health (Quarantine) Regulations 1983 reg.13(3)
Health Act 1956 s.107

If there is any suggestion there is illness on board a first porting ship then pratique must not be issued until the health protection officer or medical officer of health is satisfied that the illness is not a QUARANTINABLE disease.

Generally, the assessment will consider the symptoms, ports the vessel has visited within the relevant incubation periods, advice from the Ministry of Health on international public health risks, and any additional relevant information from the vessel (e.g., if the case joined the vessel while at sea, presence of rodents on board, etc).

If the illness is unlikely to be a QUARANTINABLE disease, then pratique should be issued and the case (and contacts) managed as they would be for a case of that disease in the community.

Health (Quarantine) Regulations 1983 reg.11
Health Act 1956 s.100
Health Act 1956 s.99

Any ship berthing without pratique is considered liable to quarantine and the ship must fly the yellow 'Q' flag. The flag must be flown in the most prominent location, and hoisted 4.5 kms (one league) from the port. On arrival at night the ship should show 'Q' lights – a red light over a white light (lights to be two meters apart). The ship's captain must display the prescribed quarantine signals until pratique is granted.

The only people who may board a vessel prior to pratique being granted are the:

- medical officer of health and health protection officer (and assistants)
- harbour pilot
- Police
- MPI, and
- Immigration and Customs officials.

However, the ship's agent and others may be permitted to board by the medical officer of health or health protection officer on the understanding that should the vessel be found to have a QUARANTINABLE disease on board, no one may leave until quarantine is lifted, including the pilot and those who are part of the boarding party (unless given consent by the medical officer of health or health protection officer to leave the ship).

Health Act 1956 s.107

Written certificates of pratique are to be issued only when pratique is issued on arrival (see Appendix 2). The certificate is issued after determining that no QUARANTINABLE disease or grave danger to public health from any INFECTIOUS disease exists on board the ship.

5.1.10 Provisions that apply if pratique is withheld

Health (Quarantine) Regulations 1983 reg. 13(3)

Until pratique is granted, incoming ships are considered liable to quarantine and the provisions in sections 99-101 of the Health Act 1956 apply.

Health Act 1956 s.99

A number of restrictions apply while a ship is liable to quarantine. In summary, unless an emergency occurs or with approval from the medical officer of health or health protection officer, the following restrictions apply:

- the vessel cannot be brought to the wharf or its landing place
- people are not to go on board the vessel (except authorised people – i.e., medical officer of health or health protection officer (and assistants), Customs, Police, MPI, etc)
- people cannot leave the vessel (except the authorised people noted above)
- goods/mail/articles, etc cannot leave the vessel
- other boats cannot draw up to the vessel, unless authorised (e.g., Police, MoH vessel, etc).

Health Act 1956 ss.101(1), (5) and (6)

Section 101(1) of the Health Act provides health protection officers and medical officers of health with the ability to board any ship liable to quarantine and inspect it for any INFECTIOUS disease before granting pratique. Because the liability to quarantine extends to people on board any ship liable to quarantine, the health protection officer or medical officer of health may also require people to present themselves for a medical examination under section 101(5).

Under section 101(6) of the Health Act the ship's master has a duty to facilitate the boarding of the ship by a health protection officer or medical officer of health.

Health Act 1956 s.111

While a ship's liability to quarantine ends when pratique is granted, the Health Act includes a provision in section 111 that enables a health protection officer or medical officer of health to board and inspect a vessel at any time. This provision is discussed in Procedure 5.2.

5.1.11 Reporting of infectious disease at any time

Health Act 1956 s.76

The Health Act 1956 requires the master of any ship in any harbour, who has a reasonable suspicion that any person on board has a NOTIFIABLE INFECTIOUS disease to notify the local medical officer of health accordingly. Notifiable INFECTIOUS diseases are listed in Part 1 of Schedule 1 of the Health Act.

This requirement applies even if vessels are no longer liable to quarantine. This provision also covers yachts and the specified navy vessels that have been exempted from liability to quarantine.

5.1.12 Quarantine inspection places

Health Act 1956 s.94

Under section 94, the Minister may from time to time, by notice in the Gazette, declare any specified portion of any harbour to be a place of inspection to which ships liable to quarantine shall be taken while awaiting inspection by the medical officer of health or health protection officer (a quarantine inspection place). In 2013, the Minister delegated this power to the Director of Public Health (or Chief Medical Officer) of the Ministry of Health.

The Health (Quarantine Inspection Places) Notice 2014 sets out the quarantine inspection places for New Zealand harbours. These are provided at Appendix 3.

5.1.13 Ship Inspections (first porting ships)

Health Act 1956 ss.110 and 111
Health Act 1956 s.102

In addition to issues of pratique upon arrival (as discussed above), ships may be subjected to inspection by a health protection officer. Inspections may be routine first-port-of-call inspections, to check sanitary conditions on board following a complaint, to respond to vector (rodent, mosquito) findings or sightings or to manage cases or outbreaks of INFECTIOUS disease.

Frequency of Inspections (first porting ships)

All first porting ships are not required to be inspected on arrival; however, public health units may periodically undertake targeted inspections of first porting ships. This could include yachts. This activity would be in addition to ship sanitation inspections and the costs of these inspections are expected to be met within contractual budgets.

The purpose of such inspections are to investigate and manage known or possible public health risks. The inspections would ideally be undertaken in conjunction with another border agency such as MPI or Maritime New Zealand. Each public health unit would work with the relevant agency to plan and determine the inspection priorities based on a risk assessment that includes the category of ship, last port of call, type of cargo, and inspection history. Liaison with shipping agents, harbour authorities and other border agencies may also be required.

Periodic inspection of foreign fishing or charter vessels that have only been 'at sea', or have visited other New Zealand ports, or have not had any crew changes with other foreign vessels which have not been granted pratique, should also be considered. The responsibility for inspecting joint venture vessels lies with the public health unit covering the base port for that vessel. The fact that these vessels are not liable to quarantine does not relieve the master of the responsibility to maintain reasonable standards of hygiene.

Matters for Inspection (routine first port inspection)

First port inspections are likely to include a review of key documents (e.g., ship sanitation certificate, Maritime Declaration of Health, integrated pest management plan, crew/passenger illness logs) and partial inspection of the ship focussing on high risk areas such as the galley, food stores, medical facilities and cabin areas, or areas of identified interest to health protection officers. Look for evidence of rodent and insect infestation, poor cleanliness/sanitation and confirm procedures are in place for identifying and controlling INFECTIOUS illness.

Any defects or insanitary conditions identified should be communicated to the master of the ship and any required significant actions should be noted on the ship sanitation certificate. If the ship does not have a ship sanitation certificate due to the nature of its operations (e.g., fishing vessels), then required actions should be communicated in writing to the master and agent. Enforcement action may be required if a significant public health risk is identified, see section 5.1.15, below.

5.1.14 Investigations on ships (hygiene complaints, reports of vectors or illness on board)

Health Act 1956 s.111

Health protection officers or medical officers of health may be required to undertake ship investigations and inspections following the receipt of complaints from other agencies about hygiene standards, sightings or findings of mosquitoes or rodents, or reports of suspected INFECTIOUS illness in one or more crew or passengers.

The health investigation and actions required will depend on the nature of the incident and potential public health risks. The medical officer of health and Ministry can provide advice as well as health protection colleagues, including those at other public health units. Health protection officers should always ensure they advise medical officers of health of public health threats and seek guidance and support for implementing appropriate control measures. Consideration must always be given to the principle intent of the International Health Regulations (2005) to protect people from the international spread of disease but also to avoid unnecessary interference with travel and trade.

International Health Regulations 2005 Articles 1-4

Report immediately to the Ministry of Health when there is an interception of exotic mosquitoes, immediate threat to public health or any intention to take

enforcement action (see Appendix 4).

Investigations of complaints will likely include all or some of the following actions:

- clarify the nature of the complaint or situation
- confirm what actions and controls have already been undertaken
- carry out a ship visit and inspection to gather further information and evidence (including samples) and confirm controls that have been implemented
- ascertain the public health risk
- confirm and implement additional control measures including, if required, enforcement action.

The ship's agent and other agencies where relevant (MPI, Customs, MNZ) should be included in the investigation.

Response to rodent sightings or interceptions

Rodent sightings or findings on ships in New Zealand occur every few months. Although not considered as significant a public health threat in New Zealand as mosquitoes, rat sightings are still expected to be responded to promptly by public health units. The response will include liaising with the ship's master, agent and possibly other border agencies; gathering full details of the incident including undertaking a site visit; ensuring appropriate controls are implemented; amending the existing ship sanitation certificate and reporting.

Confirmed rat or evidence of rat harbourage e.g., nesting, fresh droppings

The following are recommended response steps:

- undertake ship visit prior to the vessel leaving port
- confirm relevant ship details (last ports of call, proposed dates and times of next ports of call, nature of cargo, status of current ship sanitation certificate, status of IPM plan)
- provide public health advice on rodent risks and controls including trapping
- ensure an IPM plan is in place and implement any other required controls e.g., additional cleaning
- advise the Port Authority as additional port vector surveillance may be indicated
- report actions to Environmental and Border Team, Ministry of Health. Complete situation report (refer Appendix 5).

Alleged rat sighting (reported during daylight hours)

The following are recommended response steps:

- confirm details of sighting
- confirm relevant ship details (last ports of call, proposed dates and times of next ports of call, nature of cargo, status of current ship sanitation certificate and IPM plan)
- visit ship. Confirm any evidence of presence of rats. Visit should focus on reviewing documentation (current SSC, IPM plan), and visual inspection of key areas including area of reported sighting, holds, galley and stores, rope stores
- ensure IPM plan in place and implement any other required controls

e.g., additional cleaning
- amend ship sanitation certificate if indicated
- report actions to Environmental and Border Team, Ministry of Health (refer Appendix 5).

Alleged rat sighting (reported during night-time hours) and no other indications of rat infestation

The following are recommended response steps:
- confirm details of sighting
- confirm relevant ship details (last ports of call, proposed dates and times of next ports of call, nature of cargo, status of status of current ship sanitation certificate and IPM plan
- provide advice about enhanced trapping and general controls
- arrange to visit vessel in daylight at current port or liaise with public health unit at next port of call for visit to be undertaken
- report actions to Environmental and Border Team, Ministry of Health. If the ship is leaving New Zealand then the Ministry of Health can advise the National Focal Point (NFP) in the country of next port of call if further follow-up is required (refer Appendix 5).

Response to mosquito (larvae or adults) interceptions

Refer to Procedure 5.6 (Pests of public health significance) for detailed information about mosquito interception responses and reporting requirements.

Specific actions to be taken when interception occurs on a ship:
- complete ship inspection and delimiting survey. Ensure all standing water and potential breeding mosquito sites are mitigated
- confirm nature and discharge of cargo and if further assessment required
- confirm if controls are adequate or additional controls are needed, including regulatory action
- confirm ship has a documented IPM plan. If not, provide template (refer Appendix 6)
- amend ship sanitation certificate.

Response to illness or outbreaks on ships

Health Act 1956 s.76

As noted previously, the Health Act 1956 requires the master of any ship in any harbour, who has a reasonable suspicion that any person on board has a NOTIFIABLE INFECTIOUS disease to notify the local medical officer of health accordingly. This requirement applies even if vessels are no longer liable to quarantine and also covers yachts and the specified navy vessels that have been exempted from liability to quarantine.

When cases of INFECTIOUS disease or outbreaks are reported on ships these should be investigated following the usual communicable disease protocols with consideration to the ship environment, ongoing risks to the crew, passengers, New Zealand and internationally. The purpose of the investigation is to identify the possible cause of the illness or outbreak and to ensure measures are implemented to prevent any further cases or spread.

The investigation will include (but not be limited to) the following:

- gathering details of the illness on board
- confirming the control measures that have already been implemented
- conducting a ship visit to confirm actions are underway, gather further investigative detail including taking samples, and identifying additional controls needed. Control measures may include isolation of cases and contacts, enhanced cleaning, and environmental controls
- consideration may need to be given to enforcement action (refer section 5.1.15, below).

Documentation will need to be reviewed such as the current ship sanitation certificate, Maritime Declaration of Health, vaccination status of crew, ship's medical log and any information regarding the nature of illness being reported – details of cases including onset dates, symptom profile, suspected diagnosis, role of affected crew members, diagnostic tests undertaken, case risk factors (e.g., vaccination status). The master should be able to provide other documentation as requested such as drinking water or food safety records.

The ship sanitation certificate will need to be updated following any investigation to confirm the actions taken and required.

For outbreak investigations complete a situation report and submit to the Environmental and Border Health team (refer Appendix 7). For other disease investigations provide an email summary of actions to the Environmental and Border Health team in the Ministry of Health. In all cases the next port of call will need to be notified and advised if any further follow-up is required. If the next port is outside New Zealand the Ministry of Health will provide notification through the National Focal Point.

Response to outbreaks on cruise ships

Due to the large number of passengers and crew on board cruise ships it is not uncommon for outbreaks of illness such as norovirus or influenza to occur.

When notification of an illness or outbreak on board a cruise ship is received, the public health unit should confirm the epidemiology of case/s, actions undertaken or planned by the ship crew and the next port of call. Cruise ships have dedicated medical personnel and facilities, regular cleaning and sanitation programmes and triggers for implementing enhanced controls when illness is identified.

Usually the illness or outbreak can be managed adequately by the ship with its existing resources and there is no need for public health unit involvement, or for the Ministry of Health to be notified. The public health unit should, however, ensure that the next port of call is aware of the situation and request that the ship's master or doctor provides an update to the health authorities in the next port.

Public health units will need to be more actively involved if any of the following occur:

- the pattern of illness is unusual or severe (including one or more deaths on board)
- the ship's resources are overwhelmed
- specialist public health or health services are required e.g., for environmental sampling

- there is media interest
- in the case of a gastrointestinal outbreak the cumulative illness counts exceed 2% of the total number of passengers or crew on board.

If any of the above triggers have been reached further information will need to be gathered and a ship visit and investigation may be required. A situation report will need to be completed, emailed to the Ministry's Environmental and Border Health team (refer Appendix 7) and copied to the public health unit at the next port of call for their awareness and follow-up as necessary. All relevant reporting through Episurv will also need to be completed.

5.1.15 Enforcement Action

Health Act 1956 s.110

Health (Quarantine) Regulations reg.18 and 2nd Schedule (Form 4)

Regulatory action may be required to control a significant public health risk, and/or when action is required urgently and/or when the health protection officer or medical officer of heath has a low level of confidence that voluntary action will be taken.

Poor hygiene, insect or rodent infestations may require a cleansing order being issued. Any intention to issue a cleansing order needs to be reported to the Ministry of Health (refer Appendix 8).

Copies of documents may need to be sent to the ship's agent together with the actions and remedial work to be undertaken.

PROCEDURE 5.2 OTHER QUARANTINE PROVISIONS

5.2.0 Purpose

This section covers provisions in the Health Act 1956 that were not discussed in Procedures 5.0 and 5.1 above, that may be of use in managing public health risks at the border.

The key quarantine-related provisions are in Part 4 (Quarantine) of the Health Act 1956. The key provisions are described in sections 5.2.1 – 5.2.7, below. It is important to note that a number of these quarantine powers can only be used in very specific circumstances – for example, some only apply when a person is liable to quarantine. It is important that health protection officers and medical officers of health have a sound understanding of when they can be applied. For clarification on the liability of people and craft (including aircraft and ships) to quarantine refer to Procedures 5.0 and 5.1, above.

Part 3 (Infectious and Notifiable diseases) and Part 3A (Management of Infectious Diseases) of the Health Act 1956 also contain relevant provisions. While these include powers that can be applied across the country and are not specific to the border context, in appropriate circumstances they may still be relevant to managing public health risks at the border. Sections 5.2.8 – 5.2.10, below, describe the key examples.

5.2.1 Duty to comply with directions

Health Act 1956 s.97A(1)(a)

To manage public health risks at the border there may be times when it is necessary for medical officers of health to give directions to, and request information from, people who are travelling on aircraft or ships (including passengers or crew). This provision requires people who are liable to quarantine to comply with directions, requirements, conditions given, made, or imposed by a medical officer of health (or another authorised person).

Examples of such directions will depend on the circumstances but may include requiring people to:

- answer questions
- provide specified information
- remain in a place for a period of time to enable the collection of information
- accompany public health staff in order to be questioned.

The exercise of this power only applies to, person(s) liable to quarantine (note, people's liability to quarantine is distinct from the liability to quarantine of the ship or aircraft on which they travelled). The power to give directions is not available once the person in question is no longer liable to quarantine.

This power to give directions applies to medical officers of health in the first instance. However, the Health Act 1956 also allows medical officers of health to authorise other staff to give such directions – such as health protection officers or public health nurses, etc. It may also be appropriate to authorise officials from other border agencies.

The Ministry has developed an authorisation form that medical officers of health can use to authorise other suitable people such as health protection officers to give such directions (see Appendix 9). Authorisations issued should be periodically reviewed.

Health protection officers and other border staff must have authorisation before using this power to manage public health risks at the border. The Ministry recommends that all public health units proactively consider whether they should authorise their health protection officers, who work at the border, as a matter of course, so the authorisation process has been completed in advance of it being needed. Any such authorisations should be periodically reviewed to ensure they are kept up to date.

5.2.2 Duty to supply information

Health Act 1956 s.97A(1)(b)

People "liable to quarantine" must also give any information requested by a medical officer of health, or authorised person, if that officer believes on reasonable grounds the information to be necessary to manage a risk to public health.

Health Act 1956 s.97A(1)(b)(4)

This power also only applies to medical officers of health or a person authorised by a medical officer of health for example, health protection officers or public health nurses, etc. It may also be appropriate to authorise officials from other border agencies, etc.

The information that may be required to manage public health risks is set out in the Act and includes the person's:

- personal details (names, dates of birth, phone number)
- recent travel history
- recent activities
- contacts and their contact details
- previous and present address, and proposed routes, destinations, and addresses
- movements during the 14 days before their arrival
- symptoms they may be experiencing, or have recently experienced.

Again, the exercise of this power only applies to, person(s) liable to quarantine. The power is not available once the person is no longer liable to quarantine.

The Ministry's form at Appendix 9 can be used by medical officers of health to authorise health protection officers and suitable people to require such information. Electronic copies are available on EMIS.

However, it is important that health protection officers are aware that they need to get authorisation before seeking to require information under this provision. All public health units should proactively consider whether they should authorise their health protection officers, who work at the border, as a matter of course, so the authorisation process has been completed in advance of it actually being needed.

Health Act 1956 s.97A(2)-(3)

A medical officer of health, or person authorised by the medical officer of health, can require persons in charge of aircraft/ships to collect and supply information from passengers. An example of this could be distributing and collecting cards or forms for passengers and crew to complete, or by using other reasonable means.

Health Act 1956 s.97A(6)

A medical officer of health, or person authorised by the medical officer of health, can also obtain information from departments of state about people "liable to quarantine" that is necessary to trace their movements or contacts they have had with other people. This includes requiring the passenger

arrival cards to be made available.

The Ministry of Health has an agreed procedure with NZ Customs for accessing passenger arrival cards for contact tracing, and requests that public health units follow this procedure (refer Appendix 10).

The statutory contact tracing provisions in Part 3A of the Health Act 1956 are also available if needed (refer section 5.2.9, below)

5.2.3 Power to detain craft and people

Health Act 1956 ss.97B and C

The Health Act 1956 provides a power to detain a craft (including an aircraft or ship) and its passengers and crew for inspection in certain circumstances. The power may be exercised by medical officers of health, health protection officers, or persons acting under the written direction of a medical officer of health or health protection officer.

Health Act 1956 ss.97B(1)(a) and (b)(i) and (ii)

This power only applies if the craft has arrived in New Zealand and it appears to the officer that during the craft's voyage:

1. a person has died or become ill from a QUARANTINABLE disease or
2. there have been deaths of birds, insects or rodents on the craft that can't be attributed to poison (which is a sign that there may be a public health risk on board).

While the craft and persons on board are under detention, an inspection can be undertaken to identify any further controls required e.g., quarantine or isolation of other persons on board.

This power can be used to detain the craft once pratique has been issued (i.e., passengers have disembarked). However, it would not allow for the recall of people to the craft.

Model forms for the detention of craft and persons and the lifting of such detentions are provided at Appendices 11 and 12. Electronic copies are available on EMIS.

Health Act 1956 s.97B(2)

The medical officer of health or health protection officer must inform the person in charge of the airport or port concerned of any detention direction she/he gives under s.97B(1). That person must not allow the craft to leave the port or airport until written notice lifting the detention is provided to them.

Health Act 1956 s.97C

The detention of the craft is lifted when the medical officer of health or health protection officer gives written notice to that effect to the person in charge of the airport or port.

5.2.4 Powers in relation to QUARANTINABLE diseases

Health Act 1956 ss.97D and 97(2)

The Health Act provides a number of powers that health protection officers and medical officers of health can use, in certain circumstances, to help manage cases of suspected QUARANTINABLE diseases.

Health Act 1956 s.97(2)

These powers are described below, but certain pre-conditions must be met before medical officers of health or health protection officers can consider using them. Importantly, for these powers to apply:

- the person in question must be liable to quarantine, and
- the medical officer of health or health protection officer needs to believe or suspect on reasonable grounds that:
    - the person is infected with a QUARANTINABLE disease; or

- within the 14 days before the person arrived in New Zealand, he or she has been exposed to a disease that is a QUARANTINABLE disease (whether or not it was a QUARANTINABLE disease at the time the medical officer of health or health protection officer suspected such exposure).

Examples of the sorts of factors that may cause an officer to have such a belief or suspicion may include, but are not limited to, one or a combination of the following:

- reported symptoms
- travel history
- origin of the aircraft/ship and any reports of outbreaks of QUARANTINABLE diseases in the area
- history of contact with confirmed or suspected cases
- whether the WHO has declared a public health emergency of international concern (PHEIC) – but always check because some PHEICs will not be about the QUARANTINABLE diseases in the Health Act 1956
- advice from the Ministry of Health to public health units.

Health Act 1956

If a craft arrives in New Zealand carrying such a person, and the above s.97(2) prerequisites are met, then a medical officer of health or health protection officer may do the following:

s.97D(1)(a)
- require the person to be examined, for example, assessed by ambulance staff

s.97D(1)(b)
- require to be taken from the person any bodily sample the officer may reasonably require, for example, a blood or nasopharangeal sample

s.97D(1)(c)
- require to be taken from the craft, or anything in or on the craft, any reasonable sample the officer may require, for example, environmental sampling

s.97D(1)(d)
- require the captain of the craft to take or help take any steps that, in the opinion of the medical officer of health or health protection officer, are reasonably necessary to:
  - prevent the spread of infection by the person, or
  - destroy birds, insects, or rodents, or
  - remove or abate conditions on the craft likely to convey infection, including conditions that might facilitate the harbouring of vermin.

Examples include isolation of symptomatic crew or passengers, appropriate removal of affected material, additional cleaning.

5.2.5 Surveillance of people liable to quarantine

Health Act 1956 ss.97E and 97(2)

The Health Act 1956 provides a number of powers that health protection officers and medical officers of health can use, in certain circumstances, to put people suspected of having a QUARANTINABLE disease under surveillance – either at a hospital or other place, or at large (e.g., in their homes).

Health Act 1956 s.97(2)

These powers are described below, but certain pre-conditions must be met before medical officers of health or health protection officers can consider using them. Importantly, for these powers to apply:

- the person in question must be liable to quarantine, and
- the medical officer of health or health protection officer needs to believe

or suspect on reasonable grounds that:

- The person is infected with a QUARANTINABLE disease; or
- Within the 14 days before the person arrived in New Zealand, he or she has been exposed to a disease that is a QUARANTINABLE disease (whether or not it was a QUARANTINABLE disease at the time the medical officer of health or health protection officer suspected such exposure).

Examples of the sorts of factors that may cause an officer to have such a belief or suspicion may include, but are not limited to, one or a combination of the following:

- reported symptoms
- travel history
- origin of the aircraft/ship and any reports of outbreaks of QUARANTINABLE diseases in the area
- history of contact with confirmed or suspected cases
- whether the WHO has declared a public health emergency of international concern (PHEIC) – but always check because some PHEICs will not be about the QUARANTINABLE diseases in the Health Act 1956
- advice from the Ministry of Health to public health units.

Health Act 1956 s.70(1)(f)

The power to place people under surveillance can also be invoked in very rare cases if the person is liable to quarantine under s.70(1)(f). This is one of the special powers in the Health Act 1956 that medical officers of health (and not health protection officers) can apply **ONLY** if a state of emergency has been declared, the Minister has given approval to use the power, or an epidemic notice is in force. The special powers are discussed further in section 5.2.10.

Health Act 1956 s.97E(2)

People who are detained at a hospital or another place or are kept under surveillance at large under this section of the Health Act must give to the medical officer of health all information that he/she reasonably requires to manage risks to public health.

Surveillance at a hospital or other suitable place

Health Act 1956 ss.97E(3)(a) and 97(2)

If section 97(2) applies (see above), a medical officer of health or health protection officer can require a person to be moved to a hospital or other suitable place and detained under surveillance until the medical officer of health or health protection officer is satisfied that the person:

- is not infected with the disease concerned, or
- is not able to pass that disease on.

Examples of other suitable places may include District Health Board owned community facilities or a formal quarantine facility such as a hotel or motel.

This type of surveillance is recommended where the potential public health risk is high and/or a level of medical care and/or security is required for the person due to the nature of their INFECTIOUS illness, other general circumstances (e.g., person is elderly and frail), and/or there is a likelihood of non-compliance with “voluntary measures”.

Health Act 1956 s.97E(4)

The Health Act 1956 places time limits on such detention at a hospital or other suitable place. Such detention:

- must not continue for more than 28 days, and

- must not continue for more than 14 days unless the medical officer of health or health protection officer has considered the latest information on the disease concerned and is satisfied that the person is infected with it and is still likely to be able to pass it on.

The Ministry has developed a model form for public health units to use when detaining people at a hospital or other place under surveillance (see Appendix 13).

A model form to lift such detentions has also been developed for public health units (see Appendix 14).

Electronic copies of both forms are available on EMIS.

Surveillance at large

Health Act 1956 ss.97E(3)(b) and 97(2)

If section 97(2) applies (see above), a medical officer of health or health protection officer may instead decide that the best course of action is to require the person to be kept under surveillance at large. This may involve the person being allowed to go to their own place of residence, but be required to check in with the health authorities from time to time.

Surveillance at large can be used to formalise expectations for public health monitoring, where there is a more acceptable public health risk (not necessitating surveillance at a hospital or other place), where there are no security risks to the individual, and where there is a high level of confidence that the requirements will be adhered to.

Health Act 1956 s. 97E(5)

Before being placed under surveillance at large the person must give an undertaking that he or she will report to the medical officer of health or health protection officer or a medical practitioner at the times and places required.

The Ministry has developed a model form for public health units to use when obtaining such undertakings (Appendix 15). An electronic copy is available on EMIS.

Health Act 1956 s. 97E(6)

When a person is being kept under surveillance at large they must:

- present themselves for and submit to any medical examination or testing required by the medical officer of health
- give the medical officer of health or health protection officer all information he or she reasonably requires to enable the management of risks to public health
- report to a medical officer of health or medical practitioner, if instructed to do so by the medical officer of health
- report daily or at stated intervals in person to the medical officer of health or medical practitioner
- tell the medical officer of health or medical practitioner if they leave for another place, and give details of the address to which he or she is going.

The Ministry has developed a model form for public health units to use when detaining people under surveillance at large (Appendix 16). Electronic copies are available on EMIS.

A model form to lift such detentions has also been developed for public

health units (see Appendix 14).

5.2.6 Children and people with a disability

Health Act 1956 s.97F

If a person has custody or charge of a child, or the role of providing day-to-day care for a child, or who has charge of a person with a disability, then they:

- must comply with every direction, requirement or condition given, made, or imposed in respect of the child or person under disability under sections (97A-E)
- must give in respect of the child or person under disability all information required under sections (97A-E).

5.2.7 Offences

Health Act 1956 ss.97G and 136

A range of offences have been created under the Act which specifically relate to the quarantine controls in sections 97A-E. These include situations where:

- a person does not comply with directions, requirements, or conditions made by a medical officer of health or authorised person under s.97A(1)(a)
- a person does not provide the information requested by a medical officer of health or authorised person under s.97A(1)(b)
- a person who is in control of a craft does not collect and supply information from passengers to support public health officers as required under s.97A(2)
- a person in charge of a port or airport allows a detained craft to leave the airport or port before a medical officer of health or health protection officer has given notice of the lifting of the detention of the craft (s.97B(2))
- a person does not allow a medical officer of health / health protection officer to examine him/her or take a bodily sample when the officer is empowered to do so (s.97D(2))
- a person does not give the undertaking required by s. 97E(5) when being placed under surveillance at large
- a person does not comply with the requirements placed on him/her when being under surveillance at large (s.97E(6)).

No specific penalties are mentioned in the Health Act 1956 for the above offences. Therefore, the general penalty provisions in section 136 applies. The maximum fine is up to $500, and if the offence is a continuing one, a further fine not exceeding $50 for every day on which the offence is continued.

A number of other quarantine-related offences are also included in the Health Act 1956.

Health Act 1956 s.112(1)

- A master of a ship who permits anyone liable to quarantine to leave the ship without the authority of a medical officer of health or health protection officer commits an offence. If convicted, the master is potentially liable to imprisonment for a term not exceeding 3 months or to a fine not exceeding $2,000 (or both).

Health Act 1956 s.112(2)

- Any person on any ship who, being liable to quarantine, leaves the ship without the authority of a medical officer of health or health protection officer commits an offence. If convicted, the person is potentially liable to imprisonment for a term not exceeding three months or to a fine not

exceeding $2,000 (or both).

- Any person arriving on any aircraft who is liable to quarantine commits an offence if they leave without the authority of the medical officer of health or health protection officer:
  - the aerodrome, or
  - the part of the aerodrome where they are lawfully detained pending the granting of pratique, or
  - any place in which they are lawfully detained pending their release from quarantine.

If convicted the person is potentially liable to imprisonment for a term not exceeding three months or to a fine not exceeding $2,000 (or both).

Health Act 1956 s.112(4)

Any person commits an offence if they contravene or fail to comply with any provisions of Part 4 (Quarantine) of the Health Act 1956, or fail to comply with any requirement or direction of a medical officer of health or health protection officer in accordance with the provision.

5.2.8 Medical examination powers that may be relevant at the border

The Health Act 1956 contains a number of powers that may be of use at the border if medical officers of health or health protection officers consider it is necessary to medically examine a person if they suspect the person may have an INFECTIOUS disease that could pose a risk to public health.

These provisions could be applied to cases and/or contacts. The use of powers to require medical examination is only likely to be necessary in exceptional circumstances – e.g., to confirm the status of a suspected case or high risk contact. It is always expected that voluntary compliance will be sought and care should be taken when seeking to use such powers to ensure that they can be used in the specific circumstances, and they are lawfully exercised.

Health Act 1956 s.77

Under Part 3 of the Health Act, there is a power for a medical officer of health, or any medical practitioner authorised by a medical officer of health, to enter a premise and medically examine a person in certain circumstances. This provision does not apply to health protection officers.

Such an officer may, at any reasonable time, enter any premises in which he/she has reason to believe that there is or recently has been any person suffering from a NOTIFIABLE INFECTIOUS disease, or recently exposed to the infection of any such disease.

Under the Health Act the term “premises” includes a ship or an aircraft (see section 2).

The officer may medically examine any person on the premises for the purpose of ascertaining whether that person is suffering or has recently suffered from such a disease.

Section 77 of the Health Act 1956 is not restricted to use in a quarantine situation, and can be used even if pratique has been granted and the ship or aircraft is no longer liable to quarantine.

Health Act 1956 s.97D(1)(a)

This power to examine people applies to craft (including ships and aircraft) and is discussed further above. Remember, it only applies if:

- the person is still liable to quarantine
- there is a reasonable suspicion or belief that the person has a QUARANTINABLE disease or has been exposed to one in the previous 14 days.

Health Act 1956 s.101

This section provides a power to examine people on an aircraft that is liable to quarantine or any ship liable to quarantine before granting pratique.

This section gives a broad power to board and inspect **but only** where there are regulations setting out the details of how this may be done. Regulations have never been developed, therefore, these powers cannot be utilised.

Health Act 1956 s.111(1) and (2)

A medical officer of health or health protection officer, or officer of the Ministry of Health, or any person acting under the authority of a medical officer of health or health protection officer, may at any time:

- board any ship in any New Zealand port and inspect any part of the ship, and
- inspect all animals and goods on board the ship, and the passenger list, and with the prior authority of the Director-General of Health inspect the log book and other ship's papers.

Where the medical officer of health boards a ship under section 111 he/she may require any person on board who in their opinion may be suffering from any INFECTIOUS diseases to submit to any prescribed examination, and that person shall submit to such examination accordingly.

Note, this section does not apply to aircraft.

Other potential powers to require medical examination of a person, in very specific circumstances, are described in sections 5.2.9 and 5.2.10, below.

5.2.9 Controls in Part 3A of the Health Act 1956

Ministry of Health. 2017. *Guidance on Infectious Disease Management under the Health Act 1956*. Wellington: Ministry of Health.

https://www.health.govt.nz/publication/guidance-infectious-disease-management-under-health-act-1956

The Health (Protection) Amendment Act 2016 introduced a suite of new INFECTIOUS disease controls to the Health Act 1956. These controls are contained in Part 3A of the Health Act 1956 Management of Infectious Diseases.

The Part 3A measures are not specific 'border' controls like those in Part 4 (Quarantine) of the Health Act. However, in some cases they may be of use in managing public health risks at the border.

The measures in Part 3A include:

- contact tracing provisions
- the ability for medical officers of health to issue written directions
- the ability for medical officers of health to apply to the District Court for three kinds of orders (public health orders, orders for contacts of cases, and medical examination orders)
- the ability for medical officers of health to issue urgent public health orders in limited circumstances.

A summary of these measures is provided below. However, designated officers should refer to the Ministry of Health's *Guidance on Infectious Disease Management under the Health Act 1956* for further comprehensive guidance on these measures. This guidance has been developed to assist public health practitioners to use the INFECTIOUS disease notification,

contact tracing and disease management measures introduced by the Health (Protection) Amendment Act 2016.

Contact tracing

Health Act 1956 ss.92ZY-92ZZH

Contact tracing is an internationally recognised public health strategy to help reduce the spread of INFECTIOUS disease in the community. It is the process of identifying the contacts of an individual who has or may have an INFECTIOUS disease and ensuring that those contacts are aware of their risk of exposure and encouraging them to seek testing and treatment if necessary. It is also used to help identify the source, and limit the transmission of, an INFECTIOUS disease or suspected INFECTIOUS disease.

Prior to 4 January 2017, contact tracing had been undertaken on an informal basis, involving informed consent and taking account of information privacy principles in the Privacy Act 1993 and Health Information Privacy Code 1994. The Health (Protection) Amendment Act 2016 introduced a legislative framework to support formal contact tracing to be undertaken by a medical officer of health, health protection officer, or nominee. It involves specific process steps, preconditions and requirements and can only be done by specific, authorised people or office holders. It also involves a mandatory requirement that the case answer questions/provide particular information about their contacts, and failure to do so comprises an offence.

The guidance referred to above describes when formal contact tracing is appropriate and explains the mandatory process steps and statutory powers to require specific information from the case about their contacts. Formal contact tracing may be considered necessary when voluntary inquiries are unlikely to work or are inappropriate, or in situations of urgency, taking account of the presenting public health risk.

Directions

Health Act 1956 ss.92I-92M

Medical officers of health can use directions when an individual poses a public health risk, provided the statutory preconditions for each are met. These include the following categories:

- public health directions to individuals, such as to refrain from work, attend counselling, restricting travel or activities, or to take preventive steps against disease transmission
- directions to contacts – these include conditions similar to public health directions to individuals
- medical examination directions – to undertake a medical examination/s with a specified health provider/s within a specified time/s
- educational institution directions to the person in charge to close all or part of the institution, or to direct a person to remain at home.

Medical officers of health must give directions in writing. The directions are time limited, with the duration specified being within a maximum timeframe of not more than six months (most will not meet that duration).

Model templates to support medical officers of health in making directions are provided in the Ministry's guidance referred to above.

Court orders

Health Act 1956 ss.92Z-92ZE

Medical officers of health can apply to the District Court for three kinds of court orders:

- public health orders imposed on cases, such as requiring treatment, detention in a hospital, to stay at a specified residence, supervision, or to take specified actions addressing the public health risk
- orders for contacts imposed on contacts of cases – these include conditions similar to public health orders
- medical examination orders – for use when a medical officer of health or medical practitioner has asked the case to undergo an examination and the case has not complied.

https://www.health.govt.nz/publication/guidance-infectious-disease-management-under-health-act-1956

Court orders, like directions, are time limited – they are not more than six months in duration.

Model templates to support medical officers of health in applying to the District Court for such are provided in the Ministry's guidance.

Urgent public health orders

Health Act 1956 ss.92ZF-92ZG

Medical officers of health can also impose urgent public health orders, which are administrative orders. The effect of urgent public health orders is to detain a case for 72 hours at a specified premise or parts of a premise, subject to any stated conditions.

Medical officers of health can only impose urgent public health orders if the case poses a public health risk and the medical officer of health cannot adequately manage it by imposing a direction, urgent action is necessary to address the risk, and it would not be practicable to wait for the District Court's decision on whether to impose a court order.

The medical officer of health can apply to the District Court before the 72-hour period expires when the public health risk posed is likely to continue for more than 72 hours.

https://www.health.govt.nz/publication/guidance-infectious-disease-management-under-health-act-1956

A model template to support medical officers of health in making an urgent public health order is provided in the Ministry's guidance.

5.2.10 Special powers for the medical officers of health

Health Act 1956 ss.70-71

Sections 70 and 71 of the Health Act contain some special powers that can only be used by medical officers of health if prior authorisation has been given. Such authorisation must come from either the Minister of Health; or via an epidemic notice having been issued by the Prime Minister under the Epidemic Preparedness Act 2006; or via a state of emergency having been declared under the Civil Defence Emergency Management Act 2002.

Section 70 of the Health Act specifies special powers that medical officers of health can use to prevent the outbreak or spread of any INFECTIOUS disease (if authorised to use the powers via the mechanisms noted above). These are summarised below.

The power to require medical examination and medical testing, gives a medical officer of health the authority to:

Health Act 1956 s.70(1)(e)

- require persons to report themselves or submit to medical examination at specified times and places

Health Act 1956 s.70(1)(ea)

- require persons to report themselves or submit to medical testing at specified times and places – if the spread of the disease would be a significant risk to the public

Health Act 1956 s.70(1)(f)

The power to isolate or quarantine allows a medical officer of health to 'require persons, places, buildings, ships, vehicles, aircraft, animals, or things to be isolated, quarantined, or disinfected as he/she thinks fit'.

Health Act 1956 s.70(1)(fa)

The power to require testing allows a medical officer of health to require persons, places, buildings, ships, vehicles, aircraft, animals, or things to be tested as he/she thinks fit – if the spread of the disease would be a significant risk to the public.

Health Act 1956 s.70(1)(h)

The power to prescribe preventive treatment allows a medical officer of health, in respect of any person who has been isolated or quarantined, to require people to remain where they are isolated or quarantined until they have been medically examined and found to be free from INFECTIOUS disease, and until they have undergone such preventive treatment as the medical officer of health prescribes. NB: this section does not authorise a person to be compulsorily given preventive treatment.

Health Act 1956 s.70(1)(la) and s.70(1)(m)

The power to close premises such as schools under sections 70(1)(la) and 70(1)(m) can be required. This can be made by way of written order to the person in charge of the premises, or made by order published in a newspaper or broadcast by television or radio able to be received by most households in the district. If specified in the order, premises operating certain infection control measures may be exempted from closure.

Powers regarding insanitary land, building, things, etc include:

Health Act 1956 s.70(1)(a)
- declaring land, buildings or things to be insanitary and prohibiting its use

s.70(1)(b)
- requiring insanitary buildings to be pulled down and the timber and material destroyed or disposed of

s.70(1)(c)
- causing insanitary things to be destroyed or disposed of

s.70(1)(d)
- causing infected animals to be destroyed.

Powers to forbid movement of people, conveyances, things, etc including:

Health Act 1956 s.70(1)(g)
- forbidding persons, ships, vehicles, aircraft, animals, or things to come or be brought to any port or place in their health district from any port or place which is or supposed to be infected with any INFECTIOUS disease.

Health Act 1956 s. 70(1)(l)
- forbidding the removal of ships, vehicles, aircraft, animals, or things from the health district, or from one port or part thereof to another, or from the place where they are isolated or quarantined, until they have been disinfected or examined and found to be free from infection.

Other special powers under section 70 including:

Health Act 1956 s.70(1)(j)
- prohibiting the keeping of animals or of any species of animal in any specified part of the health district

Health Act 1956 s.70(1)(k)
- forbidding the discharge of sewage, drainage, or insanitary matter of any description into any watercourse, stream, lake, or source of water supply

Health Act 1956 s.70(1)(l)
- using, or authorising any local authority to use, as a temporary site for a special hospital or place of isolation any reserve or endowment suitable for the purpose, notwithstanding that such use may conflict with any trust, enactment, or condition affecting the reserve or endowment.

Section 71 of the Health Act contains **special powers of requisition** that a medical officer of health can use in the event of an outbreak of any INFECTIOUS diseases (if authorised to use the powers via the mechanisms noted above). These powers enable a medical officer of health (by requisition in writing served on the owner/occupier, etc) to:

Health Act 1956 s.71(1)(a)
- take possession of, occupy, and use any land or building (whether public or private) that in his or her opinion is required for the accommodation and treatment of patients

Health Act 1956 s.71(1)(ab)
- take possession of, occupy, and use any land, building, vehicle, or craft (other than an aircraft), whether public or private, that in his or her opinion is required for the storage or disposal of bodies

Health Act 1956 s.71(1)(b)
- take possession of and use any vehicle or craft, whether public or private, that in his or her opinion is required for the transport of: (i) patients, medical personnel, medicine, medical equipment or devices, food, or drink; or (ii) clothing, bedding, or tents or other temporary facilities or structures; or (iii) personnel involved in loading, moving, unloading, distributing, erecting, or otherwise dealing with anything transported or to be transported under (i) or (ii)

Health Act 1956 s.71(1)(c)
- require to be delivered to him/her or in accordance with his or her order, such drugs and articles of food or drink, and such other materials, as he/she deems necessary for the treatment of patients.

Health Act 1956 s.70 or s.71

Section 71A of the Health Act 1956 empowers a member of the police to do anything reasonably necessary (including the use of force) to help a medical officer of health or any person authorised by the medical officer of health in the exercise or performance of his/her special powers or functions under sections 70 or 71.

PROCEDURE 5.3 SHIP SANITATION CERTIFICATION

5.3.0 Purpose

Handbook for the Inspection of Ships and Issuance of Ship Sanitation Certificates (WHO, 2011).

This procedure explains the implementation of the International Health Regulations 2005 (IHR 2005) ship sanitation certificate requirements in New Zealand. The section should be read in conjunction with the WHO Handbook for the Inspection of Ships and Issuance of Ship Sanitation Certificates (WHO handbook).

5.3.1 Introduction

IHR (2005) requires all ships making international voyages to hold a current Ship Sanitation Control Certificate or a Ship Sanitation Control Exemption Certificate.

International Health Regulations 2005 Articles 20 and 39

- Ship Sanitation Control Certificates are issued when a public health risk (including sources of infection or contamination) has been identified on the ship that necessitate a control measure being applied.
- Ship Sanitation Control Exemption Certificates are issued where ships have been inspected and no evidence of a public health risk on board has been found.

International Health Regulations 2005 Article 1

In the case of a conveyance *"international voyage"* means a *"voyage between points of entry in the territory or territories of the same State if the conveyances have contacts with the territory of any other State on its voyage".*

IHR (2005) provide that certificates are valid for a maximum of six months.

International Health Regulations 2005 Article 1

The purpose of the ship sanitation certification system is to minimise the extent that ships undertaking international journeys pose a public health risk with national and/or international implications. Public health risk is defined as "*a likelihood of an event that may affect adversely the health of human populations, with an emphasis on one which may spread internationally or may present a serious and direct danger".*

Handbook for the Inspection of Ships and Issuance of Ship Sanitation Certificates (WHO, 2011).

Ship sanitation certificates are important because they:

- are internationally recognised evidence that a ship was inspected by an authorised body and either deemed free from infection and contamination or required to undertake measures to improve the sanitary conditions present aboard the vessel
- reduce the need for further inspection and compliance regimes during the period in which a certificate is valid, thereby reducing compliance costs
- make no distinction between the size, type, or flag of the vessel
- provide a common basis for international understanding and cooperation to tackle ship borne sources of infection and contamination, which are highly mobile due to the increased volume and speed of globalised trade.

5.3.2 Scope of the ship sanitation certificate system

Handbook for the Inspection of Ships and Issuance of Ship

Ship sanitation certificates are concerned with public health risks associated with infection or contamination, and their associated medical vectors or

Sanitation Certificates (WHO, 2011).

reservoirs. The focus is not on occupational health and safety issues for the crew. These matters are the responsibility of International Labour Organization (ILO) and, in New Zealand, Maritime New Zealand.

International agreements from the ILO are in place to address crew safety issues, such as exposure to excessive noise or lack of protective equipment for crew. Health protection officers should not focus on these as part of ship sanitation inspections. However, if health protection officers do encounter issues that raise clear health and safety implications it would be appropriate to bring the matter to the attention of the ship's master or a relevant authority. For example, reporting of an incapacitated (intoxicated) person on duty.

5.3.3 Implementing the ship sanitation certificate system in New Zealand

Health (Quarantine) Regulations 1983 regs.15-19

Drafting note: New Zealand law is being updated to support the IHR (2005) requirement for ship sanitation certificates.

5.3.4 Exemptions from Ship Sanitation Certificates in New Zealand

Circular Memorandum 1983 and Health (Quarantine) Regulations 1983 reg. 21

Yachts, and ships from the New Zealand, Australian, American, Canadian and Royal (Great Britain) navies, are not required to hold ship sanitation certificates for travelling into New Zealand ports.

Shipping and Seamen Act 1956 (now repealed)

Yachts are defined by the legislation current at the time of the 1983 circular memo: "*Pleasure yacht means a ship, however propelled, that is used exclusively for pleasure and does not carry passengers for hire or reward; but does not include a ship that is provided for the transport or entertainment of lodgers at any institution, hotel, private hotel, boarding-house, lodging house, guest house, or other establishment; and does not include a ship that is used on a single voyage for pleasure if it is normally used or intended to be normally used as a fishing boat or for the carriage of passengers or cargo for hire or reward*".

Some ships, in particular fishing boats, have foreign owners but are chartered to New Zealand companies and then operate out of a local New Zealand port. These ships may operate in international waters but will not, in normal course of events, visit overseas ports. They may also receive supplies and crew while at sea (in international waters). Such ships do not need a current ship sanitation certificate for the period of the charter operations but a valid ship sanitation certificate is needed when they first port into New Zealand and one should be issued before they depart for another overseas port.

5.3.5 Authority to issue Ship Sanitation Certificates

http://www.who.int/ihr/ports_airports/ihr_authorized_ports_list.pdf

World Health Organization (WHO) maintains a list of ports authorised to issue ship sanitation certificates. Only certificates issued from these ports are considered valid. Ministry of Health provides WHO with the details of authorised ports in New Zealand. A port does not need to be an IHR-designated port to be authorised to issue ship sanitation certificates. For example, Devonport and Taharoa.

In the United States there are no port authorities, public agencies, or private organisations authorised to issue ship sanitation certificates. Certificates issued by authorities or private companies in the United States should be

considered invalid.

International Health Regulations 2005 Article 19

New Zealand public health units have been identified as competent authorities in accordance with the IHR (2005). Health protection officers and medical officers of health employed by public health units may issue ship sanitation certificates and Evidence Report Forms. Normally it is health protection officers who undertake the ship inspections.

When ship sanitation certificates have been issued at unauthorised overseas ports the Ministry of Health should be advised so international agencies can be informed.

5.3.6 Arrival of ships with invalid or no ship sanitation certificate

International Health Regulations 2005 Articles 27, 39

If an arriving ship does not have a valid Ship Sanitation Control Certificate or Ship Sanitation Control Exemption Certificate, or does not have a certificate at all, it is considered to be an 'affected conveyance'.

Pratique does not need to be withheld from such vessels unless there is illness on board in which case usual pratique processes must be followed. A ship sanitation inspection should be undertaken as soon as practicable and prior to the ship departing for the next port of call.

Handbook for the Inspection of Ships and Issuance of Ship Sanitation Certificates (WHO, 2011), 4.4.5 page 33

The ship should be treated in the same manner as a ship that has requested a new ship sanitation certificate. This includes issuing controls and taking regulatory action if indicated.

If justified, additional health measures should be implemented, including isolation of the ship, as necessary, to prevent the spread of disease. This may include:

- requiring the ship to be disinfected, decontaminated, disinsected, or deratted, as appropriate; and
- deciding the technique to secure an adequate level of control of the public health risk.

5.3.7 Undertaking ship sanitation inspections

Handbook for the Inspection of Ships and Issuance of Ship Sanitation Certificates (WHO, 2011).

The ship sanitation inspection process can be divided into four key phases:

- Phase 1 – notification, planning, and preparation
- Phase 2 – ship visit
- Phase 3 – issuing the ship sanitation certificate, and
- Phase 4 – post visit administration.

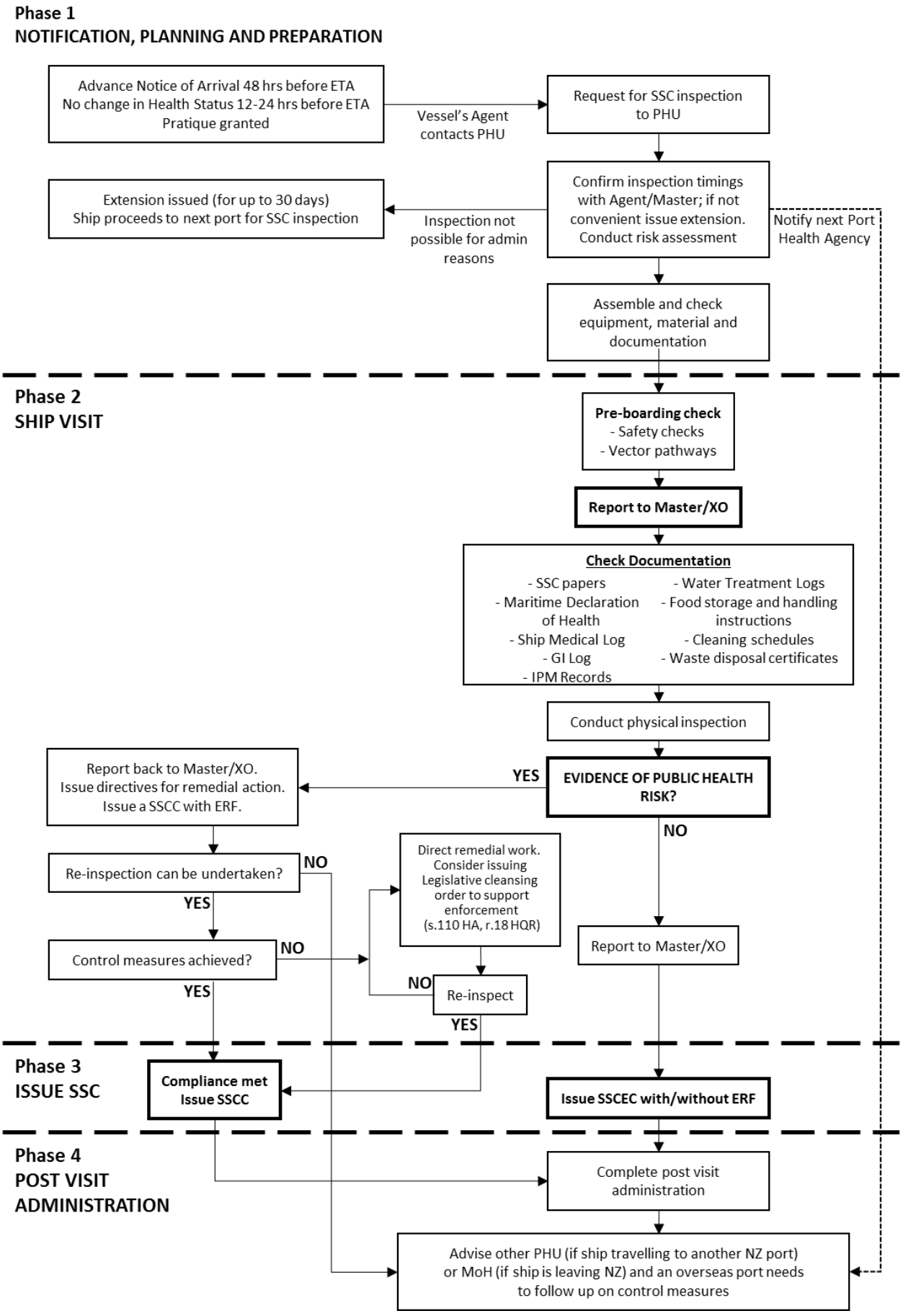
A summary of these phases is provided below.

WHO On-Line Training Package: register through 'ihrhrt@who.int'

Health protection officers undertaking ship sanitation inspections should ensure they (as a minimum):

- comply with all health and safety requirements including completing and maintaining District Health Board and port specific training
- have completed the WHO online ship sanitation inspection modules, and
- have attended a Ministry of Health border health and ship sanitation course or medical vector surveillance workshop within the last three years.

Summary of the ship sanitation certification process



5.3.7 Phase 1 – Notification, planning, and preparation

Notification requirements for ship sanitation inspections

Advance Notice of Arrival form: http://www.customs.govt.nz/news/resources/forms/Documents/NZCS%20344.docx

Ship's masters, or agents, should request ship sanitation inspections well in advance of the expiry of the ship's current certificate.

First porting ships usually make the request for an inspection when the New Zealand *Advance Notice of Arrival* is submitted. Officers reviewing the *Advance Notice of Arrival* should check the date of expiry of the certificate, the port of issue, and alert the vessel's agent if the certificate has expired, requires renewing within a month, or has been issued at a port that has not been authorised by the WHO to issue ship sanitation certificates.

If a certificate has been issued by an unauthorised port then arrangements need to be made to inspect the ship at the first port of call as soon as practicable.

Ships that have been in New Zealand waters for some time may also request a ship sanitation inspection.

After receiving a request for a ship sanitation inspection from the master or agent, an appropriate time for the visit should be agreed.

The master and/or agent should be advised of the expected process for the inspection, including the documents to be reviewed, individuals to be interviewed, and the areas of the ship to be inspected.

When agreeing the inspection time, consider:

- time of vessel arrival and departure
- time required to complete inspection.

An inspection will generally take two to three hours. If public health risks are found (e.g., insanitary conditions) or if it is a particularly large and complex ship (such as a cruise ship), then the inspection may take longer. If the ship has only a limited time in port, or is large and complex, additional health protection officers may be required to assist.

If an inspection cannot be undertaken or cannot be fully completed while the vessel is in port, refer to section 5.3.9 Granting extensions.

Follow-up inspections requested by competent authorities

Handbook for the Inspection of Ships and Issuance of Ship Sanitation Certificates (WHO, 2011), Annex 2

Follow-up inspections may be requested by one competent authority to another if public health risks have been identified or where there are outstanding control measures that require follow-up. Requests may originate from within New Zealand direct from one public health unit to another, or may come from another country via the National Focal Point system.

If follow-up is required on a ship departing to an overseas port the Ministry of Health Environment and Border Team should be notified so they can inform at the National Focal Point of the country of the next port of call.

The scope of the follow-up inspection will depend on the nature of the issue. Usually the investigation and inspection should focus on matters relating to

the issue identified and a full inspection should not be required. For example, an inspection on a cruise ship after a passenger is confirmed as having a legionella infection and travelled on the ship during the full incubation period. The focus of the visit should be on medical records and facilities, legionella management systems and any enhanced controls. It is unlikely that an inspection of areas such as stores or cargo holds would be necessary.

All follow-up visits, actions or controls should be documented on the ship sanitation certificate by updating or amending the certificate or Evidence Report Form, or, if indicated, issuing a new certificate.

Health (Quarantine) Regulations 1983 regs.15

Drafting note: At present follow-up inspections cannot be charged for. However, the Ministry is seeking a change to the Health (Quarantine) Regulations 1983 to provide this. When this work is complete the Ministry will revise the section this section of the Environmental Health Protection Manual and reissue it to public health units.

Engaging with shipping agents and other border agencies

A ship's agent may choose to be present during the ship sanitation inspection. This can be useful especially if, or when, control measures are required. If the agent is not present, then the agent must be informed of any formal control measures or of any other concerns with the vessel's operation or condition as soon as possible following the inspection. If significant concerns have been identified, the agent may be contacted and requested to be present for the inspection.

www.customs.govt.nz/about/contactus/ports/Pages/default.aspx

Liaison with Ministry for Primary Industries (MPI), Maritime New Zealand (MNZ) and/or New Zealand Customs Service (Customs) may be necessary where there are matters requiring a joint agency approach such as numerous and consistent non-compliance or if the vessel is to be inspected offshore, as occurs intermittently in Taranaki. Good operational relationships should be developed with these border agencies.

Memorandum of Understanding between MNZ and MoH, 5 December 2014

Occasionally public health units may be notified by another agency of public health concerns on ships. An MOU between Ministry of Health and MNZ requires that MNZ notify Ministry of Health of identified issues relating to crew and passenger health or conditions relating to the harbouring of disease vectors or the spread of disease. Notifications should be followed up on a case-by-case basis depending on the nature of the notification with actions or controls being implemented and documented through the ship sanitation certificate. As for follow-up visits these investigations are currently not able to be charged for with the costs expected to be covered by existing regulatory budgets.

Recommended pre-inspection preparation

Assemble and check equipment and documentation to ensure that all the inspection kit is complete, items required include:

- sampling equipment
- copies of documentation including checklists, forms and stamps
- copy of the Handbook for the Inspection of Ships and Issuance of Ship Sanitation Certificates (WHO, 2011)
- personal protective equipment
- entry ID to access the port.

Consider the type, size and known history of ship to be inspected and incorporate this into the inspection plan. Review the *Advance Notice of Arrival* and any previous records.

Ship Sanitation Inspections of cruise ships

Most cruise ships have a ship sanitation certificate inspection undertaken in the Northern Hemisphere before they depart for the Southern Hemisphere cruise season however on occasion requests for inspections of cruise ships may be received.

Cruise ships are complex environments with large numbers of passengers and crew and multiple locations of public health interest (galleys, dining areas, pools and recreation facilities, water and sewage infrastructure).

Cruise ships operate under a parent cruise line company. These companies generally have a high level of awareness of the health risks and have standardised health and safety procedures they expect to be implemented including triggers for outbreak responses and enhanced controls.

Preparation for a cruise ship inspection includes identifying the inspection team. A minimum of two persons with knowledge and expertise in drinking water treatment, public health engineering, communicable disease, vector control and food safety is highly recommended. Request to review cruise line company policies before the ship visit.

Inspections on cruise ships will include a desktop audit of operating procedures and records, a face-to-face meeting with key personnel (master, chief engineer, doctor, food services) to confirm general ship operations, and a visual inspection of some areas. This includes at least one galley, dining room, and food storage area and the medical facilities. Advise the master and agent that a full inspection of all areas of the ship will not be undertaken.

Health and safety

Working in accordance with established safety procedures is important due to the inherent safety hazards unique to the port environment. Awareness of hazards in the dock area is essential (e.g., cranes, straddle carriers, forklifts, trucks, prime movers, dunnage, drainage systems etc). Refer Appendix 17 for a list of common hazards at ports.

Wear appropriate clothing that will allow climbing ladders, entering confined spaces and moving through engine rooms and galleys. Personal protection equipment includes hard hats, hearing protection, high visibility jackets, gloves, safety shoes, head mounted LED torches and, in some environments, safety eye wear. Refer Appendix 18 for recommended equipment list.

5.3.8 Phase 2 – Ship visit

International Health Regulations 2005 Article 20

Prior to, and during boarding, observe the general condition of the ship. Check rodent guards to ensure that they have been fitted to mooring lines. If the gangplank is seen to be unsafe do not board until the hazard has been mitigated.

Documentation check

Report to the master or executive officer and advise of the purpose of the inspection. Once introductions are completed check documentation. Request hard copy, current, original documents.

The key documents include:

1. current Ship Sanitation Control or Exemption Certificate (request a copy to file)
2. Maritime Declaration of Health (if first porting)
3. crew and passenger list (if applicable)
4. vaccination list. This is usually only scrutinised if there is a specific disease threat.
5. medical log (and gastro/intestinal (GI) illness log (if available)
6. Integrated Pest Management (IPM) plan or other documentation describing pest/vector control (may be included in quality manual)
7. potable water records and water safety plan (chemical and bacteriological testing records and certification of source quality for last loaded bunkered water)
8. food handling standard operating practices and storage records (temperature checks)
9. garbage management plans and records
10. International Sewage Pollution Prevention Certificate (ISPPC)
11. cargo declaration/dangerous good manifest/and ships stores declaration.

On some smaller vessels the ship's or master's log and sanitary inspection records are where some of this information is kept.

In New Zealand Ballast water is the responsibility of MPI and need not be considered during the Ship Sanitation Control Certificate inspection.

When reviewing documentation check for the following:

- consistency between documentation, i.e., if there has been an illness it should be reported in the Medical Log
- currency of the documents and evidence updates
- evidence of samples being taken and results recorded, for example, potable water
- what notations were made during the previous inspection that are on the SSC and the Evidence Report Form
- whether the level of documentation provided appears appropriate for the size and scale of ship operations (refer to Appendix 19)
- The MoH template Integrated Pest Management plan (Appendix 6) is a guide only, plans the ship may have are not required to be in this exact form.

Inspection

Complete the physical inspection of the ship. Arrange to be accompanied by one of the ship's officers to ensure ready access to all areas being inspected and as a safety precaution.

The sequence of the inspection should be undertaken to move from clean to dirty areas avoiding cross contamination. The recommended sequence for inspection is:

1. crew and officers' quarters

2. galley, pantry and service areas
3. stores
4. childcare facilities (if applicable)
5. medical facilities
6. swimming pools, spas and saunas (if applicable)
7. solid and medical waste
8. engine room
9. potable water
10. sewage
11. cargo holds, rope stores
12. upper decks including lifeboats
13. other systems and areas (e.g., sites where standing water may accumulate).

Inspections must include, as a minimum, a visit to high risk areas such as the galley, food storage compartments, general storage (including rope stores), waste management storage, medical facilities, cabins and amenities. It is not necessary to inspect all cabins or amenities but inspection of a representative number of sites is expected.

A broad public health risk assessment approach is expected, but particular focus should be given to ensuring ships are free of vectors and vector management and controls are in place. Refer Appendices 20 and 6 for further guidance on vector detection, management and control, and an integrated pest management plan template.

The type of ship (cruise, container, fishing), size, prior ports of call, nature of cargo carried, access to holds, outcome of previous inspections or investigations, and standards found during the inspection of the minimum areas will indicate if a full inspection or more intensive scrutiny is needed.

Ships operated by major shipping companies such as Maersk or MSC have a reputation for having good standards of ship management and will likely only require the minimum inspection.

On the other hand ships that trade in the South West Pacific operated by small companies often struggle to meet the necessary standards and full inspection of these "Island Traders" will likely be needed.

If areas of the ship are not inspected then record these as "not inspected" on the ship sanitation certificate against the relevant areas.

Handbook for the Inspection of Ships and Issuance of Ship Sanitation Certificates (WHO, 2011)

Guide to Ship Sanitation (Third edition) (WHO 2011)

Prior to the inspection familiarise yourself with the WHO Handbook. The WHO Handbook details the 13 key areas on a ship, potential health risks, evidence of issues and appropriate control measures to take in response to public health risks. The WHO Handbook is to be used to define evidence of non-compliance to ensure it meets the WHO codification. It is not expected to be followed comprehensively for each inspection. This would be impractical given the level of detail required.

Ministry of Health recommends a simplified inspection process for routine inspections. Refer Appendix 19 for Ministry of Health Inspection Checklist.

Ship standards and complexity of operations varies from small poorly maintained boats with basic facilities and minimal systems to large ships with sanitised environments, highly complex infrastructure, tightly managed systems and documentation controls. Assessment of risks based on

observation and information gathered is an important component of the inspection. The risk assessment will inform decisions on the acceptability of conditions and if controls are necessary.

After the inspection

Return to meet the ship's master or executive officer in charge. Report on the inspection and ship's sanitary condition and discuss the certificate being issued and any actions/controls required. Provide the completed documentation to the ship's master before leaving the ship.

5.3.9 Phase 3 - Issuing ship sanitation certificates and determining control measures

Types of ship sanitation certificates

Handbook for Inspection of Ships and Issuance of Ship Sanitation Certificates (WHO 2011)

Health (Quarantine) Regulations 1983

There are two Certificates available (refer Appendix 21 for examples of Certificates):

- *Ship Sanitation Control Exemption Certificates* – issued when there is no evidence of a public health risk on board, and the ship is free from infection and contamination, including vectors and reservoirs.
- *Ship Sanitation Control Certificates* – issued when evidence of a public health risk (including sources of infection or contamination) has been detected on board. The Ship Sanitation Control Certificate details and confirms the control measures necessary to rid the vessel of any specified infection, contamination, vector or reservoir.

Ministry of Health provides public health units with copies of the certificates, labelled with the Ministry of Health's logo. E-copies of the certificate template are available on Health EMIS.

International Health Regulations 2005

In most cases there will not be a significant public health risk on board the ship. Sanitary standards will be acceptable or may only require some minor improvements/controls and a Ship Sanitation Exemption Certificate can be issued.

Handbook for Inspection of Ships and Issuance of Ship Sanitation Certificates (WHO, 2011)

An Evidence Report Form (ERF) may be issued attached to the Ship Sanitation Exemption Certificate if there are improvements identified or minor controls needed and there is not sufficient room to document these on the exemption certificate. These will usually be "recommended" controls. Examples of minor controls include no documented integrated pest management plan, no sharps bin, expired medicines. Refer Appendix 6 for an Integrated Pest Management Plan template that can be provided to ships.

Documenting these minor controls ensures there is a record of the controls identified so they can be considered by competent authorities in subsequent inspections.

If evidence of a public health risk is identified, a Ship Sanitation Control Certificate should be issued, with an Evidence Report Form attached documenting the control measures required.

The presence of pests or vectors of public health significance, especially rodents and mosquitoes or insanitary conditions and evidence of illness in crew and/or passengers are circumstances of when it is likely that a Ship Sanitation Control Certificate would be issued and control measures applied.

If additional or urgent controls are required, consider the need for enforcement action in consultation with the Ministry of Health. Any intention to issue a Ship Sanitation Control Certificate or any form of regulatory controls must be notified to the Ministry of Health's Senior Advisor (Border Health) or Manager (Environmental & Border Health) (refer Appendix 4).

Potential triggers for issuing certificates are discussed below.

Determining appropriate control measures

Handbook for the Inspection of Ships and Issuance of Ship Sanitation Certificates (WHO, 2011)

Refer WHO Handbook Part B to identify the specific control measures that are needed for the inspection areas. Use these controls and codes to ensure internationally consistent practice.

Corrective actions and control measures are categorised according to two broad classes:

- those that are required (for more serious risks)
- those that are recommended, but not necessarily mandatory.

Control measures are organised under a classification code system using headings and subheadings that refer to specific inspection areas and results. Use this coding when recommending or requiring control measures.

Handbook for the Inspection of Ships and Issuance of Ship Sanitation Certificates (WHO, 2011)

Below is an excerpt from the Handbook to illustrate potential control measures for certain public health risks in medical facilities.

Code of Areas	Inspection results: evidence found, sample results, documents reviewed	Control measures and corrective actions	Required	Recommended
5.4 Cleaning and maintenance				
5.4.1 ❑	No evidence of procedures and policies on cleaning, sanitation, sharps disposal or waste management.	Provide written procedures and policies relating to the complexity of medical care on board.		❑
5.4.2 ❑	Evidence of disease vectors and/or reservoirs that harbour disease vectors.	Disinfect, derat and apply insecticides immediately.	❑	
5.4.3 ❑	Toilet dirty or not flushing properly.	Clean toilets; repair toilet flushing system.		❑
5.4.4 ❑	Medical equipment and devices not in good operational and hygienic condition and not operated and maintained according to manufacturers' recommendations.	Operate and maintain equipment and medical devices according to manufacturers' recommendations.		❑

Figure: Section of the WHO Ship Sanitation Handbook pp. 68

Key considerations for applying control measures

Consider the following when deciding whether to apply control measures and/or issue a Ship Sanitation Control Certificate:

- The nature of the risk. Is it a potential public health risk of national or international concern i.e., will it be likely to create risks ashore?
- Is the risk more of a personal or occupational health issue for the crew/passengers?
- What are the consequences or magnitude of the risk if nothing further is done?
- What controls are already in place?
- What are the costs and benefits of applying the controls? Do the public

health benefits outweigh the costs?
- What is the sanitation history of the ship?
- What range of suitable control options is available?
- What is the most suitable and practical control for the particular operation?
- Can low cost controls significantly reduce the risk as effectively as high cost ones?
- Does the ship have a valid ship sanitation certificate? Have any control measures already been required or recommended? If so, what is the level of compliance?

It is the responsibility of the ship master and/or agent to take action to control any risks. Nevertheless, reasonable assistance in identifying suitable and relevant control options needs to be given.

Using Evidence Report Forms

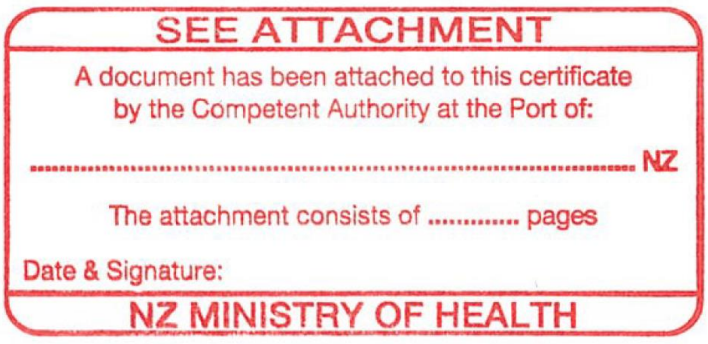
Evidence Report Forms are used because there is insufficient room on ship sanitation certificates to clearly document either evidence of public health risks found or suggested control measures. The Evidence Report Form is then attached to the ship sanitation certificate.

Use the Evidence Report Forms to:
- detail the evidence found
- set out the control measure to be applied to mitigate the public health risk
- define whether the control measure is 'required' or 'recommended'
- enable the competent authority undertaking subsequent inspections to confirm if the control measure has been successfully performed.

Any additional information must be on the Evidence Report Form - do not attach "additional comments" or other addenda to the certificate.

Once the Evidence Report Form is completed stamp the front page of the issued certificate with the standard Ministry of Health stamp. Ensure the name of the port, the date, and number of pages contained in the Evidence Report Form are entered.

Handbook for the Inspection of Ships and Issuance of Ship Sanitation Certificates (WHO, 2011)



Refer Appendix 21 for examples of completed Evidence Report Forms.

Completing Ship Sanitation Certificates and Evidence Report Forms

International Health Regulations 2005 Article 19

Health protection officers and medical officers of health can issue ship sanitation certificates, and Evidence Report Forms.

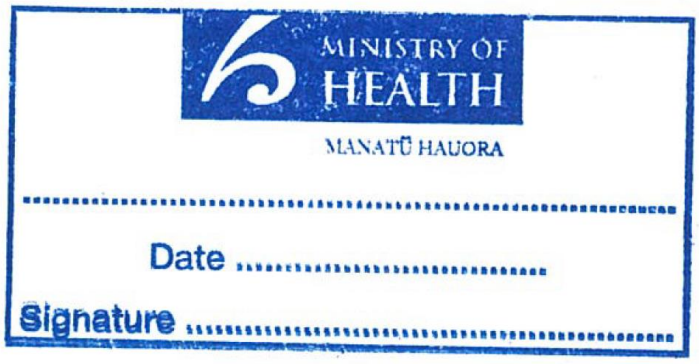
Handbook for the Inspection of Ships and Issuance of Ship Sanitation Certificates (WHO, 2011)

Complete certificates as follows:

- strike through the non-applicable certificate in the heading (either Ship Sanitation Control Exemption Certificate or Ship Sanitation Control Certificate)
- fill in the required information in the two tables (name of ship, etc)
- choose the applicable table (left: Ship Sanitation Control Exemption Certificate; right: Ship Sanitation Control Certificate)
- complete every box in all the columns
- write legibly and use consistent wording from the checklists in the Handbook
- complete the Evidence Report Form attachment where required or recommended control measures are identified
- identify areas not inspected as "not inspected"
- note areas not applicable by marking "N/A"
- use the wording "None" or "Nil" in areas in which no evidence is found
- list the documents reviewed
- use the wording "None" or "Nil" if no documents were reviewed
- if relevant i.e., samples taken, indicate if sample results are not yet available by noting "Sample results pending"
- sign, write name, date, and stamp the certificate
- ensure that all certificates are legible and written in plain English.

Certificates may be completed by hand or electronically.

Ministry of Health has issued stamps that must be used when completing certificates. Use the stamp over the signature field on the certificates and Evidence Report Form, enter the port of issue, date and sign (refer Appendix 21).



Once the documentation has been completed and signed it should be handed to the master or executive officer in charge. Take a copy for the file records. Copies can usually be made on the ship or a photo can be taken.

Follow-up on control measures

If controls are "recommended" then re-inspection will not be needed. The ship's master and/or executive officer will be expected to ensure any actions are implemented. The recommended controls will then be checked at the next six-monthly inspection.

If control measures are "required", but there is no imminent risk to public health (as defined in the handbook) then a follow-up inspection may not be required such as expired medicines replaced. These actions are the responsibility of the master to implement as soon as possible and before the

next inspection. If control measures are "required to ensure a significant threat to public health has been mitigated then a follow-up inspection will be necessary. This may occur in the current port or, if the ship is departing before the measures can be completed, at the next port of arrival. Contact the next port to alert them and to advise of the potential public health risk found, control measures applied and follow-up required. If the next port is a New Zealand port then communicate directly with the public health unit responsible for that next port. If the next port is overseas advise Ministry of Health's Environment and Border Team, who will arrange for a message to be sent via the National Focal Point to the next port of arrival.

Once the decontamination, disinfection, disinsection, or deratting or other action has been undertaken, verify that it has been completed and update the Evidence Report Form.

Enforcement and Sanctions

Health Act 1956 ss.97A, 97B and 110

Health (Quarantine) Regulations 1983 reg.18 and Schedule 2, Form 4

The IHR (2005) do not provide for enforcement and sanctions. States will apply their own domestic legislative tools to ensure effective implementation of the IHR. The Health Act, Health (Quarantine) Regulations 1983 and the Biosecurity Act 1993 contain mechanisms for enforcement if needed.

Health Act (section 97A) requires the person appearing to be in charge of the craft to promptly provide information requested by a designated officer.

Health Act (section 97B) enables a designated officer to direct a vessel to be detained for inspection if it appears that, during the voyage a person on it has died, or become ill, from a QUARANTINABLE disease; or death not attributable to poison or other measures for destruction has occurred among birds, insects, or rodents on the vessel.

Health Act (section 110) enables a designated officer, if he or she believes that a craft is in an insanitary condition or in a condition favourable to the outbreak or spread of an INFECTIOUS disease, to issue a written order requiring the craft to be cleansed, fumigated, disinfected, or treated (a 'cleansing order'). The order may be given whether or not the craft is liable to quarantine. The order must be issued by the medical officer of health or health protection officer and be in the form specified (refer Appendix 8).

Health Act 1956 s.110

If a cleansing order is not complied with, the master or executive officer commits an offence, and is liable to a fine not exceeding $10,000. In addition, the health protection officer may have the work done and all expenses recovered from the owner or agents of the vessel as a debt due to the Crown. Failure to comply with other quarantine provisions may be an offence against the Health Act and the maximum penalty, on summary conviction, is a fine not exceeding $500 and, if the offence is a continuing one, to a further fine not exceeding $50 for every day on which the offence has continued.

Reporting to the Ministry of Health

Detections of rodents or mosquitoes on ships must be notified to the Ministry of Health within two hours of the detection being notified to the public health unit.

Any intention to issue a Ship Sanitation Control Certificate or any form of regulatory controls must be notified to Ministry of Health's Senior Advisor

(Border Health) or Manager (Environmental and Border Health. If these Ministry officials are unavailable, call 0800 GET MOH then press 2 for Environmental and Border health. Environmental and Border Health Team will brief the National Focal Point as required (refer Appendix 4 for Ministry of Health reporting lines).

If a Ship Sanitation Control Certificate is required and/or other regulatory controls, notify the master and agent (it is their responsibility to carry out the required control measures). Once the decontamination, disinfection, disinsection, or deratting or other action has been undertaken, verify that it has been completed and, if so, the Evidence Report Form should be updated.

Scenarios when issuing Ship Sanitation Certificates and Evidence Report Forms

The table below provides additional guidance on issuing of ship sanitation certificates and the use of Evidence Report Forms.

Type of Certificate	Indicative scenario	Report to Ministry?
Ship Sanitation Control Exemption Certificates are issued when no evidence of a public health risk is found on board and the health protection officer is satisfied that ship is free from infection and contamination (including vectors and reservoirs).	**Ship Sanitation Control Exemption Certificate (without Evidence Report Form)** Potential triggers: • no evidence of public health risk • ship is free from infection and contamination. Example: The ship in good order, well managed and no issues of concern are identified.	**Routine matter.** No need to report to Ministry of Health.
	Ship Sanitation Control Exemption Certificate with Evidence Report Form Potential triggers: • no evidence of infection or contamination found • some items requiring action are identified, but there is no evidence of systemic issues • no known history of insanitary conditions. Example: Ship generally in good order and well managed. There may be some isolated items identified requiring action e.g., no Integrated Pest Management Plan (but no evidence of vectors), no sharps container, or isolated cleaning required. Risks may be identified but they are limited to personal health and safety risks on board the ship affecting the crew only.	**Routine matter.** No need to report each Ship Sanitation Control Exemption Certificate (and Evidence Report Form) to the Ministry of Health.

Ship Sanitation Control Certificates are issued when evidence of public health risk of national or international implications i.e., a risk posed ashore is found on board.	**<u>Ship Sanitation Control Certificate with Evidence Report Form</u>** Potential triggers: • evidence of public health risk, including infection and contamination, is found on board • threat to public health is high • inspection identifies systemic issues indicative of poor ship management and high likelihood of public health risks beyond the vessel • history of poor practice/previous non-compliance. Example: A ship where inadequate cleaning is systemic. Storage practices poor. Cockroach infestations in food prep areas. Medical log indicates diarrhoeal illness in staff.	**Always report these cases.** Report to the Ministry of Health's Senior Advisor (Border Health) or Manager, Environmental and Border Health; phone 0800 GET MOH if either official is not available.
	<u>Ship Sanitation Control Certificate with Evidence Report Form *and* invoke statutory powers</u> Potential triggers: • threat to public health is very high • there are national and international implications of not managing the risk • need high level of assurance that risk has been mitigated • operator has history of non-compliance. Example 1: Rodent infestation on board vessel. History of rodent issues previously. Poor practices. Lack of adequate cleaning and storage. Example 2: Standing water identified with mosquito larvae. No Integrated Pest Management Plan. Master has not implemented control measures to mitigate mosquito habitat documented on evidence report from attached to ship sanitation certificate.	**Always report these cases** Report to the Ministry of Health's Senior Advisor (Border Health) or Manager, Environmental and Border Health; phone 0800 GET MOH if either official is not available.

Extension of Ship Sanitation Certificates

Health (Quarantine) Regulations 1983

Ship sanitation certificates are valid for six months from the date of issue. Certificates may be extended for up to one month.

Extensions may be required for a number of reasons. For example:

- the inspection could not be completed because access to the holds (or other parts of the vessel) was not available while the vessel was in port
- required control measures could not be completed before the vessel departed for the next port
- bad weather or engine failure required the ship to enter a port and the port was not able to issue a new certificate before the old certificate expired.

An extension cannot be granted if the current certificate has expired.

Extensions should only be granted when visiting the vessel in person and a genuine reason is found as to why a standard ship sanitation inspection cannot be carried out.

An extension is authorised by the health protection officer or medical officer of health stamping the existing ship sanitation certificate with the standard Ministry of Health "extension stamp".

Handbook for Inspection of Ships and Issuance of Ship Sanitation Certificates (WHO, 2011)

The agent must be notified that the extension has been granted. Keep a record of the original certificates' reference and date of issue/expiry by taking a copy or a photo.

Charges for issuing certificates and applying control measures

Setting Fees and Charges Guidelines for District Health Board Public Health Units, August 2011, Ministry of Health

The Director General of Health fixed the fees and charges for ship sanitation inspections and certification at $96 per hour (excluding GST) for the health protection officer's time for the inspection, including travel time. Currently public health units can charge for issuing Ship Sanitation Control Certificates or Ship Sanitation Control Exemption Certificates.

The fee includes an allowance for overheads, administrative and other support services (e.g., filing documentation, invoicing etc). If more than one officer undertakes the inspection, the second officer's time can be included (provided the second officer is undertaking inspection activities and not simply accompanying the first officer). Overtime cannot be charged.

Provision to extend the current scope of charging is being sought in changes to legislation.

Protection against forgery

There is no evidence that the use of forged certificates is widespread, but it is possible that instances of forgery or production of an invalid certificate might occur (for example, changing the dates on an otherwise genuine certificate; forging a certificate in its entirety; or obtaining a certificate from a body that is not authorised to issue certificates).

Public health units should keep a copy of all ship sanitation certificates issued, and file records of inspections. These can be referred to if queries arise over whether a certificate was issued at a particular port on a particular date. If a ship loses their ship sanitation certificate, a copy of the file record can be provided. A new ship sanitation certificate can only be issued if another inspection is undertaken.

Always use the stamps provided by Ministry of Health.

5.3.10 Phase 4 – Post visit administration

On return to the office:

- check the kit and ensure stocks are replenished, batteries charged, any repairs made
- if significant public health risk is identified the agent should be advised. They can facilitate the prompt mitigation of any required actions
- inform other agencies of any concerns noted (e.g., MPI for biosecurity risks, MNZ of concerns about occupational health and safety issues or the crew's health and wellbeing)

- ensure documents are appropriately filed
- ensure administrative staff have logged the inspection and have information needed to charge for the inspection
- inform the public health unit at the next port of call in New Zealand if any required control measures require follow-up
- inform Senior Advisor (Border Health) or Manager (Environmental & Border Health of any matters that need to be passed on to the National Focal Point in the country at the next port of call (if overseas).

PROCEDURE 5.4 CORE CAPACITIES AT POINTS OF ENTRY

5.4.0 Purpose

This procedure explains the core capacity requirements for New Zealand points of entry under the International Health Regulations (IHR) (2005). Ensuring these core capacities exist will minimise public health risk from the international spread of disease.

5.4.1 Cross-agency requirements

http://www.customs.govt.nz/about/contactus/airports/Pages/default.aspx

NZ Customs requires all craft and people arriving into New Zealand to arrive or depart from a "customs place" (Customs port or airport). The customs places are listed on NZ Customs website.

http://www.customs.govt.nz/about/contactus/ports/Pages/default.aspx

The Chief Executive of Customs may also give approval for arrivals into non-customs places.

https://www.mpi.govt.nz/importing/border-clearance/places-of-first-arrival/

MPI requires all arriving craft and people to enter through a place of first arrival. The places of first arrival (PoFA) are listed on MPI's website.

A number of smaller ports and airports, such as Napier and Nelson airport are not "customs places", but they are MPI PoFA and do receive a number of international arrivals annually after being issued specific approval from Customs.

International Health Regulations 2005 Annex 1B

In addition to the Customs and MPI port/airport status, the Ministry of Health has designated some New Zealand airports and ports as points of entry under the IHR (2005). Such designations were initially given after these airport and ports were assessed by public health units, in 2012 and 2013, and found to meet the core public health capacity requirements under the IHR (2005).

Public health units undertake annual verification exercises to check that the core capacities are being maintained, and report on their status to the Ministry of Health (see Procedure 5.5, below). The Ministry of Health collates this information and reports annually to the WHO on the status of New Zealand's IHR-designated points of entry.

5.4.2 Public health units' roles as competent authorities

International Health Regulations 2005 Articles 19 and 22

A competent authority is defined as an authority responsible for the implementation and application of health measures under the IHR (2005). Article 19 requires each State Party to (among other things) "Identify the competent authorities at each designated point of entry in its territory".

The Ministry of Health has identified the relevant DHB public health units as the competent authority for each designated point of entry (and for other international ports and airports).

Article 22 describes the role and activities of competent authorities. In New Zealand, most of these roles are performed by other agencies (e.g., MPI). If this is the case, public health units, as the designated competent authorities, must check that these roles and activities are being undertaken and be assured there are appropriate processes and procedures in place.

The public health responsibilities of competent authorities are largely given

effect through the implementation of the Health Act 1956 and other legislation such as the Radiation Safety Act 2016, the Hazardous Substances and New Organisms Act 1996, and the Biosecurity Act 1993.

Appendix 22 summarises the core roles of agencies at points of entry in the New Zealand context.

5.4.3 Risk assessment of points of entry

Public health units must be aware of the status of the airports and ports in their areas, and plan and prioritise their border work accordingly. This includes being prepared to respond effectively to public health incidents and emerging threats at the border if, and when, they arise.

A risk assessment of each point of entry should be undertaken and be reviewed annually. The risk assessment is a tool to clarify the overall public health risk at the point of entry and to identify work priorities. The level of public health activity required at non-designated points of entry will largely be determined by factors such as the frequency and type of inbound conveyances, and the nature and volume of the passengers, goods, and cargo being transported.

A model risk assessment tool to support public health units to conduct a risk assessment at their points of entry is provided at Appendix 23.

The level of public health engagement at the point of entry should be proportional to the risk profile, regardless of whether or not it is an IHR-designated point of entry. Activities should be prioritised to ensure appropriate public health controls are in place that are proportionate to the risks identified.

Ports and airports that are not IHR-designated, but are MPI PoFA (that is have first port arrivals) should be encouraged to achieve as many of the IHR core capacities as possible as these provide the benchmark for border health protection. The public health activities at these ports/airports are likely to include mosquito and vector surveillance, maintaining links with stakeholders, protocols for managing ill passengers, and emergency response plans (for ports with high numbers of first porting passengers and/or high risk cargo). Refer to Procedure 5.7 for template for Ill Traveller protocol.

5.4.4 IHR (2005) core capacity requirements

International Health Regulations 2005 Articles 19- 22 and Part B of Annex 1

As a signatory to the IHR (2005), New Zealand is obliged to ensure that its IHR-designated points of entry meet the required core capacities. These capacities reflect fundamental standards of public health preparedness and are regarded as critical for identifying and managing potential public health risks including preventing the international spread of disease.

The Ministry of Health oversees New Zealand's core capacity programme and is responsible for designating New Zealand international ports and airports. Border health protection officers in public health units confirm and verify annually that the IHR-designated points of entry in their region meet the core capacities.

Public health units must also ensure they meet the core capacity requirements for surveillance and response in the IHR (2005).

International Health Regulations 2005 Annex 1A

IHR-designated points of entry must sustain, at all times, the capability to manage public health issues. If the competent authority or designated point of entry cannot demonstrate that the core capacities will be provided for at all times, then point of entry IHR-designation will be withdrawn. The designation status may be removed if the risk profile at that port changes and it is no longer deemed necessary to hold that status.

Surveillance and response capacities

International Health Regulations 2005 Articles 5 and 13 and Annex 1A

Annex 1A of the IHR (2005) details the core capacity requirements for surveillance and response systems. These are broad capacities required of countries' health sectors at national, regional and local levels. These capacities are not limited to border activities, but include broader requirements for surveillance, reporting, notification, verification, response and collaboration in general.

These capacities are given effect through the wider contractual responsibilities of public health units.

In summary, they include the capacity to notify and respond to public health events 24/7. This includes surveillance capacity, the ability to determine and implement control measures in a public health response, facilitating specialist services (such as laboratory analysis), communicating with relevant stakeholders, and reporting.

Core capacity requirements for IHR-designated ports and airports

International Health Regulations 2005 Annex 1B

Annex 1B details the core capacities required for designated airports and ports.

There are two categories of core capacities required:

- those required "at all times"
- those required during a public health emergency of international concern (PHEIC).

<u>Core capacities required at all times</u>

International Health Regulations 2005 Annex 1B, list 1

These are standards or arrangements that IHR-designated points of entry must have 24/7. They are regarded as 'business as usual' standards and include:

- access to medical services and diagnostic staff and equipment
- access to staff and equipment for the recovery and transportation of ill travellers
- access to trained personnel for the inspection of aircraft or ships
- a healthy environment for users of international airport or port facilities including safe water and food, clean catering facilities and wash rooms, sewage and waste disposal services and an inspection programme
- access to trained staff and programmes for vector control (e.g., rats and mosquitoes).

Further guidance on applying the "at all times" core capacities in New Zealand is provided at Appendix 24.

<u>Capacities required during a public health emergency of international concern (PHEIC).</u>

International Health Regulations 2005 Annex 1B, list 2

These capacities focus on being prepared for, and being able to appropriately respond to, a significant public health event that could impact on the international community. They include:

- emergency response planning and coordination capacity

- having communication contact points for relevant airport and ports, public health authorities, and other agencies
- ensuring assessment and care for affected travellers, animals, and goods by establishing arrangements with medical and veterinary facilities for isolation and treatment
- providing a space to interview suspect or affected persons away from other travellers
- the capacity to assess and quarantine suspect or affected travellers at facilities away from the international port
- being able to implement recommended control measures to disinsect, disinfect, and decontaminate baggage and other cargo
- being able to implement entry/exit control for departing and arriving passengers
- ensuring access to required equipment and protection gear for personnel to transfer travellers with infection/contamination.

Guidance on applying these PHEIC core capacities in the New Zealand context is provided at Appendix 24.

Refer to Procedure 5.7 for detailed information on preparing for and responding to public health threats of international concern.

5.4.5 New Zealand's IHR-designated points of entry

Airports

- Auckland International Airport
- Christchurch International Airport
- Wellington International Airport
- Dunedin International Airport
- Whenuapai Air Base
- Ohakea Air Base.

Other regional airports (PoFA) may receive unscheduled international flights from time to time.

International ports

- Centreport (Wellington)
- Eastland Port Limited (Gisborne)
- Lyttelton Port of Christchurch
- Northport (Whangarei)
- Marsden Point
- Marsden Cove
- Opua (Bay of Islands)
- Ports of Auckland Limited
- Port Marlborough (Picton)
- Port of Napier Limited
- Port Nelson Limited
- Port Otago (Port Chalmers)
- Port Taranaki (New Plymouth)
- Port of Tauranga
- PrimePort (Timaru)
- South Port NZ Limited (Bluff).

5.4.6 Maintaining the IHR core capacities

Public health units must work closely with their designated points of entry, border stakeholders, and the health sector to ensure that the core capacities for IHR designation are maintained and risks to public health minimised. The key public health risks to New Zealand are the introduction of medical vectors of public health significance and imported cases of disease (QUARANTINABLE and emergent diseases).

The core capacities programme should be the foundation for public health unit engagement with border stakeholders and the wider health sector (DHBs, laboratories, primary care and ambulance services). Ensuring that the core capacities are being maintained is a continual process. Border activities and engagement should occur throughout the year. The verification process is ongoing and should not simply be seen as 'filling in a form' at the end of the year.

The scale and scope of public health unit activity should be consistent with the risk profile for each point of entry. For example, the Ministry would expect the level of public health activity at a major international airport such as Auckland to be much higher than an airport such as Dunedin with a much smaller number of international arrivals.

Public health unit operational activities, as part of the core capacity programme, should include (but are not limited to):

- site visits to the point of entry
- face to face meetings with port and airport authorities
- attending stakeholder meetings
- sharing information on public health risks and emerging threats
- running or attending training sessions for border stakeholders
- participating in exercises and on occasion conducting exercises
- developing and implementing ill traveller protocols and public health contingency plans in conjunction with stakeholders
- ensuring there is a capability and capacity for responding to a public health event or emergency
- reviewing key documents – including vector management programmes, waste management plans, place of first arrival audit reports, food premises inspection records, etc.

A number of tools have been developed to support public health units to undertake their role as competent authorities. These include:

- the risk assessment tool (refer to Appendix 23)
- guidance on applying the capacities in New Zealand (refer to Appendix 24).

Refer also to the Annual Border Health Returns (Procedure 5.5), below, for a reporting template which can be used as a checklist to aid your assessment.

It is expected that public health units will keep records of the operational activities they undertake in the event that additional evidence is required by the Ministry of Health. Records could include a log of meetings, copies of meeting minutes, training records, exercise planning and debriefing documents.

As described in Procedure 5.5, below, public health units provide annual

summary reports to the Ministry of Health on border activities undertaken over the last year, including verification that the IHR core capacities for designated points of entry are being maintained. The core capacity verification section of the annual Border Health Return report is only a summary. Public health units should focus on any outstanding activities from previous years' assessment and any emerging "risk" areas.

PROCEDURE 5.5 ANNUAL BORDER HEALTH RETURNS

5.5.0 Purpose

This procedure explains the requirements for public health units to complete annual Border Health Returns and provide these to the Ministry of Health.

5.5.1 Reporting process

Public health units are required to report annually to the Ministry of Health on border health activities.

A separate report summary is expected for each international point of entry even if it is not an IHR-designated port or airport. This includes MPI PoFA and Customs ports.

There are different forms required to be submitted for the different classifications of New Zealand's international points of entry. Appendix 25 is for IHR-designated points of entry and Appendix 26 is the form to use for MPI PoFA (i.e., not designated as an IHR point of entry).

IHR-designated port or airport

Appendix 25 is the Annual Return Form for those airports and ports that have been designated as IHR points of entry. Part 1 consists of a reporting template, which can be used as a checklist to aid your assessment.

Part 2 of the Annual Return Form covers other border health activities (including pratique and ship sanitation certification).

Public health units responsible for IHR-designated points of entry must complete, in full, Parts 1 and Part 2 of the Annual Return Form.

Places of first arrival

Public health units with airports or ports that are PoFA, (but not IHR-designated points of entry) are still required to report to the Ministry, using the form in Appendix 26. The Ministry expects that there will be a level of activity to report. As a minimum, the report should describe:

- vector control activity over the past year (e.g., the vector surveillance and suppression programmes and any vector interception responses)
- the status of the ill traveller protocol for the airport or port
- key relationship management activity with key stakeholders at the port or airport.

Timing for reporting processes

Returns for the previous calendar year must be submitted by the end of January in the following year. The Border Health Returns are used to:

- identify emerging border health issues, risks, and trends
- inform national border health planning and border health advice to public health units
- monitor the national status of core capacities at New Zealand's IHR-designated points of entry
- inform New Zealand's reporting expectations on border health to the WHO.

The Ministry of Health collates and analyses the returns and provides

summary information back to public health units. Where necessary, the Ministry may require a public health unit to provide additional reports or clarification on specific items.

PROCEDURE 5.6 PESTS OF PUBLIC HEALTH SIGNIFICANCE

5.6.0 Purpose

This section provides guidance relevant to pests of public health significance. While there is a particular focus on activities relating to exotic mosquitoes of public health significance, public health units also need to be mindful of, and give appropriate attention to, other pests of potential public health significance (e.g., rats).

The key procedures covered include:

- appointments of officers under the Biosecurity Act 1993
- exclusion of public health pests (including border control activities and surveillance)
- responses to an interception or incursion
- control measures.

This section should assist public health units with the practical interpretation and application of the Biosecurity Act 1993, and parts of the Health Act 1956.

5.6.1 Introduction

The Biosecurity Act 1993 provides a legislative framework for measures to control the importation of goods and organisms that are a risk to human health. Biosecurity activities complement, and need to be co-ordinated with, the implementation of related public health legislation, such as the Health Act 1956, the Hazardous Substances and New Organisms Act 1996, and the Resource Management Act 1991.

NZ BioSecure – Southern Monitoring Services, *Medical Vectors – An Education Guide for Border Health and Integrated Pest Management*
http://www.smsl.co.nz

Communicable Disease Control Manual

This guidance should be read in conjunction with the technical workbook *Medical Vectors – An Education Guide for Border Health and Integrated Pest Management.* This workbook provides detailed technical guidance about vector biology, vector borne diseases, surveillance techniques and controls. The surveillance techniques are endorsed by the Ministry of Health and should be adopted as recommended practices.

Further detail on imported disease control activities is contained in the *Communicable Disease Control Manual*.

New Zealand has remained free from many exotic diseases and disease vectors. It is important that effective biosecurity and public health quarantine frameworks are in place (including exclusion, surveillance, and response activities) and complement each other, because there is a clear overlap in their core objectives. Unwanted pests can have detrimental implications to both public health and biosecurity. Our quarantine and biosecurity frameworks are supported by natural barriers such as New Zealand's geographical separation from other countries. Both help to prevent the entry and establishment of new diseases or disease vectors.

Pests of public health significance are also known as medical vectors. They are a public health concern because of the role they play in the transmission of diseases. They can carry pathogens from one host to another (such as

viruses, bacteria, protozoan parasites).

Vectors are generally considered to be invertebrate animals – specifically arthropods. However, vertebrates can also act as vectors. There are numerous medical vectors of potential public health significance including mosquitos, rats, fleas, lice, bed bugs, cockroaches, ticks, and mites.

The Ministry for Primary Industries (MPI) has primary responsibility for broadly managing biosecurity risks. Currently, exotic mosquitoes are the main unwanted organisms of public health significance for which the health sector has some responsibility under the Biosecurity Act 1993 and Health Act 1956.

Key biosecurity activities undertaken by public health unit staff include import controls on conveyances, goods and cargo, controls on international travellers, and vector controls. Public health staff should advocate the use of Integrated Pest Management practices in the control of pests of public health significance (refer Appendix 6). Effort should be concentrated on maintaining effective border control to avoid the high cost of fixing problems arising from an importation and establishment of an unwanted organism.

Accordingly, it is necessary to provide for:

- effective management of significant public health risks associated with importation of risk goods
- continuous monitoring of New Zealand's status in regard to pests and unwanted organisms
- appropriate public health precautionary actions, emergency and other urgent arrangements, and pest management strategies
- effective prevention, management, or eradication of unwanted organisms if emergencies or other urgent needs occur
- actions to enable New Zealand's international reporting obligations and trading requirements to be met insofar as they relate to public health.

5.6.2 Appointment of officers under the Biosecurity Act 1993

Biosecurity Act 1993

Criteria for the appointment of Statutory officers (May 2016), Ministry of Health

The Biosecurity Act 1993 provides for the appointment of a range of statutory officers, with varying powers, to support the implementation of the Act. Such officers include:

- chief technical officers (Health) (CTO)
- deputy chief technical officers (Health) (DCTO)
- authorised persons
- accredited persons
- inspectors.

The CTO (Health) appoints non-Ministry employees only as authorised or accredited persons and only delegates limited powers to them.

Chief Technical Officer (Health)

Biosecurity Act 1993 s.101(2)

One or more CTOs (Health) may be appointed by the chief executive of a department recognised by a responsible Minister (e.g., the Minister for Primary Industries).

The Director-General of Health has been recognised by the Minister of Biosecurity as having responsibility for human health and may appoint

CTOs (Health) who may exercise all the powers and perform all the functions and duties conferred on a CTO by the Biosecurity Act 1993 for exotic mosquitoes of public health significance (except powers under ss.103(1), 116 ,126 and 127).

Biosecurity Act 1993 s.102

Deputy CTOs may also be appointed.

Biosecurity Act 1993 s.22

Currently the Manager, Environmental and Border Health, Ministry of Health is the CTO (Health), and there is no DCTO (Health).

The CTO (Health) may recommend the making of an import health standard under the Biosecurity Act 1993. However, public health unit clearance at the border is not required under the Act as MPI is responsible for providing such border services.

The Ministry's policy on circumstances where the CTO (Health) may declare that an organism is unwanted is attached at Appendix 27.

Biosecurity Act 1993 s.103(1) and (7)

The CTO (Health) or DCTO (Health) may appoint authorised persons or inspectors for the purposes of administering and enforcing the provisions of the Biosecurity Act 1993 insofar as they relate to public health. The CTO (Health) and DCTO (Health) can also accredit persons for the purposes of performing particular functions that are consequential upon the exercise of powers under this Act by an inspector or authorised person, or that have been prescribed in regulations made under the Biosecurity Act 1993.

Biosecurity Act 1993 s.128

Where a notice is given requiring specific actions and those actions have not been undertaken within the time specified, or within a reasonable time, the CTO (Health) may cause the actions to be undertaken; and then recover the costs of those actions from the person who failed to undertake them.

Authorised persons

Biosecurity Act 1993 s.103

Authorised persons are appointed to help support the implementation of the Biosecurity Act 1993. For public health units, these are usually qualified health protection officers or medical officers of health working to support the implementation of the Biosecurity Act – usually undertaking activities relating to mosquito surveillance and other port health responses.

A letter of appointment, accompanied by a summary of provisions of the Biosecurity Act 1993, is issued to all authorised persons at the time of their appointment confirming, amongst other things, any restrictions on the appointment.

Depending on the terms of their appointment, authorised persons may have a range of powers under Part VI (Administrative provisions) of the Biosecurity Act 1993. Only authorised persons and inspectors, appointed by a CTO (Health) or DCTO (Health), may administer and enforce Part III of the Act (relating to border control activities undertaken by MPI).

The Biosecurity Act 1993 contains various powers which an authorised person may exercise. The Ministry of Health limits the powers and responsibilities to those that it believes are necessary for routine biosecurity activities and can limit the powers available to authorised persons.

Biosecurity Act 1993 ss.43, 106, 109, 112, 113, 114, 115, 119, 121, 121A, 122

Officers should always check their letters of appointment which identify the powers they can use. The powers usually issued to authorised persons include powers to:

- require information to be provided (s.43)
- employ or request any person to assist them (s.106)
- enter and inspect any place other than a dwelling house, marae or building associated with a marae (ss.109, 112)
- record information (s.113)
- use general powers to eradicate or manage a pest or unwanted organism (s.114)
- use devices (s.115)
- seize abandoned goods (s.119)
- examine organisms, organic material, goods or material (s.121)
- apply an article or substance to a place to ascertain the presence or absence of a pest or unwanted organism(s.121A)
- give directions to treat goods, water, places, equipment etc; to destroy any pest or unwanted organism or harbourage; or take steps to prevent the spread of any pest or unwanted organism (s.122).

Biosecurity Act 1993 ss.103(4), 104, 163, 164

The exercise of these powers is subject to the following:

- the authorised person must have the appropriate experience, technical competence and qualifications to be appointed (s.103(4))
- the authorised person must comply with instructions from the CTO (Health) (s.104)
- the authorised person must act in good faith, with reasonable cause, and take reasonable care at all times (ss.163, 164).

Authorised persons must produce their letter of appointment if they are exercising a power of entry, and on every occasion they exercise that power (even on subsequent visits).

Biosecurity Act 1993 ss.55, 103(6), 110, 111, 112, 118, 120, 123, 130, 133, 134, 152, 154, 155, 161

Conversely, the Ministry of Health considers that the following powers are NOT likely to be required by an authorised person on a routine basis. Accordingly authorised persons are not authorised to use them, unless they receive further written notice from the Ministry (refer s.103(6)). Should an authorised person expect to need to use any of the powers listed below, they should contact the Ministry urgently to discuss the matter:

- powers in relation to small-scale pest management programmes (s. 55)
- applications for warrants to enter and inspect marae or dwelling houses etc. (ss.110, 112)
- applications for warrants for the entry and search of any place where an offence punishable by imprisonment may have occurred or be occurring (s.111)
- seizing evidence (s.118)
- intercepting and inspecting baggage and parcels etc. (s.120)
- vaccinating organisms (s. 123)
- declaring a restricted place (ss.130, 133, 134)
- carrying out steps as directed by the chief technical officer as required in a provisional control programme (s.152)
- investigating and/or instituting enforcement action for offences under the Biosecurity Act 1993 (ss. 154, 155, 161).

The appointment letter for an authorised person must be kept secure. It is

proof of appointment and has to be produced in certain situations as proof of the authorised person's status under the Biosecurity Act 1993 (e.g., see s.112). Copies should be carried with the officer so they can produce it if required (e.g., in their on call bag).

With respect to the provisions of the Biosecurity Act 1993, authorised persons should note:

Biosecurity Act 1993 s.43
- who should be providing information about pests and unwanted organisms
- how these provisions may be useful in the course of monitoring (e.g., for exotic mosquitoes of public health significance)

Biosecurity Act 1993 s.109
- what powers of entry they have (except to enter dwelling places and marae without a search warrant) to confirm the presence of an unwanted organism
- what general powers they have for preventing the spread of an unwanted organism if they have lawfully entered a place. These powers would include the removal or treatment of potential habitats.

Appointment as an accredited person

Biosecurity Act 1993 s.103(7)

Some public health units employ health assistants or technicians, who work under the direction of authorised persons, and do routine activities relating to mosquito surveillance and other port health responses. These accredited persons are not health protection officers or medical officers of health, but their appointment recognises that they have undertaken the required training courses and have particular skill sets.

Accredited persons are accredited for the purposes of performing functions consequential upon the exercise of powers under the Act by an authorised person or inspector. This means that accredited persons may only carry out functions that are necessary due to the exercise of powers by an authorised person or inspector. This may involve administrative functions or other follow-up activity (such as conducting tests on goods or specimens) once an authorised person has exercised certain powers. It does not necessarily imply that the accredited person must perform functions under the supervision or direction of the authorised person or inspector.

Accredited persons are appointed by the CTO (Health) or DCTO (Health) under the Biosecurity Act 1993 to perform functions under the Act, insofar as they relate to public health. A letter of appointment, accompanied by a summary of the provisions of the Act, is issued to all accredited persons confirming, among other things, any restrictions on the appointment. The appointment letter must be kept secure as it is proof of appointment and has to be produced in certain situations as proof of the accredited person's status under the Act (e.g., see section. 112).

Biosecurity Act 1993 s.103(7), 163, 164

The role of an accredited person is subject to the following:
- the accredited must have appropriate experience, technical competence and qualifications (s.103(7))
- the performance of any function is consequential upon the exercise of powers under the Biosecurity Act 1993 by an inspector or authorised person
- the accredited person must act in good faith, with reasonable cause, and take reasonable care at all times (ss. 163, 164)
- the accredited person must use best endeavours to comply with, and

give effect, to any relevant performance or technical standards.

Inspectors

Biosecurity Act 1993 s.103(2)

Biosecurity agencies have agreed that the appointment of inspectors will be limited to staff who are directly employed by a government agency and who need to exercise all the powers of inspectors. The CTO (Health) or DCTO (Health) has appointed the Ministry of Health's enforcement officers as inspectors under the Biosecurity Act 1993.

5.6.3 Exclusion of pests of public health significance

International Health Regulations 2005 Articles 22 and 34

The IHR (2005) require that, as far as practical, facilities used by travellers at points of entry are maintained in a sanitary condition and kept free of sources of infection or contamination, including vectors and reservoirs. In addition, containers and container loading areas are to be, as far as practicable, kept free from sources of infection or contamination, including vectors and reservoirs.

The Ministry reports annually to the WHO demonstrating the extent to which the ports and airports are kept free from disease vectors, including mosquitoes (refer to Procedure 5.5).

Managing the public health risks from exotic mosquitoes is a high priority. There is a focus on exclusion and surveillance activities undertaken by MPI under operational agreements, or directly by public health units.

Activities overseas will, to an extent, reduce the likelihood of medical vectors entering New Zealand. Regular monitoring of controlled breeding habitats in and near New Zealand port environments may be of use in detecting incursions and preventing incoming mosquitoes from escaping the port areas. Mosquito exclusion activities should be integrated with surveillance programmes. Integrated Pest Management practices should be strongly encouraged as a risk minimisation strategy.

There are two key components of a programme to exclude pests of public health significance. Both should be recognised as being critical and both need to be well maintained:

(1) Border health activities such as inspection and decontamination, disinfection, disinsection, and deratting of vessels, aircraft and risk goods to deter incursions of exotic species, and

(2) surveillance at and near points of entry (and including transitional facilities) to detect incursions of exotic species of concern or any presence of local species to identify potential habitats that may be utilised by exotic species if these escape detection on arrival.

Inspection and disinsection of craft and risk goods

Memorandum of Understanding on Biosecurity Activities between Ministry of Agriculture and Forestry and Department of Conservation, Ministry of Fisheries and Ministry of Health 31 October

A Memorandum of Understanding agreed in 2006 between the Ministry of Health and MPI covers biosecurity activities – in particular, arrangements in relation to the exclusion and control of exotic mosquitoes of public health significance.

MPI acts as the border control delivery agency for the Ministry of Health and is responsible for:

- implementing aircraft disinsection

2006.

Health (Quarantine) Regulations 1983 reg.5

Schedule of Aircraft Disinsection Procedures for Flights into Australia and New Zealand V4.1 Feb 2017. *MPI*. Available at: http://www.agriculture.gov.au/biosecurity/avm/aircraft/disinsection/procedures/schedule-aircraft-disinsection

MPI Requirements for Vessels Arriving in New Zealand Revised April 2013. Available at: https://www.mpi.govt.nz/importing/border-clearance/vessels/arrival-process-steps/

- the inspection of imported risk goods
- implementing systems for the inspection and treatment as set out in import health standards for goods such as forestry and agricultural equipment from any country.

MPI will also advise the relevant public health unit of all detections of suspected exotic mosquitoes within one hour of such a detection. MPI will also continue to undertake animal *Culicoides* surveillance in accordance with the relevant MPI standard.

NZ legislation requires that every aircraft arriving from a foreign place has been disinsected so as to destroy all mosquitoes (if any) in the aircraft. An approved insecticide and methodology must be used. MPI implements the national disinsection programme.

Subject to the provisions of relevant legislation, all international first port of call vessels (including yachts), will, as far as is practicable, be inspected by MPI for biosecurity risks including the presence of exotic mosquitoes (all life stages) or of actual or potential breeding sites for exotic mosquitoes.

Border Health staff are expected to maintain operational relationships with MPI staff. The contact for MPI nationally is via the MPI National Operations Centre: noc@mpi.govt.nz or 0278015590.

Pre-border inspection and clearance of risk goods

The first line of defence against the importation of exotic mosquitoes includes the pre-border clearance of risk goods conducted by MPI Quarantine officers at off-shore sites. The programmes for residual spraying with insecticides of aircraft that fly international routes are another component of the integrated exclusion strategy.

Vessels and cargo inspection/disinsection

The inspection of sea vessels (including yachts) arriving at ports, the disinsection of untreated aircraft arriving at airports, and the inspection of their high-risk cargo, are other lines of defence. These activities are undertaken by MPI Quarantine officers.

Transitional facilities (TF)

Imported goods, especially plants, animals, and related products, need to first go through a transitional or containment facility and may need to be quarantined. Import health standards specify what is required for certain goods.

Transitional facilities are approved by MPI to receive containers and goods that may pose a biosecurity risk. Goods or containers may need to be inspected or treated at the facility before they can be 'cleared' for entry into New Zealand. Every transitional facility has to have an MPI-approved transitional facility operator and, if receiving containers, an accredited person available (who may also be the operator) who has been approved by MPI.

Transitional facilities can hold, inspect, treat, identify, or destroy and dispose

of uncleared risk goods. Types of goods that need to go to transitional facilities include:

- agricultural chemicals and veterinary medicines
- animals and animal products
- biologicals
- food products
- plants and plant products
- other organisms
- used machinery or vehicles
- wood and wood products.

Link to the standards, operator manuals and other requirements for Transitional facilities. Available at: http://www.mpi.govt.nz/importing/border-clearance/transitional-and-containment-facilities/

Facilities need to meet the physical and operational requirements contained in the MPI Standard. Facilities will have a supporting biosecurity procedures manual, and site plans are prepared specifically for each, describing all biosecurity activity.

The use of transitional facilities to hold and manage imported risk goods is becoming increasingly prevalent and their potential risk as a site for interceptions of pests of public health significance is also increasing. Public health units should have an awareness of transitional facilities in their region including their location, in particular those considered to pose a high public health risk due to the nature and quantity of imported goods and/or the management practices. It may be useful to accompany MPI staff when they undertake audits of these high-risk sites.

Surveillance

Part IV of the Biosecurity Act 1993 provides for the continuous monitoring of New Zealand's status in regard to pests and unwanted organisms. Surveillance is one aspect of the monitoring programme. The Ministry of Health, through public health units, continues to take responsibility for surveillance for exotic mosquitoes.

Surveillance for exotic mosquitoes at points of entry

Medical Vectors – An Education Guide for Border Health and Integrated Pest Management. Available at: www.smsl.co.nz

For guidance about managing samples, the sample collection form, mosquito surveillance equipment and techniques, and the locations of traps is provided in the referenced *Medical Vectors* resource. This has been provided to all public health units and is available online. It has been endorsed by the Ministry of Health, and is used as part of the Ministry's Border Health training courses for health protection officers and medical officers of health.

The monitoring of mosquito populations at ports and airports is another line of defence against importations of exotic mosquito species. Either public health units or port companies may do this. If port/airport companies undertake this function for any given port or airport then the results of surveillance should be audited by the relevant public health unit. This surveillance also provides critical data regarding the potential for ports/airports to export indigenous species to other countries.

WHO pamphlet (vector surveillance and control at POE)

http://www.who.int/ihr/p

Vector surveillance and control is a constant cycle of evaluation, risk assessment, surveillance, evaluation and response (if needed).

The generic monitoring methodologies that are currently employed variously

orts_airports/WHO_VECTORS_3V_14_21_0701.pdf?ua=1

across the range of ports and airports are:

1. larval traps (sentinel tyre traps and less frequently ovitraps)
2. larval surveys (ground pools and receptacles)
3. adult traps (CO2 light traps, fry ice, BG and GAT traps).

All of these methodologies are acceptable but an effective programme will utilise them all as part of a suite of trapping techniques to monitor for the target species at various stages of the insect's life cycle.

The primary aim of port/airport surveys and other monitoring (now being conducted on an on-going basis by most public health units) is to support other biosecurity activities by:

- checking for the arrival/establishment of exotic mosquitoes of public health significance
- identifying potential mosquito breeding sites and arranging for these sites to be eliminated or to be the subject of active, ongoing control measures
- recording the distribution and habitat preference of mosquito species in New Zealand. Such information can be used in predictive models for the establishment of new exotic species.

In most circumstances, sampling is targeted at specific phases of the insect's life cycle. Ovitraps collect eggs, larval traps collect larvae and adult traps collect female adults. The type of trap used will reflect the sampling programme and it is essential that the sampling programme is shaped to provide the most efficient use of resources. The Ministry of Health supplies standard mosquito monitoring equipment.

When planning surveillance activities, priority should be given to:

- ongoing surveillance of habitats (or potential habitats) for fresh water container-breeding mosquitoes within a minimum of 400m around international ports of entry (ports, airports)
- ongoing surveillance around international yacht berths (first port of call), and premises of importers of high risk goods
- surveys at least once a year in a surrounding five km buffer zone of ports and airports as well as other high-risk sites and favoured mosquito habitats within the metropolitan region
- removal or treatment of all larval habitats where feasible for mosquitoes within the 400 m or 1 km port/airport zone within three working days of detection.

Medical Vectors – An Education Guide for Border Health and Integrated Pest Management. Available at: www.smsl.co.nz

Public health units are expected to:

- maintain staffing capability to undertake mosquito surveillance and response activities
- prepare and manage samples in accordance with Ministry guidance
- maintain surveillance equipment with support from New Zealand BioSecure
- maintain accurate records
- provide timely surveillance reporting via the national database.

5.6.4 Response

Investigation of public information or complaints

Reports from the general public to public health units of any exotic organisms other than mosquitos should be urgently reported to the MPI exotic disease and pest emergency hotline, 0800 809 966 (either by the complainant or public health unit).

Reports of organisms of public health significance already established in New Zealand may be responded to as a nuisance under the Health Act 1956 (e.g., Australian Redback spiders, wasps, ants, etc).

Follow-up investigation and taxonomic identification of suspected exotic mosquitoes submitted by the general public should be undertaken within three working days of the complaint being received (unusual biting activity led to the discovery of *Ae. camptorhynchus* in Napier in 1998 and in Blenheim in 2004).

Response to suspected (detection response) or confirmed (interception response) exotic mosquitoes of public health significance

A mosquito response is defined as any actions taken to prevent the establishment and spread in New Zealand of an exotic mosquito of public health significance. This will include similar actions taken in the event of a mosquito detection, interception, incursion, or establishment; however, the scale of the response may vary.

Response measures for exotic mosquitoes need to be based on relevant legislation (including International Health Regulations 2005, Resource Management Act 1991, Health and Safety at Work Act 2015, Biosecurity Act 1993, and Health Act 1956).

Biosecurity Act 1993 ss.43, 106, 109, 112, 113, 119, 121

Officers should check their warrants of appointment but, in general, persons authorised under the Biosecurity Act 1993 have the following powers for use in a response:

- may require information to be provided (s.43)
- employ or request any person to assist them (s.106)
- enter and inspect any place other than a dwelling house, marae or building associated with a marae (ss.109, 112)
- record information (ss.113)
- use devices (s.115)
- seize abandoned goods (s.119)
- examine organisms, organic material, goods or material (s.121).

The mosquito response will be triggered by the reporting of suspected or confirmed exotic mosquitoes (usually from surveillance or exclusion activities). During preparation times and during a response, delivery needs to be monitored to ensure that the following occur:

- transparent budget and management structure
- financial reporting
- progress reporting
- audit.

Mosquito detection and interception response

An exotic mosquito response may be initiated by the detection of mosquito biomass in or on risk goods by MPI staff at the border (i.e. an airport or port), the identification of an exotic mosquito (larvae or adult) from a trap or from the identification of a specimen handed in to the public health unit by a member of the public, workers at a devanning site or other organisation or agency.

The **detection** response begins when one or more adult mosquitoes or larvae have been found at or before the border or in association with recently arrived risk goods or travellers and laboratory identification has not yet confirmed it is an exotic species.

Detection responses must be reported to the Environmental and Border Team within 2 hours of the public health unit being notified. Call a senior advisor or manager during office hours or 0800 GET MOH after hours.

The key steps of a vector detection/interception response are described in Appendix 29. Appendix 30 contains a supporting Task Table for public health units.

If the laboratory identification confirms the sample is an endemic species further actions such as a comprehensive delimit survey, enhanced surveillance and situation reporting will **not** be required however an email summary of the actions taken must still be sent

Once a biomass detected has been recognised as being mosquito based, the response becomes the responsibility of the Ministry of Health although MPI staff will deal with any risk goods. MPI will complete a handover certificate to formally hand the responsibility to public health staff who then take the lead in the operational response.

The certificate used in a handover, along with supporting guidance, is provided at Appendix 31.

An interception is defined as *"the confirmation that adult mosquitoes or larvae detected at or before the New Zealand border, or in association with recently arrived travellers or goods such as at an MPI approved transitional facility, are exotic mosquitoes of public health significance"*.

An interception response is required when an adult exotic mosquito is confirmed during an inspection of imported item(s) at the border (port, airport, or importer's premises). In this scenario, one or more adults may have escaped into New Zealand during the time between arrival and inspection.

If an exotic mosquito is confirmed a situation report must be submitted to Environmental and Border Team within 24 hours of the public health unit being notified (email: notifyenvhealth@moh.govt.nz).

See Appendix 32 for a summary report template.

Mosquitoes found during routine surveillance at the point of entry

In this situation mosquitoes are found during routine surveillance at the point of entry (port, airport or importer's premises) – for example, larvae in tyre traps or an adult mosquito in an attractant trap. Because endemic species are currently found by both trap methods a response is initiated **after** the identification of exotic specimens has been made by the Laboratory (NZ BioSecure). This means that all specimens collected from surveillance should be dispatched to the laboratory without undue delay.

In this scenario, an exotic mosquito has breached the quarantine system and a generation of breeding may have already occurred. A delimiting survey and enhanced monitoring must be activated. Adulticide treatments of appropriate harbourage sites must be considered, supplemented by the prophylactic treatment of larval habitat with slow release or residual products. These decisions need to be technically based and tailored to suit the specific profile of the exotic mosquito or mosquitoes being dealt with.

If an exotic mosquito is confirmed a situation report must be submitted to Environmental and Border Team within 24 hours of the public health unit being notified (email: notifyenvhealth@moh.govt.nz).

See Appendix 32 for summary report template.

Once confirmation of an exotic species is made, and if breeding has been confirmed, the response will transfer to MPI, as an exotic mosquito incursion response. Public health staff are expected to cooperate with, and work alongside, MPI staff until a transition is seamlessly completed.

If, after appropriate surveillance, no additional exotic mosquito biomass are found, this indicates that a population is either absent or below the levels of detection. At this time, MPI will terminate the incursion response and routine public health unit surveillance is resumed. The finding of additional exotic biomass will mean the incursion response continues.

Exotic Mosquito Incursion Response

An incursion response is initiated following the confirmation of the post-border detection and breeding of exotic mosquitoes of public health significance not previously known to be established in New Zealand and not in direct association with recently arrived travellers or goods. Immature or adult stages of exotic mosquitoes may be confined to one small area (e.g., a property or suburb) or may be found at multiple locations or over a widespread area.

https://www.health.govt.nz/system/files/documents/publications/cd-manual-arboviral-diseases-may2012.pdf

MPI will lead any incursion response but may require support from public health staff. This support may include alerting stakeholders (particularly medical practitioners) or providing field assistance. Public health staff may also be required to initiate secondary disease control measures such as promotion of mosquito avoidance behaviour, provision of advice on arboviral disease risks and management, and enhanced arboviral surveillance.

Biosecurity Response Contingency Plan

A contingency plan should be developed and maintained by each public health unit for responding to biosecurity risks of public health significance.

The plan will, amongst other things, provide for the following:

- initial response, establishment of a control centre, and call in of personnel
- assisting with local information releases
- provision of maps and aerial photographs
- appointing, equipping, and mobilising personnel undertaking a delimiting survey
- completing a delimiting survey and environmental review
- providing information to assist with the determination of the scale and nature of the response
- securing of resources to support ongoing response
- appointing, briefing, equipping and mobilising personnel required to undertake ongoing field work
- actively communicating and implementing a local control/eradication programme (where directed by CTO or DCTO)
- implementing enhanced surveillance
- quality auditing and follow-up to ensure efficacy.

Without pre-formulated plans, in the event of an interception, incursion or establishment:

- there will be delays while responsibilities are allocated and a response plan is designed. Thus, crucial time is lost while the mosquito population may disperse, increasing the expense and difficulty of successful eradication or management
- rapidly assembled ad hoc actions will not necessarily be the most efficient, nor most effective options.

It is therefore crucial that each public health unit have up to date contingency plans for response to vector intrusions.

5.6.5 Control measures

Control and elimination of larval habitats

International Health Regulations 2005 Article 19

The IHR (2005) requires that mosquito habitats detected within the 400m exclusion zones be removed or eliminated, or at least modified or treated to make them unproductive of mosquitoes. The mitigation of mosquito habitats within the international gateways should be an ongoing campaign that needs to be pursued vigorously. All agencies and stakeholders need to be involved in ensuring this action.

At some airports, and at most ports, urban development and/or naturally vegetated areas exist within the 400m zone prescribed in the IHR (2005). The cooperation of local authorities should be sought with respect to an extension of surveillance and intervention activity if so required. However, the realities of this situation should serve to further emphasise the importance of the border control procedures, particularly vessel inspection and port sanitation, with respect to receptacles.

Health Act 1956 ss.23, 29, and 33

The nuisance provisions of the Health Act 1956 may be useful for undertaking surveillance for mosquitoes.

While territorial authorities (TA) are responsible for undertaking inspections and ensuring the abatement of nuisances, anyone may lay an injunction with the District Court to seek a court order for the abatement of nuisance conditions (Health Act 1956 s. 33). For example, stacks of used tyres providing breeding habitats for mosquitoes

Biosecurity Act 1993 ss.106, 114, 121A, 122

Officers should check their warrants of appointment but, in general, persons authorised under the Biosecurity Act 1993 have the following powers for control purposes:

- employing or requesting any person to assist them (s.106)
- general powers to eradicate or manage a pest or unwanted organism (s.114)
- applying an article or substance to a place to ascertain the presence or absence of a pest or unwanted organism (s.121A)
- giving directions to treat goods, water, places, equipment etc; to destroy any pest or unwanted organism or harbourage; or take steps to prevent the spread of any pest or unwanted organism (s.122).

Removal or treatment of larval habitats

Medical Vectors – An Education Guide for Border Health and Integrated Pest Management. Available at: www.smsl.co.nz

Source reduction, i.e., the removal of standing water is an important tool in mosquito control.

The Ministry for the Environment is currently developing a proposed National Environmental Standard for the Outdoor Storage of Tyres. This will enable local authorities to appropriately manage the risks that can arise from outdoor tyre storage.

If source reduction is not possible then habitats may need to be treated. A range of treatment options for the management of larval habitats are available. These are outlined in the Mosquito Control section of the *Medical Vectors* guidance.

<u>S-methoprene</u>

The EPA has issued approval for the use of *S-methoprene* by public health officials in mosquito monitoring and surveillance activities. This approval is valid until June 2024. A copy of the permission is available on Health EMIS.

The EPA permits the application of *S-methoprene* to “non-dispersive” water bodies by persons who are not approved handlers. The Ministry of Health believes the use of *S-methoprene* in accordance with the EPA permission does not require public health unit staff to be approved handlers.

Note, it is expected that *S-methoprene* is being routinely applied to surveillance larval traps as detailed in the *Medical Vectors* technical guidance. Supplies of *S-methoprene* are provided to public health units by NZ BioSecure who can also provide further information about use.

5.6.6 Cost recovery

Biosecurity Act 1993 s.122

In general, the costs for routine duties of public health staff are not recovered. There is no provision for a person directed under the Biosecurity Act 1993 to take action in response to a mosquito problem (such as eliminating or treating a habitat) to then charge the public health unit for any costs incurred in doing the work.

However, because this direction involves the exercise of a statutory power, it would be subject to judicial review if it had not been exercised properly. For example, if there was a lack of evidence of a mosquito problem requiring action or availability of alternative and less costly measures, then the direction could be challenged.

Biosecurity Act 1993 s.128(3)

Where a person fails to comply with a lawful direction or requirement under the Biosecurity Act 1993, and some action is required as a result of that failure, the CTO (Health) is able to recover the reasonable costs of that action.

PROCEDURE 5.7 PREPARING FOR AND RESPONDING TO PUBLIC HEALTH THREATS OF INTERNATIONAL CONCERN

5.7.0 Purpose

This procedure provides operational guidance and tools to assist in planning for and responding to public health threats of international concern at the border.

Drafting note: This is a new and large procedure. It is intended that the content will be populated to public health units through national training courses, exercises and other training opportunities. As this occurs we intend to update the procedure with helpful operational tips and may refine the content further.

5.7.1 Introduction

Risks to public health include the international spread of established infectious diseases, such as polio or Ebola virus disease, emerging infections, such as Middle East respiratory syndrome coronavirus (MERS-CoV), and other threats such as hazardous substances, radiation, vectors and other pests of public health significance.

The IHR (2005) specify a range of surveillance, risk assessment, response and reporting requirements for managing risks to public health at the community, national and international levels. Procedure 5.4 outlines the core capacities required at points of entry at all times and during an emergency. This procedure further develops the requirements in an emergency. Border responses may include both entry and exit measures.

Responding to Public Health Threats of International Concern at New Zealand Air and Sea Ports – Guidelines for public health units, border agencies and health service providers

Available at:
http://www.health.govt.nz/publication/responding-public-health-threats-international-concern

or

http://www.health.govt.nz/our-work/border-health/border-health-protection/border-health-measures

Guidance released by the Ministry of Health discusses the suite of interventions that could be implemented at the border in response to public health threats. The guidance describes each intervention, highlights the potential benefits and limitations/consequences, and identifies criteria for decisions on what border health intervention(s) to implement.

The interventions fall into three main groupings:

- measures at international air and sea ports including messaging, screening, travel restrictions, diversion of craft and border closures.
- measures to manage symptomatic and/or exposed international travellers:
- exit controls.

Ministry of Health will continue to provide national direction and instruction to public health units and border stakeholders on the implementation of border measures as it did to guide the border responses to Ebola and Zika in the last few years.

The health measures considered most viable for implementing at New Zealand international air and sea ports in response to public health threats may include:

- providing proactive public health advisories and alerts for travellers (and also on the Ministry of Foreign Affairs and Trade's Safe Travel website and the Ministry of Health's website)

- enabling traveller self-reporting
- providing passenger locator information to manage/monitor exposed travellers
- having a visible public health presence at international air and sea ports
- screening travellers from high-risk countries or with high-risk exposures to provide them with targeted advice
- using a range of platforms to communicate information effectively (electronic message boards, forms and handouts, targeting 'meeters and greeters', etc)
- providing landside monitoring and support to travellers, that is once they have been processed through passport and customs control.
- isolating symptomatic travellers
- offering treatment for symptomatic travellers
- tracing contacts
- conducting regular air and sea port workforce briefs (eg, personal protective equipment training).

These interventions are likely to be applied in combination depending on the public health threat being faced. It is important that any interventions taken against a public health threat are proportional to the level of risk, and take into account the potential health, social, and economic impacts of their implementation, along with the compliance costs to implement them.

Other measures may be appropriate in specific situations, and the Ministry of Health will provide recommendations and advice on a case-by-case basis.

The following sections provide further guidance and tools to plan for and respond to threats.

5.7.2 Public Health Emergency of International Concern

International Health Regulations 2005 Part II

International Health Regulations 2005 Annex 2

Serious public health events that endanger international public health may be determined under the IHR to be public health emergencies of international concern (PHEICs). This term is defined in the IHR (2005) as an extraordinary event which is determined:

- "to constitute a public health risk to other States through the international spread of disease; and
- to potentially require a coordinated international response".

This definition implies a situation:

- that is serious, unusual or unexpected
- that carries implications for public health beyond the affected State's national border, and
- where there is a significant risk of international travel or trade restrictions. Not all of these criteria need to apply at the same time.

The responsibility for determining whether an event is within this category lies with the WHO's Director-General and requires the convening of a committee of experts – the IHR Emergency Committee. This committee advises the Director-General on the recommended measures to be promulgated on an emergency basis, known as temporary recommendations. Temporary recommendations include health measures to be implemented by the country (known in the IHR as the State Party) experiencing the PHEIC, or by other countries, to prevent or reduce the international spread of disease and avoid unnecessary interference with

international travel and trade.

5.7.3 National IHR Focal Point (NFP)

A National IHR Focal Point (NFP) is a national centre, designated by each country, which is accessible at all times for communications with WHO IHR contact points. NFPs collate and disseminate information within their own countries and externally to WHO and other countries. Collectively, NFPs provide an international system for communication if a PHEIC is announced. NFPs are also used to communicate health information between countries even if a PHEIC has not been announced.

The New Zealand NFP is the Office of the Director of Public Health in the Ministry of Health. The Ministry may receive communication through the NFP which it will then disseminate to one or more public health units depending on the nature of the information. Public health units will not be communicating directly to NFP in other countries. The communication will always come through the New Zealand NFP.

On occasion a public health unit may have information that needs to be communicated to the New Zealand NFP or to the NFP in another country. Examples of common communications include requests for contact tracing, follow up on ship sanitation control measures, or to report a suspected emerging disease threat. If urgent or after hours contact 0800 GET MOH (0800 438 664). If not urgent and during working hours contact the relevant team in the Ministry of Health (usually the Communicable Diseases Team and/or Environmental and Border Health Team).

Appendix 35 describes the information that the Ministry of Health will need if an emerging disease threat be identified.

5.7.4 Travel advice, alerts, advisories, and communications to the health sector

Health advice for departing travellers

Public health units may occasionally respond to requests for health advice from persons travelling to other countries.

https://www.safetravel.govt.nz/health-and-travel

SafeTravel is the official site travellers departing NZ should go to for health advice. The Ministry of Health provides health information and alerts to SafeTravel.

Specific *travel alerts* may be issued for destinations where there may be potential public health risks such as occurred in 2016 with increased risk of Zika infections for those travelling to some Pacific Islands. The Ministry of Health will work with the Ministry of Foreign Affairs and Trade on travel alerts.

Formal Travel Advisories will only be used in situations of extreme threat (such as war or civil unrest) and will make it unlikely travellers will be able to obtain travel insurance to travel to the destination that is subject to the Travel Advisory. They are a final resort and would only be considered for a public health threat if WHO recommends against travel to an affected country. Travel Advisories will always be prepared by the Ministry of Health.

Public health units will be advised if travel alerts or advisories are issued and should disseminate the information to their contacts.

Health advice for arriving travellers

http://www.health.govt.nz/system/files/documents/pages/border-poster_1.pdf

http://www.health.govt.nz/our-work/border-health/health-advice-cards-people-arriving-new-zealand

Generic health messaging (posters and health advice cards) for arriving travellers has been developed by the Ministry of Health. Some international airports are also displaying electronic messaging. The generic messaging is considered business as usual and is expected to be displayed/available at all IHR-designated airports and busy international airports. Public health units are expected to work with the airports to ensure the messaging is in place and stocks of the health advice cards are maintained.

It is also recommended that signage and health advice cards are displayed at maritime ports receiving a high number of cruise ships during the cruise season.

A stock of cards should be held by public health units for use in an 'ill traveller response'. The cards can be given to travellers, who are not considered close contacts but who have travelled on the same craft. Health Advice Cards are in Appendix 36.

If a PHEIC is announced, public health units may be requested to distribute specific messages to border stakeholders and at the points of entry. This will need to be managed according to risk and developed protocols.

Health advice for health practitioners

The Ministry of Health will distribute advice from WHO to public health units. Public health units should keep health practitioners updated on any health risks for overseas travellers, particularly if outbreaks are occurring, and encourage health practitioners to contact them to report any suspected cases of infectious diseases in travellers. If notification is not mandated by law, the information may need to be anonymised if the patient has not given permission for their details to be provided to health authorities.

Health practitioners should also be reminded to implement appropriate infection prevention and control measures when treating a *symptomatic* traveller.

Public health units should distribute to health practitioners current WHO guidelines, or their national equivalents, on surveillance, infection prevention and control measures and clinical management of diseases of concern.

Public health units should ensure that information on how to obtain laboratory services and clinical referral is provided to health care providers and facilities. Where specialist laboratory services are necessary, such as off-shore the Ministry of Health will facilitate the access to these services.

A suspected or probable case may need to be isolated and safely transported to a receiving hospital for treatment. Contacts

5.7.5 Notification and response to ill travellers on aircraft

Aircraft have procedures and trained personnel on board to deal with suspected cases of communicable diseases, including respiratory illnesses, foodborne diseases, etc. The Captain of an aircraft arriving from overseas

is required to notify if passengers or crew on board the craft have "symptoms of concern".

The symptoms of concern are defined by the WHO and the International Civil Aviation Organization as a fever (temperature of 38°C or greater) associated with one or more of the following:

- appearing obviously unwell
- persistent coughing
- impaired breathing
- persistent diarrhoea
- persistent vomiting
- skin rash
- bruising or bleeding without previous injury
- confusion of recent onset.

An Ill Traveller Protocol is expected to be in place at every aviation point of entry that receives direct international arrivals. This includes regional airports that may only receive a small number of arrivals (private or charter flights). The Ill Traveller Protocol details the procedures for responding to the notification of symptoms of concern on board an aircraft.

Appendix 37 provides some resources that can be used to develop an Ill Traveller Protocol. This includes:

- Initial notification and risk assessment form
- Flow diagram of the process
- Contact details for key border stakeholders
- Summary of roles and responsibilities matrix.

Notification of Ill Travellers may occur at any time even if a PHEIC has not been announced. If public health unit staff are notified of an ill passenger or crew the Ill Traveller Protocol must be activated. The subsequent actions will be dependent on the public health risk assessment. In most situations the management of an Ill Traveller will **not** trigger the requirement for withholding pratique (ie, reasonable suspicion that a quarantinable disease risk exists on board the craft). The situation will be able to be managed using business as usual case management and contact tracing processes and ensuring effective communication between border agencies.

If the notification occurs during a PHEIC and the Ill Traveller/s have a history of travel to the affected region it is likely that the notification may be treated with a higher level of suspicion than usual. If the symptoms of concern and history obtained from the passenger provide a reasonable suspicion of a QUARANTINABLE disease risk, pratique should be withheld.

When pratique is withheld, the aircraft will need to be met on arrival. It is likely that the public health emergency contingency plan will also need to be activated. The public health contingency plan may also need to be activated if the Ill Traveller response is likely to demand significant resources (even if there is no current PHEIC). For example, if there is a large number of ill travellers/crew. Refer below for further information on public health emergency contingency plans. There are a range of legislative powers that are available to assist in managing the craft and passengers if needed (see section. Refer to Procedures 5.0 and 5.1 (aviation and maritime) for detail about pratique processes and available legislation).

The key components of an ill traveller response are:

- management of initial notification
- co-ordination and communication
- suspected case risk assessment and management
- contact tracing and management
- infection prevention and control and cleaning
- risk communication.

Ministry of Health. 2012. *Communicable Disease Control Manual*. Wellington: Ministry of Health.

In most Ill Traveller responses, business as usual processes for the follow up of notifiable diseases will be able to be applied (refer to Ministry of Health *Communicable Diseases Manual*). For information about contact tracing processes refer below.

Management of initial notification of an ill traveller

Initial notification will be received by the on-call health protection officer or medical officer of health – usually from Air Traffic Control but sometimes from the Ground Handler depending on the notification arrangements at the specific airport. Public health units should regularly confirm the notification process with border stakeholders.

Information that is needed to inform the initial risk assessment and response includes: the symptoms, in particular fever (at least 38°C), onset date of illness, and travel history in the previous 30 days. Any known risk factors are also helpful. Communication with the craft through Air Traffic Control is very limited and further information may need to be obtained when/if the Ill Traveller is assessed by ambulance staff on arrival. Refer to Ill Traveller Protocol Template (Appendix 37) for suggested initial notification form.

Although less common, notification of an Ill Traveller may sometimes be made by other order agencies such as New Zealand Customs, particularly if there is a PHEIC in place and there is heightened awareness of illness.

It is important to note the quarantine provisions of the Health Act 1956 will still apply while an ill traveller is located in the customs controlled area. Refer to Procedure 5.2 (Other Quarantine Provisions) for more information about liability to quarantine, as well as controls that are available under the Health Protection Amendment Act.

It is desirable for public heath staff to make their way to the airport when notified of an Ill Traveller, to ensure arrangements are in place and to provide advice and reassurance to border officials and point of entry staff who may be concerned about potential exposure risk. However, sometimes this is not possible, when there is short notice of the arrival.

Notification of ill travellers on board vessels

Usually there is more notice given with the notification of Ill Travellers on board vessels. In addition, large vessels are equipped with medical facilities and sometimes specialist medical staff. The maritime pratique procedures outlined in Procedure 5.1 should be followed along with business as usual processes for disease case management (see Ministry of Health *Communicable Diseases Control Manual*).

5.7.6 Public Health Emergency Contingency Plan

The Public Health Emergency Contingency Plan (PHECP) details the expected response to a public health risk at a maritime or aviation point of entry.

International Health Regulations 2005 Annex 1

The establishment and maintenance of a PHECP is one of the capacities required by the IHR (2005). The scope of the PHECP includes communicable diseases, chemical or radiological incidents and biological/biosecurity risks. In New Zealand, the focus of the PHECP is on a communicable disease event as the other responses are addressed as follows:

- chemical responses are to be led by Fire and Emergency NZ with support from public health (addressed though National Hazmat Emergency Response plan)
- radiological events are to be led by the Office of Radiation Safety (Ministry of Health) with support from National Centre for Radiation Science (ESR) (addressed though National Hazmat Emergency Response plan)
- biosecurity risks: are Ministry of Health led for organisms of public health significance, and MPI led for all other pests/vectors/fomites. Responsibility is addressed through biosecurity response procedures.

PHECPs are expected to be in place at all IHR-designated points of entry, and at points of entry that have large volumes of first porting passengers and/or high risk cargo. Public health units should work with border stakeholders to develop and maintain the PHECP. It should be reviewed annually and exercised every 1-2 years in part or full. Refer to Appendix 38 for recommended contents of PHECP. Examples of PHECPs developed for New Zealand aviation and maritime points of entry are available on EMIS.

The PHECP will be activated when a traveller arriving either by sea or air, is suspected of having a QUARANTINABLE disease, or when a PHEIC has been announced and enhanced border measures are being implemented. Refer to Appendix 39 for management of aircraft when pratique is withheld.

The sections below provide further guidance for processing inbound travellers.

5.7.7 Co-ordination and communication

Effective inter-agency co-ordination and communication are key to a timely and appropriate response. The Ill Traveller Protocol summarises the response process, key tasks of the various agencies, and includes the contact details of relevant agencies. The PHECP should describe the key roles and responsibilities of stakeholders (refer Appendix 38).

Public health unit staff have a responsibility to ensure all border agencies know and understand the processes and are aware of their expected roles and responsibilities, and that internally, public health unit staff understand and know what is required of them. Reminders at stakeholder meetings, debriefs of responses, desktop or full exercises and training are all opportunities for re-enforcing the process and roles.

Command and control arrangements, including the trigger and

arrangements for establishing an emergency operations centre, and confirmation of which agency will fill the Incident Controller role must be documented in the PHECP. It is generally expected that the Incident Controller will be someone very familiar with the airport facilities and operations. The medical officer of health or public health lead will provide leadership on public health matters and will work closely with the Incident Controller.

5.7.8 Point of entry screening

Targeted screening of travellers from high-risk countries (or with high-risk exposures) to provide them with specific advice may be implemented during a PHEIC, or in response to an emerging disease threat. Point of entry screening, managed by NZ Customs and public health units was implemented in New Zealand at all international airports in response to the 2014/2015 Ebola outbreak in West Africa.

Public health units would only undertake point of entry screening as directed by the Ministry of Health. The Ministry of Health would need to review recommendations from WHO before considering imposing additional point of entry screening measures. Countries that adopt measures that significantly interfere with international traffic (such as refusal of entry or departure of international travellers for more than 24 hours) may be required to provide WHO with the public health rationale and scientific information for their actions under the IHR (2005). Due to resource implications, it is unlikely that enhanced screening of **all** arriving craft and passengers would be implemented.

Screening aims to identify ill or potentially ill travellers at the point of entry before they enter the country. There are a number of ways that screening can be undertaken. These include screening on board conveyances, using health declaration forms, visual or temperature screening of travellers, or using a rapid laboratory investigation.

Point of entry screening is unlikely to be effective in detecting all cases of illness among travellers as some cases may be pre-symptomatic or asymptomatic, or some cases may attempt to disguise their symptoms. Point of entry screening can be extremely resource-intensive and will create significant delays for travellers and for transport operators. Similarly, thermal screening of passengers at points of entry is not recommended by the WHO, as it is very unlikely to detect anyone arriving with a disease of concern, because a traveller may be asymptomatic or pre-symptomatic.

Providing information to travellers, such as through border advisories or the health advice cards is considered more effective. However, low-level point of entry screening may provide reassurance that high-risk travellers are identified, while avoiding unnecessary travel delays.

http://www.customs.govt.nz/inprivate/onyourarrival/presentingdocuments/Pages/default.aspx

http://www.customs.govt.nz/news/resources/forms/Documents/Passenger%20Arrival%20Card%20English%20language%20version.pdf

If screening is to be implemented, the Ministry of Health will provide guidance on how to do so. It is likely that this would take the form of targeted questioning of travellers travelling from high risk countries following identification of such travel through Customs data or the Passenger Arrival Cards. This initial first screening step may be undertaken by other border agencies such as NZ Customs if this has been agreed nationally.

For more information about screening, refer to:

- Appendix 40 for a Point of Entry Screening Advice template for travellers about enhanced border measures
- Appendix 41 for Point of Entry Screening Questionnaire template
- Appendix 42 for the Health Risk Assessment form template.

The Screening Questionnaire includes a series of questions for travellers. If the traveller answers 'no' to all questions, they can be given the health advice card and reminded to seek medical attention if they develop symptoms of concern. If the traveller answers 'yes' to any of these questions, the traveller should be isolated for a more detailed health risk assessment by public health officers to determine whether they may pose a public health risk.

Note: if a traveller reports symptoms, they should be managed as a 'suspected case' until determined otherwise. Ensure that the patient is isolated and, if relevant for the disease of concern, is provided with a mask and other appropriate PPE. The interviewing officer may also need to wear appropriate PPE.

5.7.9 'Suspected case' management

If a suspected case is identified either through point of entry screening or following an Ill Traveller response the following must be undertaken.

If there is a reasonable suspicion that the ill traveller has a QUARANTINABLE disease pratique must be withheld and the craft met on arrival. The PHECP must be activated.

Ensure the patient is isolated and, if relevant for the disease of concern, is provided with a mask and other appropriate protection. The interviewing officer may also need to wear appropriate PPE.

Information that must be gathered and considered in the risk assessment of a suspected case includes:

- onset date of illness and symptoms, in particular fever (at least 38°C)
- any history of potential exposures during the incubation period
- confirm the travel history, exposure assessment and symptoms meet the current case definition for the disease of concern (if a PHEIC has been announced)
- complete a suspected case risk assessment form (Refer Appendix 43).

If the Ill Traveller meets the case definition, or the risk assessment indicates there is a public health risk that requires further management, the following actions should be taken:

- ensure the suspected case has been reported to the Ministry of Health National IHR Focal Point (refer Appendix 35). For any illness among arriving travellers, the National IHR Focal Point should be informed in case of the need to liaise with other country's National Focal Points or the WHO
- ensure transmission-based precautions are immediately implemented by border agencies including the appropriate use of PPE. PPE standards are assessed by each agency using their own protocols
- implement the PHECP to ensure the suspected case is safely transported to the appropriate hospital and facilitate medical assessment and diagnosis including relevant clinical testing

- assess any risk of transmission during the flight
- commence contact tracing (refer to section 5.7.10 below).

If not already provided, Ministry of Health can provide guidance on suspected/confirmed case definitions and follow-up required.

In managing the suspected case and contacts, legislative controls may be needed, including quarantine measures being applied to the craft and passengers (Refer to Procedure 5.2: Other Quarantine Provisions) for detail on these provisions, including standardised forms.

5.7.10 Contact tracing

Contact tracing is necessary for the prevention of onward transmission, awareness-raising and early detection of suspected cases. For some diseases of concern and many emerging diseases, there will not be specific treatment available, but supportive treatment increases survival chances, especially if applied early.

International Health Regulations 2005 Article 18 Paragraph 1.

The WHO and the Ministry of Health will provide disease specific guidance on case and contact definitions, and recommendations for contact tracing. Refer also to the Ministry of Health *Communicable Disease Control Manual*.

Ministry of Health. 2012. *Communicable Disease Control Manual*. Wellington: Ministry of Health.

Available at: https://www.iata.org/whatwedo/safety/health/Pages/locator-form.aspx

If pratique has been withheld contacts will be able to be identified directly from the aircraft seating. If Passenger Arrival Cards need to be retrospectively accessed follow the process for requesting this through NZ Customs. (Refer Appendix 10).

NZ Customs can facilitate requests to airlines for seating plans and spreadsheets. If required, International Air Transport Authority (IATA) has developed a Passenger Locator Form to be completed by contacts in flight or during disembarkation. IATA also has a form for national authorities to request contact lists from airlines, although this is not usually used in New Zealand due to our requests being made to NZ Customs.

Requests to airline agents for passenger details should be made using the agreed format using the following link: https://www.iata.org/whatwedo/safety/health/Documents/request-form-passenger-contact-tracing.pdf

Passengers and crew from the affected flight or vessel must be processed as quickly as possible. There is almost certain to be significant concern among passengers and crew. It is important for travellers to be given clear advice about the risk of contracting the disease and an opportunity for them to obtain information after they leave the point of entry.

For examples of standard communications messages including inflight messaging prior to passengers disembarking refer to the Risk Communication section, below (section 5.7.14).

The first step should be to identify direct contacts and classify them as high or low risk. (Refer Appendix 44).

Those passengers who are not considered to be low risk contacts can be provided with the Fact sheet for Casual Contacts and Non-contacts (refer Appendix 45).

Transmission on aircraft

The main route of transmission on flights is by direct contact with infectious body fluids (including respiratory droplets). For most diseases the duration of the flight should be taken into account, with long distance flights (8 hours or longer) being the greatest risk for respiratory disease transmission. Other relevant factors include:

- severity of symptoms of the ill passenger and details of any incidents resulting in contamination from body fluids (particularly blood, urine, faeces, vomit)
- use of facilities on the aircraft/vessel (or in the point of entry on arrival) if they are likely to have been contaminated by body fluids, as above
- seat location of symptomatic traveller
- nature of contact between symptomatic traveller and other travellers and crew.

Airborne transmission is not considered a significant risk on aircraft because of the aircraft ventilation and filtration systems. For this reason, contact tracing is usually only considered necessary for those passengers seated in the same row, two rows ahead and two rows behind. If other passengers or crew have had close or lengthy contact with the suspected case then they should also be included in contact tracing. In some situations, for example a new emerging disease threat, a precautionary approach will be taken and contact tracing will include all passengers and crew. Public health units should contact Ministry of Health at the time if they need guidance.

Transmission on vessels

Transmission of disease on vessels poses less urgent border health concerns because:

- of the duration of most voyages
- the vessel will provide a health status report some days or hours in advance of berthing, and
- a vessel will usually be able to safely anchor off-shore while arrangements are put in place to respond to any health issues on board.

Cruise vessels will have their own medical staff and medical facilities, with detailed procedures for responding to ill passengers or crew.

The public health officer should check arrangements for disembarking passengers and crew to assess whether they may be contacts or pre-symptomatic or asymptomatic cases.

The public health officer should check whether the vessel's doctor will be requiring additional medical supplies and/or access to laboratory tests or specialised medical advice, but may otherwise leave the vessel's medical staff to deal with ill travellers, providing the response is able to be managed with their resources and capability (eg, medical staff, facilities, etc).

Depending on the level of risk, the contact will be managed as follows:

- provided with a fact sheet and health advice card, and reminded to seek medical attention if they develop symptoms of concern.
- provided with advice and advised to contact a doctor or the public health

unit if symptoms develop
- provided with advice and requirements for additional controls which may include requirements for daily monitoring and reporting (see Appendix 46 for template) and restrictions of movement, including restrictions in onward travel. Refer section 5.7.13 Exit Measures for more information.

Depending on the nature of the disease, close contacts may be placed under voluntary or mandatory quarantine (termed surveillance in New Zealand legislation) until the incubation period has passed since their last high-risk contact. Refer to Procedure 5.2: Other Quarantine Provisions for relevant legislation and standardised forms.

For contacts who are asked to self-monitor their health the public health officer should provide the guidance and expectations including the 'measuring your temperature form' (see Appendix 47). Arrangements should be made to contact the person daily to monitor their health and provide any additional advice or support required.

For other resources refer to:
- Appendix 36 for an example of a health advice card
- Appendix 46 for an example of daily contact monitoring form
- Appendix 47 for an example of a 'measuring your temperature' form
- Appendix 45 for an example of factsheet for casual contacts (low risk or non-contacts)
- Appendix 48 for an example of factsheet for close contacts (high risk).

Sometimes one or more contacts will require monitoring and accommodation will need to be arranged. This may be because they do not have accommodation arranged or perhaps additional security or controls are deemed necessary. Refer to section 5.7.11 below on accommodation facilities for travellers under quarantine.

5.7.11 Travellers under quarantine

International Health Regulations 2005 Article 1

This refers to quarantine as defined in the IHR (2005) Article 1. This is the restriction of activities and/or separation of others from suspect persons who are not ill to prevent the possible spread of infection or contamination. In most cases the measures are likely to be voluntary, however there are provisions in the Health Act 1956 if mandatory measures are deemed necessary.

Quarantine measures can be applied to an initial suspected case or a contact of an initial suspected case, in a way that prevents the possible spread of infection or contamination (as opposed to isolation, which relates to people who are symptomatic). Quarantine may also include separating goods, aircraft, or ships for further examination or decontamination. Quarantine could be implemented at the traveller's home or in a facility (eg, a hospital or community building).

Options for the management of contacts of a case include:
- no quarantine (only focus on self-monitoring and reporting any illness in exposed travellers)
- quarantining close contacts of a probable or confirmed case
- quarantining close contacts of a suspect case
- quarantining all contacts of a probable or confirmed case

- quarantining all contacts of a suspect case.

Self-health monitoring and illness reporting is less resource intensive and should always be encouraged, as compared with formalised quarantine measures with movement restrictions. However, this option carries the risk of a traveller infecting or contaminating others before their symptoms begin. If this option is used, the risk could be mitigated by advising exposed travellers to minimise contact with others and to avoid gatherings and crowded areas for a period of time.

Formal quarantining of contacts may be useful in preventing the spread of disease or contamination. The challenge is in balancing expected public health benefits against the cost and consequences of such a measure. It is important to avoid unnecessarily quarantining large numbers of people who may only be a low risk, based on the assessment.

Quarantine should be voluntary to the greatest extent possible. Mandatory measures should only be instituted as a last resort, when voluntary measures cannot reasonably be expected to succeed and the failure to institute mandatory measures is likely to have a substantial impact on public health. Refer to Procedure 5.2 for detail about the legal framework for formal surveillance of persons liable to quarantine including template forms.

Control measures appropriate to each confinement context must be implemented to protect others from potential infection or contamination. Individuals should be confined in safe, habitable and humane conditions, including providing basic necessities and, if necessary, psychological support. Potential financial and employment consequences of confinement should be considered. The interests of household members of those under home quarantine should be protected, especially those at increased risk of illness (eg, immune-compromised family members). People who are quarantined should be monitored and offered medical treatment where appropriate.

Quarantining and self-monitoring/reporting can be used concurrently, according to the risk that the contacts have been infected or contaminated; with quarantining used for those at higher risk and self-monitoring/reporting used for those at lower risk.

Accommodation facilities for travellers under quarantine

International Health Regulations 2005 Annex 1B

The IHR (2005) specifically require that IHR-designated points of entry have the capacity to, if required, quarantine suspect travellers, preferably in facilities away from the point of entry.

Public health units are expected to work closely with DHB emergency planners to ensure there are arrangements in place for accommodating travellers under quarantine if required. While the IHR (2005) explicitly refers to the requirement for facilities for quarantine planning must also include ensuring facilities for the isolation of confirmed cases have also been identified.

It is also expected that consideration will have been given to accommodation for travellers in centres that receive direct international arrivals, but may not be an IHR-designated point of entry such as Napier

and Hamilton. The level of formality of arrangements should be consistent with the likelihood of requiring a facility. Memorandums of Understanding have been used previously in Auckland and Christchurch. Increasingly letters of agreement are being used to confirm arrangements including with smaller motel or serviced apartment providers to use one or two rooms as necessary.

The Tourism Industry Association, formally Hotel Council of New Zealand continues to be available to support engagement from members (motel and hotel providers) who are willing to provide facilities for travellers for quarantine purposes.

In addition to hotels and motels, potential facilities that could also be considered are DHB owned houses or accommodation and camping grounds and motorhomes.

If a facility is required by a public health unit to be used for the purposes of accommodating one or more travellers the costs for this facility and related services such as catering and entertainment (such as books, movies, internet) are expected to be met by the DHB.

5.7.12 Infection prevention and control

The health and safety of point of entry and airline/vessel staff is the responsibility of their respective employers in conjunction with the workplace health and safety authority. However, public health officers can give general advice about public health risks.

Guidance for Airline Cleaning Personnel

Airlines have the responsibility for cleaning their aircraft and dealing with contaminated items soiled with body fluids, and will have their own procedures. However, Appendix 49 provides guidance, including advice adapted from CDC guidelines, which may be helpful background for public health officers during discussions with airline and cleaning staff.

Cleaning Residually Treated (Disinsected) Aircraft

Schedule of Aircraft Disinsection Procedures for Flights into Australia and New Zealand V4.1 Feb 2017. *MPI*. Available at:

http://www.agriculture.gov.au/biosecurity/avm/aircraft/disinsection/procedures/schedule-aircraft-disinsection

Ministry for Primary Industries and the Australian Department of Agriculture have compiled a joint Schedule of Aircraft Disinsection that all airlines comply with when flying internationally into New Zealand or Australia. Both agencies manage the compliance of this process.

Following a residual spray application and where internal areas of aircraft receive additional or substantial cleaning to sections such as wall linings, carpets etc, then these areas must undergo a supplementary disinsection 'touch-up'. The touch-up may be from an aerosol spray containing permethrin.

For further information, refer to:

- Appendix 49: Cleaning advice for aircraft and baggage handlers
- Appendix 50: Process for cleaning residually treated (disinsected aircraft).

5.7.13 Exit measures

Exit measures include:

- health advice and alerts for travellers

- screening
- international travel advisories
- travel restrictions and potential border closures
- passenger locator information
- medical assessment
- isolation of symptomatic travellers
- treatment
- contact tracing
- self-health monitoring and illness reporting
- quarantine exposed travellers.

Triggers for exit measures

There are a number of situations where exit measures could be considered or applied. The most likely scenarios will be:

- when the PHEIC originates within New Zealand and/or WHO recommends exit measures for people leaving New Zealand (see below)
- when New Zealand receives a request from an overseas government to implement exit measures on ships and aircraft departing New Zealand for that specific country (the most likely cases for this will be requests from small Pacific nations, especially those where most of the air traffic is via New Zealand)
- when WHO issues a recommendation under the IHR (2005) that exit measures be implemented
- in relation to specific measures for travellers transiting through New Zealand
- when New Zealand implements advisory or voluntary exit measures (eg, travel advisories warning airlines, shipping agents and travellers against leaving New Zealand to travel to particular destinations).

Until recently, there was very limited information and evidence regarding specific exit measures. However, the 2014/15 Ebola virus disease epidemic in West Africa provided the opportunity for countries to exercise exit screening as a tool to prevent the international spread of the disease. Exit screening of high-risk contacts and/or symptomatic travellers at points of departure were reported to be effective in limiting the international spread of the disease.

Where possible, exit measures should be applied as early as possible. In some cases, this can be at the time of booking travel or before the person goes to the air/sea port (eg, issuing travel advisories to people recommending they do not travel at all or to given destinations). Exit measures should only be applied at the boarding gate/entry to the aircraft if absolutely necessary, given the costs involved and the disruption to travellers, airlines and airports.

The Ministry of Health considers that, in most cases, exit measures would be implemented only on the recommendation of the WHO or the request of the destination country and, in the latter case, exit measures are likely to be in combination with entry measures at the destination country.

The WHO may recommend that affected countries screen departing travellers. Exit screenings may be conducted at sea and/or airports to identify sick travellers or travellers who may have been exposed to the

disease or contaminant of concern and to delay them from boarding an airplane or ship until it is safe for them to travel. Exit screening might differ for each outbreak or contamination event, but may contain similar basic elements. These are as follows.

All travellers:

- have their temperature taken and/or other medical and/or contamination checks completed
- answer questions about their health and exposure history
- are visually assessed for signs of potential illness
- are required to produce evidence of vaccination or decontamination.

Travellers with symptoms or possible exposures are separated and assessed further. This assessment determines whether they should be:

- allowed to travel
- not allowed to travel on a commercial flight and referred to a public health authority for further evaluation
- not allowed to travel on a commercial flight until they demonstrate they have received an appropriate vaccination or decontamination.

Legislative controls

Health Act 1956 s.92

Ministry of Health. 2017. *Guidance on Infectious Disease Management under the Health Act 1956*. Wellington: Ministry of Health.

https://www.health.govt.nz/publication/guidance-infectious-disease-management-under-health-act-1956

Legislative controls are available, if needed to restrict cases or contacts (Health Act, s.92) provided the statutory preconditions for these are met. These include the issuing of public health directions to cases, directions to contacts, and if necessary applying for court orders or urgent public health orders. More detail on these is available in Procedure 5.2 (Other Quarantine Provisions) and in the *Guidance on Infectious Disease Management under the Health Act 1956.*

Health officials may work with Customs officials to place alerts on the passports of persons who are at particularly high risk and indicate they are intending to travel overseas.

Public health units are expected to have considered how exit measures would be implemented at points of exit if this was requested.

5.7.14 Risk communication

It is likely that there will be significant media interest in any event. Public health staff must refer any media enquiries to the appropriate sections or spokespeople according to local policies and protocols.

Good risk communication will be crucial in any point of entry health response. Communication will be required for affected passengers and crew, border agencies and ground handlers and other point of entry staff, health services and the media. For examples of standard communications messages including inflight messaging prior to passengers disembarking see Appendix 51.

Examples of possible general key messages are:

- It is very unlikely that *[New Zealand or Region]* will have a confirmed case of *[disease of concern]* because of our geographic isolation and the lack of direct flights from the affected countries. Additionally, the affected countries are not common destinations for [Pacific Island Country or Area] travellers.

- In the event that there was a case of *[disease of concern]* in *[New Zealand or Region]*, the risk of it spreading is extremely low.
- *[Insert key points about how the disease of concern is transmitted]*
- Local and international expert advice, together with international experience of managing other cases of *[disease of concern]*, is that the *[disease of concern]* would be well contained in countries with health services like ours.
- *[Insert key points from the WHO and country risk assessment*]
- The health sector is very familiar with controlling and managing cases of infectious diseases. If there was a suspected case of *[disease of concern],* the person would be treated in hospital isolation. Isolation facilities and existing infection control protocols in *[New Zealand or Region]* hospitals are adequate for treating an imported case. Given the serious nature of the disease, samples would be sent to a high security reference laboratory overseas.
- The Ministry of Health is closely monitoring the advice from, and actions being taken by, the World Health Organization and other countries in relation to the *[disease of concern]* outbreak in *[affected countries].*
- *[Insert key points from the WHO risk assessment about any travel measures or that travel measures are not recommended]*
- Thermal screening of passengers at points of entry is not recommended by the WHO. The World Health Organization considers thermal screening very unlikely to detect anyone arriving with *[disease of concern],* which has an incubation period of *[insert incubation period]* days and symptoms that are not specific.
- The Ministry has recently reminded border agencies of the protocols around dealing with ill travellers. Up-to-date clinical information on *[disease of concern]* has also been sent to health services and health professionals. This is something the Ministry does as required.
- Any response to national health emergencies is led by the Ministry of Health and involves all health services, which are familiar with the established protocols and processes in the national health emergency plan. There is an overarching framework for the health sector to work together to respond to any health emergencies.
- Advice to the public and health professionals is available on the Ministry's website – *[insert web link].* Up-to-date information for travellers is also available on the *[insert website]* website - *[insert web link].*

Health advice cards (Refer Appendix 36) can be given to people who have travelled on the same aircraft as a probable or confirmed case but who do not meet the definition of a close contact.

Refer Appendix 51 for example of standard messaging.

APPENDICES

APPENDIX 1: NO CHANGE OF HEALTH STATUS FORM

NO CHANGE OF HEALTH STATUS REPORT FOR HEALTH PRATIQUE

The Master must fill out this section and complete the form. This is a notice to confirm the health status aboard your vessel <u>following</u> your earlier "New Zealand Advance Notice of Arrival".

Please complete this form and send to the Port Health Authority (Public Health Service) between 12 – 24 hours of your arrival. Failure to provide this status report within the required time frame means the vessel will be liable to quarantine and must be met on arrival.

To: ……..Public Health Service
E-mail:
Fax:

From Vessel: **MV** _____
(Print Vessel's name)

Since sending my "New Zealand Advance Notice of Arrival" there has been: *(Tick the appropriate box)*

☐ **No change to the health status aboard my vessel** (Refer to health questions and Schedule in Maritime Declaration of Health)

☐ **A change to the health status** (Complete and attach Maritime Declaration of Health)

Signed: _____ **Master's Name** _____
(Print)

This Form must be sent from your vessel to the Port Health Authority no earlier than 24 hours and not later than 12 hours before arrival. The Port Health Authority will then send confirmation of the vessel Pratique status.

Agent's details *(pratique message will be copied to the agent):*

<u>Company name</u>: **<u>Fax</u>**:

<u>Agent's name</u>: **<u>Cell-phone</u>**:

<u>Email:</u>

APPENDIX 2: WRITTEN CERTIFICATE OF PRATIQUE

CERTIFICATE OF PRATIQUE

Under Section 107 of the Health Act 1956

*Airport/Port of ……..…..……

I hereby certify that the *ship/aircraft " ……."

……*Captain/Master

has this day been duly granted pratique.

Given under my hand, at ……a.m./p.m.

this…….. day of ……..……20……

……..
*Health Protection Officer/Medical Officer of Health

*Strike out that which does not apply

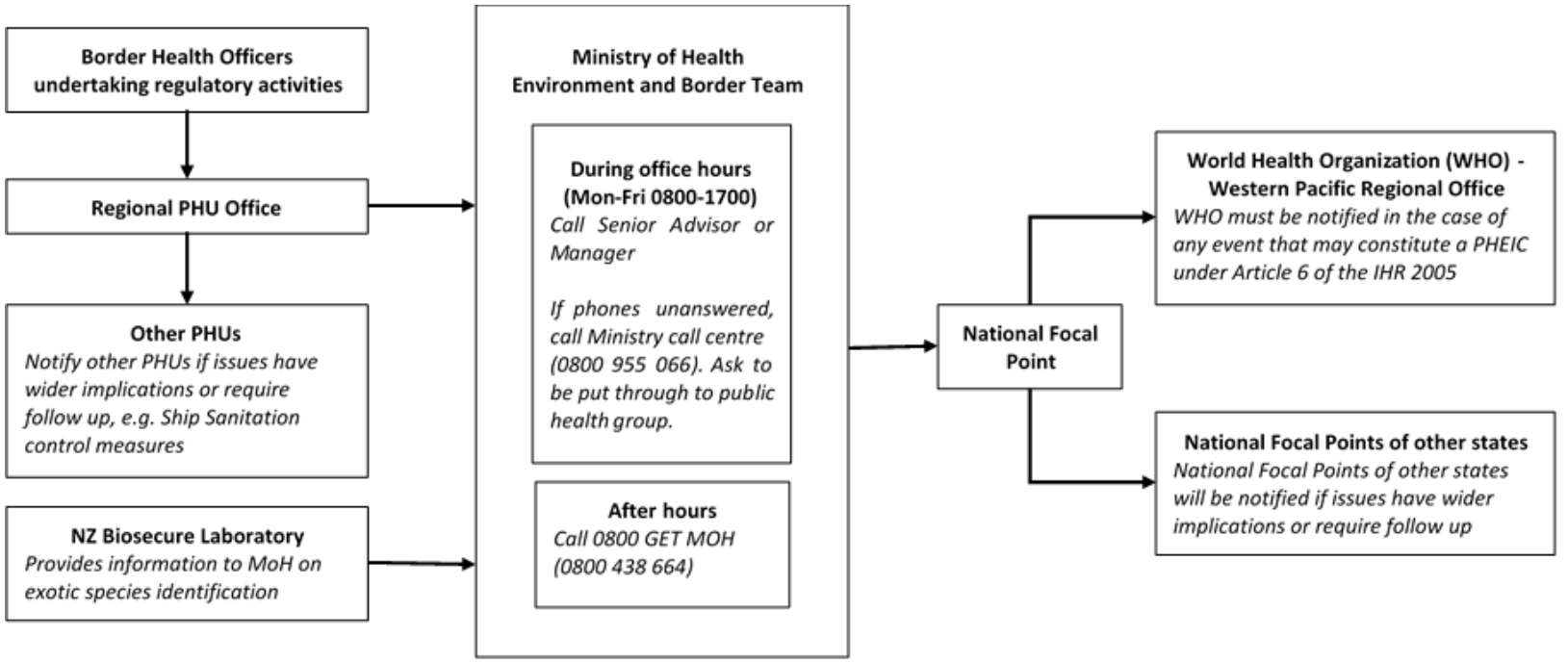
Extract from Health Act 1956

107. Grant of Pratique *– (1) Subject to the provisions of any regulations made under this Act, when the Medical Officer of Health or Inspector of Health is satisfied, with respect to any ship liable to quarantine, that no quarantinable disease exists on board the ship, he shall give the master of the ship a certificate of pratique in the prescribed form. (2) Subject to the provisions of any regulations made under this Act, when the Medical Officer of Health or Inspector of Health is satisfied, with respect to any aircraft liable to quarantine, that no quarantinable disease exists on board the aircraft, he shall give the pilot in command of the aircraft a certificate of pratique in the prescribed form.*

APPENDIX 3: QUARANTINE INSPECTION PLACES

Harbour	Place of Inspection
Auckland Harbour, Motuihe Channel	Within the area bounded by straight lines from the west point of Browns Island 008° to the shore of Rangitoto Island; then 083° to Emu Point, Motutapu Island; then 139° to the shore of Motuihe Island; then 232° to Musick Point; then to the south point of Browns Island; then by high water mark the shortest distance to the point of commencement.
Auckland Waitemata Harbour	In the navigable areas contained between a line drawn from the light on Orakei Wharf (occulting red every 6 seconds), 355° to North Head and a line drawn 035° from the head of Wynard Wharf to the light known as Bayswater light beacon (flashing red every 3 seconds). Anchorage number 10 is at position 36 42.0S 174 54.0E.
Bluff Harbour	In the open roadstead within the navigable area enclosed by a circle having a radius of 3 miles from the flagstaff on Stirling Point, or in any other position indicated by the Southland Harbour authorities on any occasion having regard to weather conditions.
Gisborne Harbour	In the anchorage position as marked on chart NZ5571 approximately 2 miles north of Young Nick's Head.
Lyttleton Harbour	In a position 2.4 miles northeast by north from Godley Head at 52° 33.0 minutes south and 172° 50.0 minutes east.
Napier Harbour	In a position with Westshore Light bearing 266° 5.35 miles.
Nelson Harbour	In a position with Boulder Bank Old Light House bearing 158° 2.05 miles.
Oamaru Harbour	In a position 2 miles distant from South Head light structure indicated by the intersection of South Head light structure 253° and the head of the Breakwater 263°.
Opua, Bay of Islands Harbour	In the navigable area off Russell, Bay of Islands, lying between Tapeka Point 090° and the southern extremity of Kororareka Point 090° and eastward of the dredged channel leading beacons
Otago Harbour	In a position with Taiaroa Head lighthouse bearing 160° 3.2 miles or in any other position indicated by the Otago Harbour authorities on any occasion having regard to weather conditions.
Picton Harbour	The area west of Mabel Island, taken from the western-most point: in a direction of 225° to the foreshore; in a direction of 347° for a distance of 2.65 cables (0265 miles), thence in a direction of 220.5° to the foreshore in Shakespeare Bay (as shown on charts NZ 6153 and NZ 6154) and applies to vessels of up to 120m in length.
Port Taranaki	In the open roadstead within the navigable area enclosed within the arc of a circle having a radius of 2 miles from the light tower on Mikotahi, or in such other position as may be indicated by the Taranaki Harbour authorities.
Taharoa Harbour	At the loading buoy at Taharoa in position latitude 38° 17'S, longitude 174 ° 500'E.
Tauranga Harbour	In a position 075° 3.25 miles from the Mount Maunganui main light (flashing every 15 seconds), that is in a position 37°36.8′S, 176°14.3′E.
Timaru Harbour	In a position with the Timaru Harbour Eastern Extension Light (flashing red every 5 seconds) bearing 300° 2.4 miles or in any other position indicated by the Timaru Harbour authorities on any occasion having regard to weather conditions.
Wanganui Harbour	In the open roadstead at a position with the signal station 031° in 18.3 metres of water at M.L.W.S., or any other position within a radius of 3 miles of the flagstaff indicated by the Wanganui Harbour authorities on any occasion having regard to weather conditions and vessel size (unable to accept vessels longer then 80m and with a draft of more than 4.5m).
Wellington Harbour	That area of the harbour contained within a circle of radius 0.2 miles having as its centre a point bearing 347° 0.56 miles from Point Jerningham Lighthouse or any other position within Wellington Harbour indicated by the Wellington Harbour authorities on any occasion having regard to weather conditions.
Whangarei Harbour	In the area marked Anchorage Area A, 1.5 miles south of Bream Head (as marked on chart NZ 5214) or in any other position indicated by the Whangarei Harbour authorities on any occasion having regard to weather conditions.

APPENDIX 4: POINTS OF CONTACT AND REPORTING FOR BORDER HEALTH



When and what to report to the Ministry of Health

Immediately – *if there is an immediate threat to public health (including a suspected quarantinable disease), or an intention to undertake enforcement action at the border, or any non-routine control measures applied to any craft. Notify the Ministry by phone call.*

Within two hours of notification – *for vector interception responses (including mosquitoes, rodents, other pests of public health significance). Notify the Ministry by phone call.*

As required – *when requested, eg, Ministry of Health Border Annual Returns.*

Use notifyenvhealth@moh.govt.nz for follow-up emails and situation reports – NOT URGENT NOTIFICATIONS.

APPENDIX 5: RESPONSE FORM

SUMMARY REPORT ON VECTOR INTERCEPTION RESPONSE (MOSQUITO/RODENT/OTHER)

This report summarises PHU response actions and control measures for a vector interception response. Submit following a confirmed exotic mosquito (Laboratory ID) or pest of public health significance interception ***within 24 hours of initial notification.***

Send to: *notifyenvhealth@moh.govt.nz*

Date/Time submitted: *xxxxxxxxxxxx*

Person Submitting Report*:* *xxxxxxxxxxxxxx*, Health Protection Officer

Organisation: *xxxxxxxxxxxxxxxx* Public Health Service

Appointment: Health Protection Officer/Biosecurity Authorised Person

Contact Tel Number: *XXXXXXXXX*

Findings ***(complete sections that apply)*** *Where information is not available or does not apply note this in the relevant space.*		
	Item	**Comments**
1	**Notification received from** Name and occupation Company/organisation Contact details	
2	**Details of vector discovered** Date/Time notified to PHU, Vector type (mosquito (adult, larva, pupae) or rodent Number. Dead or alive	
3	**Circumstance of discovery** Location (point of entry, transitional facility, craft, other) When & how found	
4	**Risk assessment** Craft arrival date into NZ Last port/s of call Origin and type of goods, owner of the goods, distribution Treatment Vector management activities (IPM, SSC) Current surveillance activity	
5	**Sample-collection and despatch** Date/Time collected/despatched, sample number	
6	**Laboratory initial identification** Date/Time	

7	**Delimit Survey-** Brief outline of your survey response Date/Time survey conducted (attach map/sketch) of interception site if possible Outline the survey area Findings from the survey Risk assessment outcome	
8	**PHU Actions** Enhanced surveillance/trapping (attach map or plan if available) Trapping Plan-locations Recommendations to site Consider management (including treatment) of goods, craft, port airport, wider area, surrounding area	
9	**MPI Actions** Name of treatment agent applied Other MPI controls implemented	
10	**Notifications (where relevant) – who and when** ☐ MoH Environmental and Border Team ☐ Own PHU staff ☐ MPI ☐ Port/Airport Authority ☐ Local Authority ☐ Other PHUs for follow-up	
Additional Comments		

APPENDIX 6: INTEGRATED PEST MANAGEMENT PLAN TEMPLATE

Integrated Pest Management Plan

___(insert name of vessel___

The core components of an integrated pest management plan are:

- identification
- preventative practices
- monitoring
- mechanical controls
- pesticides.

Identification

Identification refers to deciding which organisms are pests that must be controlled, and which are not. For example, mosquitoes must be controlled as they can spread serious infections and therefore present a significant health threat.

Identification should be conducted by <the shipping company> and communicated to all crews to ensure the scope is understood and the plan is conducted effectively.

Preventative Practices

For example:

- appropriate storage of garbage that may attract pests
- regular cleaning of the vessel
- removing standing water.

Monitoring

For example:

- regular inspections of areas likely to harbour pests
- encouraging crew to report sightings of pests.

Mechanical controls

For example:

- deployment of rat guards
- rat traps
- door and window screens.

Appropriate Pesticide Use

For example:

- rat poison
- insecticide sprays
- s-methoprene.

The <Chief Officer/master> will conduct <weekly> inspections of the ship and conduct a review of the measures taken. This will be recorded in the pest/vector log.

Area	Preventative Practices	Monitoring	Mechanical Controls	Appropriate Pesticide Use
Galley and Provisions store	e.g., cleaning up spilled food **Responsibility of:** Galley Staff	e.g., weekly inspection **Responsibility of:** master	e.g., deploying cockroach traps **Responsibility of:** Galley Staff	e.g., use of insecticides **Responsibility of:** Galley Staff
Crew Accommodation	e.g., garbage bins used and emptied regularly **Responsibility of:**	e.g., weekly inspection **Responsibility of:**	e.g., windows screened **Responsibility of:**	e.g., use of pesticides **Responsibility of:**
Holds	e.g., cleaning of holds Use of fumigants **Responsibility of:**	**Responsibility of:**	**Responsibility of:**	**Responsibility of:**
Deck and deck stores	**Responsibility of:**	**Responsibility of:**	**Responsibility of:**	**Responsibility of:**

Area	Preventative Practices	Monitoring	Mechanical Controls	Appropriate Pesticide Use
Mess Rooms	**Responsibility of:**	**Responsibility of:**	**Responsibility of:**	**Responsibility of:**
Offices	**Responsibility of:**	**Responsibility of:**	**Responsibility of:**	**Responsibility of:**
Bridge	**Responsibility of:**	**Responsibility of:**	**Responsibility of:**	**Responsibility of:**
Toilet/showers/laundry	**Responsibility of:**	**Responsibility of:**	**Responsibility of:**	**Responsibility of:**

Space for pest/vector log if no separate log exists e.g..:

Details of Inspection	Name & rank	Date

Plan signed off by Master, 1st officer, 2nd etc.

References:

WHO International Health Regulations 2005
WHO Medical Guide for Ships, Version 3. Chapter 29.
WHO Guide to Ship Sanitation, Third Edition, Version 10. October 2007

APPENDIX 7: SITUATION REPORT TEMPLATE FOR RESPONSE ON A SHIP

DISEASE OUTBREAK SITUATION REPORT – SHIP

To: notifyenvhealth@moh.govt.nz, notifycommdiseases@moh.govt.nz

Purpose of situation report: a summary report to Ministry of Health officials of disease outbreak investigations on ships for their information and action as indicated, for example, international notification.

Date/Time:
Officer Submitting Report:
Public Health Unit: **Contact Phone No:**
Sitrep No.

Serial	Item	Remarks
1	Name of Ship	
2	Last port of Call	
3	Next Port of Call and ETA	
4	Date Outbreak Detected	
5	Total Number of Cases to date	Passengers Crew
6	Current Number of Cases	Passengers Crew
7	Samples taken? Cases requiring medical attention?	
8	Causative organism (Presumptive or confirmed)	
9	Actions taken to contain outbreak	
10	PHU actions • Ship visit • Controls assessed • Additional controls required • Ship sanitation certificate updated • Complete reports e.g., Episurv	
11	Further actions required? Notify Next Port of Call	
12	PHU support required?	
13	Media interest (if any)	
14	Additional comments	
15	Recommendations	

APPENDIX 8: CLEANSING ORDER TEMPLATE

ORDER TO CLEANSE, FUMIGATE, DISINFECT OR TREAT A SHIP

(Under Regulation 18 of the Health (Quarantine) Regulations 1983)

To: …….captain of ……..[*name of ship*]

In my opinion the above-mentioned ship is in an insanitary condition (or in a condition favourable to the outbreak or spread of a notifiable infectious disease). Pursuant to section 110 of the Health Act 1956, I hereby order that the ship be taken to ……. and there to be [*specify in detail process of cleansing, fumigation, disinsection or treatment*]:

……

……

within ……..….[*state time within which work shall be done]* after the date of this order.

I hereby notify that such work shall be carried out under my supervision and to my satisfaction.

Dated at…….. this …….. day of…….20…

……

Medical Officer of Health / Health Protection Officer

APPENDIX 9: AUTHORISATION FORM

MINISTRY OF HEALTH
MANATU HAUORA

Authorisation by Medical Officer of Health

Pursuant to section 97A of the Health Act 1956, I authorise

_____ of

(insert person's name)

_____

(insert name of agency)

for the purposes of section 97A of the Health Act 1956 to:

(a) require people liable to quarantine to comply with directions, requirements or conditions given, made, or imposed by the authorised person; and

(b) require people liable to quarantine to give any information that the authorised person believes on reasonable grounds is necessary to enable the management of risks to public health.

Dated this _____ day of _____(insert month/year).

_____ _____

Name of medical officer of health Signed:

_____ Public Health Unit

Explanatory note

This form has been developed by the Ministry of Health for District Health Board public health units. It is a procedural tool that medical officers of health may elect to use to authorise suitable persons (such as health protection officers) to use certain powers under section 97A of the Health Act 1956 in relation to persons liable to quarantine (namely, requiring persons to comply with direction or to provide information necessary to manage public health risks).

The text of section 97A is provided below.

Health Act 1956 - S97A People liable to quarantine to comply with directions and supply information

(1) A person who is liable to quarantine—

(a) must comply with all directions, requirements, or conditions given, made, or imposed by the medical officer of health or a person authorised by the medical officer of health under this Part; and

(b) must, on request by the medical officer of health or a person authorised by the medical officer of health, give any information the officer believes on reasonable grounds to be necessary to enable the management of risks to public health.

(2) In the case of people arriving in New Zealand by craft, the medical officer of health or a person authorised by the medical officer of health may request information under subsection (1)(b) by requiring the person appearing to the officer to be in charge of the craft to collect or supply some or all of it—

(a) by requiring the person to distribute and collect cards or forms for passengers and crew to fill in; or

(b) in any other reasonable manner the officer may require.

(3) A person required under subsection (2) to collect or supply information must take all reasonably practicable steps to do so promptly.

(4) For the purposes of subsection (1)(b), the information that may be requested from a person includes—

(a) his or her name; and

(b) his or her recent travel history; and

(c) his or her recent activities; and

(d) his or her previous and present addresses, and proposed routes, destinations, and addresses; and

(e) his or her movements during the 14 days before his or her arrival; and

(f) whether he or she is experiencing or has recently experienced particular symptoms.

(5) Subsection (2) does not limit subsection (1).

(6) The medical officer of health or a person authorised by the medical officer of health may obtain from the department of State responsible for keeping it (and the department may supply to the medical officer of health or a health protection officer) any information about a person who is liable to quarantine that the officer believes on reasonable grounds to be necessary to obtain in order to trace the person's movements or discover the contacts the person has had with other people.

(7) Subsection (1)(b) does not limit the generality of subsection (1)(a).

APPENDIX 10: PROCESS FOR OBTAINING ARRIVAL AND DEPARTURE CARDS

Process for obtaining passenger arrival and departure cards for health purposes.

Guidance for Public Health Units (PHUs), May 2017.

For passenger information from flights that have arrived or departed in the previous 24 hours.

Source: NZ Customs at point of entry (cards held at airports/ports for 24 hours following arrival or departure). Access for PHUs: request directly from NZ Customs at local Airport.

Airport	**NZ Customs contact numbers**	
Auckland	(09) 275 0842 (09) 255 6697	Control Room Control Room
Wellington	(04) 901 4805	Control Room
Christchurch	(03) 363 4601 029 239 7906	Control Room Team Leader on call
Queenstown	(03) 441 4357	Control Room
Dunedin	(03) 486 1172	Control Room
Regional airports and ports	Use operational contacts	

For passenger information from flights that have arrived or departed more than 24 hours previously.

Source: NZ Customs at point of entry, or Statistics New Zealand
Access for PHUs: check with local NZ Customs staff if arrival cards are still at point of entry. If yes access as above.
If the cards are no longer being held by NZ Customs the PHU must request access to the cards through the Ministry of Health. Ministry of Health will then facilitate the card request through NZ Customs Integrated Targeting and Operations Centre (ITOC) and Statistics NZ.

During business hours Ministry of Health contacts are:

Sally Giles ☎ *04 816 4470* *021 921 220* *E-mail: sally_giles@moh.govt.nz*

Sally Gilbert ☎ *04 816 4345* *021 369 764* *E-mail: sally_gilbert@moh.govt.nz*

After Hours contact the Ministry of Health (0800 GET MOH) and select 2 for Environmental Health.

APPENDIX 11: DETENTION OF CRAFT AND PERSONS FORM

MINISTRY OF HEALTH
MANATU HAUORA

DETENTION OF CRAFT AND PERSONS

(pursuant to Section 97B of the Health Act 1956)

In accordance with section 97B of the Health Act 1956, it appears that during the voyage to New Zealand of:

_____ _____

(insert craft name, flight number/IMO number) (insert pilot or captain's name)

- a person has died or become ill from a quarantinable disease while on board the craft; or
- death, not attributable to poison or other measures for destruction, has occurred among birds, insects or rodents on the craft.

(delete that which is not applicable)

I therefore direct the craft and the crew and passengers to be detained for inspection until such time as written notice is given under the Health Act 1956 that the detention has been lifted.

Dated this _____ day of _____ (insert month/year) at _____hours

_____ _____

Name of Medical Officer of Health/ Signed:

Health Protection Officer

(*delete that which does not apply*)

_____ Public Health Unit

CC Shipping Agent
Airport or Port Authority

Explanatory note

This form has been developed by the Ministry of Health for District Health Board public health units. It is a procedural tool that medical officers of health or health protection officers may elect to use when using certain powers under section 97B of the Health Act 1956 (namely, directing that arriving craft and passenger and crew be detained for inspection in certain circumstances).

Allowing the craft to leave the airport or port before such detention has been lifted by written notice (under s 97C) is an offence under the Health Act 1956.

The text of section 97B is provided below.

Health Act 1956 – 97B Detention of craft and people

(1) The medical officer of health, a health protection officer, or a person acting under the written directions of the medical officer of health or a health protection officer, may direct that a craft and its passengers and crew be detained for inspection if—

(a) the craft has arrived in New Zealand; and

(b) it appears to the officer that, during the voyage of the craft,—

(i) a person on it has died, or become ill, from a quarantinable disease; or

(ii) death not attributable to poison or other measures for destruction has occurred among birds, insects, or rodents on the craft.

(2) The medical officer of health or health protection officer must tell the person in charge of the airport or port concerned of any direction he or she gives under subsection (1); and that person must not allow the craft concerned to leave the airport or port until given written notice under section 97C of the lifting of the detention of the craft.

APPENDIX 12: LIFTING OF DETENTION FORM

MINISTRY OF HEALTH
MANATU HAUORA

Lifting of Detention of Craft

(pursuant to section 97C of the Health Act 1956)

To _____ (being the person in charge of this port of entry).
(insert name of person in charge)

I hereby certify that the craft identified as

_____
(insert craft name, flight number/IMO number)

Piloted or captained by:

_____
(insert pilot or captain's name)

and the crew and passengers thereon, are no longer detained under section 97B of the Health Act 1956.

Dated this _____ day of _____(insert month/year) at _____hours

_____ _____

Name of Medical Officer of Health/ Signed:

Health Protection Officer

(*delete that which does not apply*)

_____ Public Health Unit

CC Shipping Agent
Airline agent

Explanatory note

This form has been developed by the Ministry of Health for District Health Board public health units. It is a procedural tool that medical officers of health or health protection officers may elect to use when lifting the detention of a craft that has been detained for inspection.
The text of section 97C is provided below.

Health Act 1956 – 97C Lifting of detention of craft

The detention of a craft under section 97B ceases when the medical officer of health or a health protection officer gives the person in charge of the airport or port written notice to that effect.

APPENDIX 13: DETENTION UNDER SURVEILLANCE FORM

MINISTRY OF HEALTH
MANATU HAUORA

Detention under Surveillance of Person Liable to Quarantine

(under sections 97(2) and 97E(3) of the Health Act 1956)

Name:	
Date of birth	
Passport number:	
Who arrived on flight/vessel number:	
Date:	

The medical officer of health believes or suspects on reasonable grounds that you (details stated above) are:

- infected with a quarantinable disease, or
- have been exposed to a quarantinable disease in the 14 days before arriving in New Zealand.

Under section 97E(3)(a) of the Health Act 1956 you will be placed under the restrictions of quarantine.

You will be removed to a hospital or other suitable place and detained under surveillance until a medical officer of health or health protection officer is satisfied that you are not infected with the disease concerned, or are not able to pass that disease on to other people.

If requested you must provide all information that is reasonably required to enable the management of public health risks.

You will be removed to (insert name and address of hospital or other suitable place):

_____

for a period of up to 28 days from the date of issue of this detention (with a review after 14 days).
.

_____ _____

Name of Medical Officer of Health / Signed:

Health Protection Officer

(*delete that which does not apply*)

_____ Public Health Unit

Dated this _____ day of _____ (insert month/year) at _____hours

Explanatory note

This form has been developed by the Ministry of Health for District Health Board public health units. It is a procedural tool that medical officers of health or health protection officers may elect to use to detain a person, who is liable to quarantine, at a hospital or other suitable place under surveillance (under section 97E(3)(a) of the Health Act 1956). To use this power a medical officer of health must believe or suspect on reasonable grounds that the person concerned is infected with a quarantinable disease, or has been exposed to one within 14 days prior to their arrival in New Zealand.

Health Act 1956 - 97 People liable to quarantine

(1) A person is liable to quarantine if he or she is on board, or disembarks from, a craft that is liable to quarantine.

(2) This subsection applies to a person liable to quarantine if the medical officer of health believes or suspects, on reasonable grounds,—

(a) that he or she is infected with a quarantinable disease; or

(b) that, within the 14 days before he or she arrived in New Zealand, he or she has been exposed to a disease that (whether or not it was a quarantinable disease at the time of the believed or suspected exposure) is a quarantinable disease.

97E Surveillance of certain people liable to quarantine

(1) This subsection applies to a person if—

(a) section 97(2) applies to him or her; or

(b) he or she is liable to quarantine and has been quarantined under section 70(1)(f).

(2) A person to whom subsection (1) applies must (whether or not he or she is detained under subsection (3)(a) or kept under surveillance at large under subsection (3)(b)) give to the medical officer of health all information he or she reasonably requires to enable the management of risks to public health.

(3) The medical officer of health or a health protection officer may cause a person to whom subsection (1) applies—

(a) to be removed to a hospital or other suitable place and detained under surveillance until the medical officer of health or a health protection officer is satisfied that he or she—

(i) is not infected with the disease concerned; or

(ii) is not able to pass that disease on; or

(b) to be kept under surveillance at large.

(4) Detention under subsection (3)(a)—

(a) must not continue for more than 28 days; and

(b) must not continue for more than 14 days unless the medical officer of health or a health protection officer has considered the latest information available on the disease concerned, and is satisfied that the person is infected with it and still likely to be able to pass it on.

(5) Before being placed under surveillance at large, a person must give an undertaking, in a form prescribed by regulations made under this Act, that he or she will report to the medical officer of health or a medical practitioner at the times and places required.

(6) While kept under surveillance at large, a person must—

(a) present himself or herself for and submit to any medical examination or testing required by the medical officer of health in whose district he or she may be:

(b) give to the medical officer of health all information he or she reasonably requires to enable the management of risks to public health:

(c) if instructed to do so by the medical officer of health, do either or both of the following:

(i) report on arrival in any district to the medical officer of health or to a medical practitioner nominated by the medical officer of health:

(ii) report in person daily or at stated intervals to the medical officer of health or a medical practitioner nominated by the medical officer of health:

(c) if he or she leaves for another place, tell the medical officer of health, or the medical practitioner nominated by the medical officer of health, and give details of the address to which he or she is going.

APPENDIX 14: LIFTING OF DETENTION FORM UNDER SURVEILLANCE

MINISTRY OF HEALTH
MANATU HAUORA

Lifting of Detention Under Surveillance or Surveillance at Large

Name:	
Date of birth	
Passport number	
Who was placed under detention or surveillance at large on (date):	

I hereby certify that on this date: _____

you _____(insert name) are now released from quarantine and are no longer required to remain under detention or surveillance at large pursuant to section 97E(3) of the Health Act 1956.

_____ _____

Name of Medical Officer of Health/ Signed:

Health Protection Officer

(*delete that which does not apply*)

_____ Public Health Unit

Explanatory note

This form has been developed by the Ministry of Health for District Health Board public health units. It is a procedural tool that medical officers of health or health protection officers may elect to use to discharge a person from

being detained under surveillance at a hospital or other place under section 97E(3)(a) of the Health Act 1956, or

being under surveillance at large under section 97E(3)(b) of the Health Act 1956.

APPENDIX 15: FORM TO ASSIST OBTAINING AN UNDERTAKING

MINISTRY OF HEALTH
MANATU HAUORA

Undertaking of Person Placed Under Surveillance At Large

(under section 97E(5) of the Health Act 1956)

Name:	
Date of birth	
Passport number:	

Having arrived on the ship/aircraft …….

and being liable to quarantine under the Health Act 1956, I undertake, if released under medical surveillance, to report to the medical officer of health or a medical practitioner nominated by the medical officer of health at the times and places required.

Date/ time to report	Place to report	Name of person to report to

My contact details during the next ____ days are as follows:

Address: _____

Phone: _____

Email: _____

Signature of person released …….. Date …….

Explanatory note

This form has been developed by the Ministry of Health for District Health Board public health units. Section 97E(5) requires that before being placed under surveillance at large, a person must give an undertaking in a form prescribed by regulations.

The undertaking involves the person agreeing that they will report to the health authorities as required. Failure to comply with sections 97E(5) or (6) are offences under the Act.

Before a person is placed under surveillance at large, a medical officer of health must believe or suspect on reasonable grounds that the person concerned is infected with a quarantinable disease, or has been exposed to one within 14 days prior to their arrival in New Zealand.

97E Surveillance of certain people liable to quarantine

(1) This subsection applies to a person if—

(a) section 97(2) applies to him or her; or

(b) he or she is liable to quarantine and has been quarantined under section 70(1)(f).

(2) A person to whom subsection (1) applies must (whether or not he or she is detained under subsection (3)(a) or kept under surveillance at large under subsection (3)(b)) give to the medical officer of health all information he or she reasonably requires to enable the management of risks to public health.

(3) The medical officer of health or a health protection officer may cause a person to whom subsection (1) applies—

(a) to be removed to a hospital or other suitable place and detained under surveillance until the medical officer of health or a health protection officer is satisfied that he or she—

(i) is not infected with the disease concerned; or

(ii) is not able to pass that disease on; or

(b) to be kept under surveillance at large.

(4) Detention under subsection (3)(a)—

(a) must not continue for more than 28 days; and

(b) must not continue for more than 14 days unless the medical officer of health or a health protection officer has considered the latest information available on the disease concerned, and is satisfied that the person is infected with it and still likely to be able to pass it on.

(5) Before being placed under surveillance at large, a person must give an undertaking, in a form prescribed by regulations made under this Act, that he or she will report to the medical officer of health or a medical practitioner at the times and places required.

(6) While kept under surveillance at large, a person must—

(a) present himself or herself for and submit to any medical examination or testing required by the medical officer of health in whose district he or she may be:

(b) give to the medical officer of health all information he or she reasonably requires to enable the management of risks to public health:

(c) if instructed to do so by the medical officer of health, do either or both of the following:

(i) report on arrival in any district to the medical officer of health or to a medical practitioner nominated by the medical officer of health:

(ii) report in person daily or at stated intervals to the medical officer of health or a medical practitioner nominated by the medical officer of health:

if he or she leaves for another place, tell the medical officer of health, or the medical practitioner nominated by the medical officer of health, and give details of the address to which he or she is going.

APPENDIX 16: SURVEILLANCE ORDER FORM

MINISTRY OF HEALTH
MANATU HAUORA

Surveillance Order at Large for Person Liable to Quarantine

(under section 97E(3)(b) of the Health Act 1956)

Name:	
Date of birth:	
Passport number:	
Who arrived on flight/vessel number:	
Date of arrival in NZ:	

The medical officer of health believes or suspects on reasonable grounds that you (details stated above) are:

- infected with a quarantinable disease, or
- have been exposed to a quarantinable disease in the 14 days before arriving in New Zealand (section 97(2) of the Health Act 1956).

Under section 97E(3)(b) of the Health Act 1956, you are to be kept under surveillance at large. You may be required to:

- Present for, and undergo, a medical examination or testing;
- Provide all information that is reasonably required to enable the management of public health risks;
- Report to a medical officer or health or a medical practitioner on arrival and/or daily or at regular intervals as stated below;
- Tell a medical officer of health or medical practitioner if you leave for another place and give address details of the place.

Requirements while under surveillance at large to be noted here:

_____ _____

Name of Medical Officer of Health/ Signed:

Health Protection Officer

(*delete that which does not apply*)

_____ Public Health Unit

Dated this _____ day of _____ (insert month/year) at _____hours

Explanatory note

This form has been developed by the Ministry of Health for District Health Board public health units. It is a procedural tool that medical officers of health or health protection officers may elect to use to detain a person, who is liable to quarantine, under surveillance at large (under section 97E(3)(b) of the Health Act 1956). To use this power a medical officer of health must believe or suspect on reasonable grounds that the person concerned is infected with a quarantinable disease, or has been exposed to one within 14 days prior to their arrival in New Zealand.

97E Surveillance of certain people liable to quarantine

(1) This subsection applies to a person if—

(a) section 97(2) applies to him or her; or

(b) he or she is liable to quarantine and has been quarantined under section 70(1)(f).

(2) A person to whom subsection (1) applies must (whether or not he or she is detained under subsection (3)(a) or kept under surveillance at large under subsection (3)(b)) give to the medical officer of health all information he or she reasonably requires to enable the management of risks to public health.

(3) The medical officer of health or a health protection officer may cause a person to whom subsection (1) applies—

(a) to be removed to a hospital or other suitable place and detained under surveillance until the medical officer of health or a health protection officer is satisfied that he or she—

(i) is not infected with the disease concerned; or

(ii) is not able to pass that disease on; or

(b) to be kept under surveillance at large.

(4) Detention under subsection (3)(a)—

(a) must not continue for more than 28 days; and

(b) must not continue for more than 14 days unless the medical officer of health or a health protection officer has considered the latest information available on the disease concerned, and is satisfied that the person is infected with it and still likely to be able to pass it on.

(5) Before being placed under surveillance at large, a person must give an undertaking, in a form prescribed by regulations made under this Act, that he or she will report to the medical officer of health or a medical practitioner at the times and places required.

(6) While kept under surveillance at large, a person must—

(a) present himself or herself for and submit to any medical examination or testing required by the medical officer of health in whose district he or she may be:

(b) give to the medical officer of health all information he or she reasonably requires to enable the management of risks to public health:

(c) if instructed to do so by the medical officer of health, do either or both of the following:

(i) report on arrival in any district to the medical officer of health or to a medical practitioner nominated by the medical officer of health:

(ii) report in person daily or at stated intervals to the medical officer of health or a medical practitioner nominated by the medical officer of health:

(d) if he or she leaves for another place, tell the medical officer of health, or the medical practitioner nominated by the medical officer of health, and give details of the address to which he or she is going.

APPENDIX 17: COMMON HAZARDS AT SEAPORTS

The maritime industry is a hazardous environment whether ashore or on board a vessel. Officials should be prepared to identify and deal with risks associated with these industrial sites. All PHU staff working at ports must ensure that they complete the relevant health and safety induction for their port.

Staff awareness of hazards in the dock area is a key component of such procedures.

Dockside the hazards include:

- mechanical handling equipment
- trip hazards (rail lines, slot drains, gully traps, sumps, dunnage etc)
- cargo stacks
- service vehicles.

On board the vessel staff will need to maintain vigilance and constantly look out for:

- wet and slippery decks, companionways and ladders
- moving machinery
- cargo loading or discharge
- unstable cargo or stores
- high voltage wiring
- hot surfaces (galleys and engine rooms)
- moving lifts, cranes and forklifts (both on the vessel and on the dockside)
- working fans and fan blades
- dangerous goods
- low overhead clearances
- gangways
- closed compartments (freezers – cold stores).

Line Hazards

Ship lines, winch lines, and crane lines are to be treated with the utmost caution. Staff should at all times ensure that they do not place themselves between objects being moved or secured by lines and the winding engine. Tidal movement and cargo discharge or loading will affect ship lines.

Buddy Awareness

If there are two or more officials then the “Buddy System” should be adopted whereby the staff team up and ensure their co-workers are safe and accounted for at all times.

APPENDIX 18: RECOMMENDED EQUIPMENT LIST

Equipment Checklist

The table below details a suggested list of items that HPOs might have for the conduct of a SSC inspection. The list is not exhaustive and there may be other items required.

Serial	Type	Item	Remarks
1	Admin & documentation to be carried	Blank SSC forms Port pass HPO warrant of appointment Photo ID Check list WHO SSC Handbook Blank directive forms Health Act 1956 Health (Quarantine) Regulations	A true copy of the MoH template Valid Valid Current For inspection
2	Personal Clothing to be worn or to be available	Hard hat High visibility jacket/vest and overalls Safety shoes Wet weather gear Gloves Hearing protection	
3	Equipment to be carried	Back pack and/or belt bag Torch Cell phone with translation app SSC stamp Notepad Aerosol of insecticide Specimen sample tubes (larvae/insects) Collection dipper Camera (or Smart phone) First aid kit Talcum powder	For carrying equipment so HPO can operate hands free
4	Equipment to be accessible (located in HPO's vehicle)	Hazard lights Pest control products Sampling kit (H2O) H2O sample bottles	On vehicle In vehicle – for display *Bti* Pyrethroid residual insecticide S methoprene

APPENDIX 19: SHIP SANITATION INSPECTIONS TEMPLATE

MINISTRY OF HEALTH
MANATU HAUORA

Name of vessel	
Type of Vessel	
Date of inspection	

Checklist for Ship Sanitation Inspections undertaken in New Zealand

Vessel documentation to be sighted and reviewed		
Document	**What to check**	**Sighted/Comments**
Current or expiring SSC	*Any evidence of problems, any outstanding control measures not completed*	Yes / No
Maritime Declaration of Health (if not seen already)	*No cases of illness* *All Health Questions answered*	Yes / No
Medical Log and vaccination list	*Indication of illness of public health concern e.g., gastro outbreak* ***(ref 5.6.1 (no log)*** *Galley staff unwell while working* ***(ref 2.1.2)***	Yes / No
Garbage Management Plan (required for vessels >400tonnes or 15 or more persons on board)	*Specific crew are designated to deal with waste* ***(ref 7.2.1 (no plan))*** *All crew have signed to say they are trained* ***(ref 7.3.1)***	Yes / No
Garbage Record book (required for vessels >400tonnes or 15 or more persons on board)	*Waste is being disposed of regularly. No build up.* ***(ref 7.1.1 (no log)*** *Waste is disposed of appropriately* ***(ref 7.11.1)***	Yes / No
International Sewage Pollution Prevention Certificate (ISPPC)	*Certificate expiry date (less than 5 years old)* ***(ref 10.1.1)***	Yes / No
Cargo Declaration and Ship's Stores Declaration	*Useful information to inform risk assessment pre-vessel inspection*	Yes / No
Potable water analysis reports/records	*FAC test results is applicable* *E coli (0 E coli per 100ml water* ***(ref 9.1.1 (no analysis))***	Yes / No
Integrated Pest Management plan and records	*Pest sighting logs, treatment records* ***(ref 13.1.2 (No IPM))*** *Regular inspections to confirm vessel is in insanitary condition*	Yes / No
Temperature records (food) (see page 53)	*Food is stored at safe temperatures* ***(ref 2.5.1)***	Yes / No
Ship's log/ Sanitary Inspection (smaller vessels only)	*May include inspections of galley, stores and accommodation*	Yes / No
Comments:		

Note: Refer the WHO Handbook for Inspection of Ships and Issuance of Ship Sanitation Certificates when detail on the Handbook Codes is required. Guide for indicators for issuing controls at back of checklist.

Area 2 - Galley Pantry	
Key IHR Criteria	**Comments/Observations**
☐ *In good repair* ☐ *Vector/reservoir-free* ☐ *Good food storage/safety practices* ☐ *Toilet, hand washing & drying facilities for food handlers* ☐ *Temp controls within acceptable limits (pg 53 Handbook)* ☐ *Good personal hygiene practices of staff* ☐ *Clean and tidy* ☐ *Waste management practices good*	

Area 3 - Stores	
Key IHR Criteria	**Comments/Observations**
☐ *In good repair* ☐ *Clean and tidy* ☐ *Vector/reservoir-free* ☐ *Good food storage/safety practices* ☐ *Temp controls within acceptable limits (pg 53 Handbook)* ☐ *Separate storage of chemicals*	

Area 5 - Medical Facilities	
Key IHR Criteria	**Comments/Observations**
☐ *Dedicated room/area* ☐ *In good repair* ☐ *Clean and Tidy* ☐ *Toilets and hand washing facilities* ☐ *Vector/reservoir-free* ☐ *Documented medical log* ☐ *Designated crew member* ☐ *Medicines on board to control public health risks* ☐ *Sharps container and medical waste management*	

Area 1 - Quarters	
Key IHR Criteria	**Comments/Observations**
☐ *Toilet facilities provided* ☐ *Hand washing and drying facilities* ☐ *Acceptable cleanliness* ☐ *Vector/Reservoir-free*	

Area 8 - Engine Room	
Key IHR Criteria	**Comments/Observations**
☐ *Clean and tidy* ☐ *Vector/reservoir-free*	

Area 9 - Potable Water	
Key IHR Criteria	**Comments/Observations**
☐ *System for providing potable water* ☐ *Disinfection process* ☐ *Potable water provided where required for human consumption* ☐ *Safe bunkering procedures* ☐ *Filling hoses in sanitary condition* ☐ *Backflow preventers in place* ☐ *Hot water system above 65C*	

Area 10 - Sewage	
Key IHR Criteria	**Comments/Observations**
☐ *No spills, leaks, blockages, cross connection* ☐ *Sewage holding tank required for all vessels >400 tonnes or with >15 persons on board* ☐ *Treatment system operational (if installed)* ☐ *No unpermitted discharges*	

Area 7 - Solid and Medical Waste	
Key IHR Criteria	**Comments/Observations**
☐ *Practices and processes for managing & disposing of waste* ☐ *Waste containers intact, tightly covered* ☐ *Vector/reservoir-free* ☐ *Designated haz sub storage area*	

Area 12 - Cargo Holds	
Key IHR Criteria	**Comments/Observations**
☐ *Vector/reservoir-free* ☐ *Nil cross contamination of cargo*	

Area 13 - Other Systems and Areas	
Key IHR Criteria	**Comments/Observations**
☐ *Rat guards in place* ☐ *Deck including storage area (bosuns store, forepeak, afterpeak) has no standing water or evidence of vectors.*	

(refer WHO Handbook for code areas and control measures to quote)

Other	
Key IHR Criteria	**Comments/Observations**
Area 4 – Childcare facilities – refer to Handbook Area 6 – Swimming pools – refer to Handbook	

General Additional Notes

Date of SSC Inspection/Certificate Issued	
Evidence Report Form Issued	
Next Port follow-up inspection required If YES notify the PHU asap	
Name of HPO	
HPO Signature	

Indicators for considering controls (guidance only)

Area 1 - Quarters

Indicators for considering controls (refer IHR Handbook for code areas and control measures to quote):

- Toilet or hand washing facilities not available or not operational (1.1.6, 1.2.1, 1.2.2)
- Significant vector infestation (1.1.9, 1.3.1, 1.3.7)
- Cases of illness or disease outbreak on board **and** lack of adequate hand washing/drying facilities **and/or** no cleaning programme **and/or** vector infestation (1.2.1, 1.2.2, 1.3.1, 1.3.7)

Area 2 - Galley Pantry

Indicators for considering controls (refer IHR Handbook for code areas and control measures to quote):

- Facilities in very poor repair (2.3)
- Hand washing in galley absent (2.2.1)
- Significant vector infestation (2.7.7, 2.7.8)
- Cases of illness or disease outbreak on board **and** inadequate cleaning (2.7.5) **and/or** poor food hygiene practices (2.4, 2.5) **and/or** personal hygiene practices (2.6.1) **and/or** sick food handlers working (2.6.2) **and/or** inadequately equipped hand washing in galley (2.2.1)

Area 3 - Stores

Indicators for considering controls (refer IHR Handbook for code areas and control measures to quote):

- Facilities in very poor repair (3.1.1, 3.1.2)
- Significant vector infestation (3.2.3, 3.4.4)
- Significant and widespread poor food storage/safety practices (3.2.1, 3.2.2, 3.3.1, 3.4.1, 3.4.3, 3.4.5, 3.4.6, 3.5.1)
- Cases of illness or disease outbreak on board and poor food storage/safety practices (3.2.1, 3.2.2, 3.3.1, 3.4.1, 3.4.3, 3.4.5, 3.4.6, 3.5.1)

Area 5 - Medical Facilities

Indicators for considering controls (refer IHR Handbook for code areas and control measures to quote):

- Cases of illness or disease outbreak on board and insanitary facilities/practices in medical facility/room (5.2.1, 5.2.2, 5.2.3)
- Cases of illness or disease outbreak on board and no medical log being kept (5.6.1)
- No designated crew member or medical doctor (required if >100 PAX for international voyage for >3 days) (5.5.1, 5.5.2, 5.5.3).

Area 7 - Solid and Medical Waste

Indicators for considering controls (refer IHR Handbook for code areas and control measures to quote):

- Significant vector infestation & no garbage management records (7.1.1, 7.2.1)
- Significant vector infestation & poor garbage management practices (7.4.1, 7.4.2, 7.4.3, 7.4.5, 7.4.6, 7.10.5, 7.10.6)
- Cases of illness or disease outbreak on board and poor management of medical waste (7.5.1, 7.5.2, 7.5.3, 7.5.4, 7.5.6, 7.5.7, 7.5.9, 7.7.3, 7.8.4, 7.8.6, 7.8.8, 7.9.1, 7.9.5, 7.9.9)

Area 8 - Engine Room

Indicators for considering controls (refer IHR Handbook for code areas and control measures to quote):

- Significant vector infestation (8.2.1)

Area 9 - Potable Water

Indicators for considering controls (refer IHR Handbook for code areas and control measures to quote):

- No supply of potable water (9.2.3)
- Analysis reports indicate evidence of contamination and no evidence controls implemented
- Possible waterborne illness on board and lack of potable water (inadequate treatment, contaminated supply) (9.1, 9.3, 9.4, 9.5, 9.6, 9.7, 9.8, 9.9, 9.2.2)
- Insanitary practices and engineering (9.5, 9.9, 9.10, 9.13, 9.14, 9.15, 9.16, 9.17, 9.18)
- Absence of legionella controls (9.12.4, 9.14.5)

Area 10 - Sewage

Indicators for considering controls (refer IHR Handbook for code areas and control measures to quote):

- Untreated sewage has been discharged into port basin (10.11.1)
- ISPPC is not available (10.10.1)
- Insanitary conditions on board due to poorly operated sewage system (10.4.3, 10.7, 10.8, 10.9, 10.10, 10.11, 10.12, 10.13)

Area 12 - Cargo Holds

Indicators for considering controls (refer IHR Handbook for code areas and control measures to quote):

- Evidence or vectors or reservoirs (12.2.2, 12.3.2, 12.6.2)

Area 13 - Other Systems and Areas

Indicators for considering controls (refer IHR handbook for code areas and control measures to quote):

- Evidence of live vectors and harbourage conditions (standing water, nesting) (13.2.2).

APPENDIX 20: SSC INSPECTION VECTOR GUIDANCE

INTEGRATED PEST MANAGEMENT (IPM)

Item	Remarks/Requirements
IPM Plan to be documented	Every ship must have a documented IPM Plan that documents effective monitoring and control strategies for pests. If the ship has no documented IPM this should be recorded on the SSC/Evidence Report Form at the time of inspection. A copy of the template IPM (Appendix 6) can be provided to the ship's master and agent to use.
IPM – what to check	Insects, rodents, and other pests are effectively controlled to minimise their presence in the food storage, preparation, and service areas.
	Areas of harbourage for pests/vectors/rodents have been eliminated
	Incoming shipments of food and supplies are routinely inspected for evidence of insects, rodents, and other pests.
	Entry points where rodents may enter the vessel are protected.
	Records of sanitary checks, inspections, reports of sightings or infestations and treatment (if applicable).
	When trapping has been implemented dead or trapped insects, rodents, and other pests must be removed from control devices and the vessel at a frequency that prevents their accumulation or decomposition, or the attraction of pests.

VECTOR DETECTION – checking for rodents

Item	Remarks/Requirements
Places to inspect	Inspect spaces listed on the SSC systematically. Note that a sample of crew and officer accommodation are to be inspected as representative of all such accommodation. Particularly check for rodent evidence in mooring ropes, galleys and food stores. The holds are best inspected when empty as this enables the inspector to observe all concealed niches and grain residues. Accommodation and food stores should normally be examined before the holds because they are 'clean' areas. Rat or mouse droppings are usually found in hidden places in galleys, storerooms, food handling rooms, refuse storage areas and deck stores.
Aids to Identification	Rat marks are dark greasy smears resulting from contact with the dirty fur of the rodent. They should be looked for in runways, especially on deckhead pipes and on the underside of deck beams. The marks are sometimes difficult to detect and on old ships usually indicate a long-standing infestation. Talcum powder may be laid in runways, near doors, around food stores, in galleys or kitchens and near garbage bins to aid the identification of the presence of rats. The powder should be laid in the evening and inspected the next morning for marks left by tails and feet of rodents.
Harbourage sites	Harbourage sites for rodents and opportunities for gnawing may be limited in ships of modern construction, but should be drawn to the attention of the ship's master if found.
Levels of infestation	Usually it is not possible to confirm actual numbers of rodents however a relative measure of the level of infestation can be determined. Methods which can be used are: • identification of rat signs • actual observation or visual sightings

	• census of food consumption. Indications of infestation levels will determine the action required by the MOH or HPO. For example, a light infestation may be dealt with by baiting or trapping, while a high or heavy infestation will require fumigation of the ship. Factors such as the general level of ship sanitation and type of cargo carried will need to be taken into account. Light infestation: A single rat sighting or small infestation present might indicate that the infestation is new or only recent. The presence of droppings, smear marks, urine, gnawings, footprints, especially on overhead girders, tail marks, nests and food caches indicate a larger infestation. It may be difficult to see rats during the daytime and more likely at night using a torch. A dead rat that shows no signs of having been bitten (since rats may eat corpses where there is a high infestation and no other food source is available) could be indicative of light infestation. The rat may have died through poisoning or disease. Heavy infestation: The presence of all rat signs mentioned above along with the sighting of rats during the daytime indicates a large infestation. As a guide if one rat is seen there may be ten rats or more in the area. The sighting of rats during daytime is dependent on activity on the vessel and a tendency for rats to come out when disturbed. Estimations of rodent population should not be made while cargo unloading is taking place. The bodies of rats that have just died may be examined for the presence of bites from other rats.

VECTOR DETECTION – checking for larvae and mosquitoes

Item	Remarks/Requirements
Places to inspect	Check for and inspect standing water commonly found on decks and lifeboats but may also be seen elsewhere. It is not expected that cargo will need to be inspected. This is the role of MPI. However be aware of the nature of cargo carried and any increased mosquito risks. Check common indoor areas and cabins for any potential breeding receptacles such as pot plants.
Aids to Identification	Take samples of any larvae or adult mosquitos found during the inspection. Photos taken of samples can be sent to NZ BioSecure during the inspection for preliminary identification. Activate an interception response for all first porting ships. Check medical log for illness reported consistent with suspected arboviral diseases.
Harbourage sites	Breeding habitats or standing water may be limited in ships of modern construction, but should be drawn to the attention of the ship's master if found.

APPENDIX 21: SAMPLES OF COMPLETED SSCEC, SSCC AND ERF

NEW ZEALAND SHIP SANITATION CONTROL EXEMPTION CERTIFICATE/ ~~SHIP SANITATION CONTROL CERTIFICATE~~

MINISTRY OF HEALTH
MANATŪ HAUORA

Port of Wellington Date 5 May 2016

This certificate records the inspection and **(1)** exemption from control or ~~(2) control measures applied~~.

Name of ship or vessel MV Brown Owl Flag Panama ~~Registration~~ / IMO no. 9455373

At the time of inspection the holds were ~~unladen~~/laden with 15600 tonnes of containerised cargo.

Name and organisation of inspecting officer Sally Giles, Regional Public Health

1. Ship sanitation control exemption certificate

Areas (systems and services inspected)	Evidence found (1)	Sample results (2)	Documents reviewed
Galley	None	None	Temperature and cleaning records
Pantry	None	None	Temperature and cleaning records
Stores	None	None	Temperature and cleaning records.
Hold(s) / cargo	Not inspected	None	None
Quarters			
Crew	None	None	sanitary inspection 10g
Officers	None	None	None
Passengers	None	None	None
Deck	NA	NA	NA
Potable water	None	Yes	Analysis reports water management plan

Indicate when the areas listed are not applicable by marking N/A.

2. ~~Ship sanitation control certificate~~

Control measures applied	Re-inspection date	Comments regarding conditions found

PTO to complete

Areas (systems and services inspected)	Evidence found (1)	Sample results (2)	Documents reviewed
Sewage	None	NO	ISSP - International Sewage Pollution Prevention
Ballast tanks	Assessed by MPI		None
Solid and medical waste	None	NO	Garbage Management Plan
Standing water	None	NO	Sanitary Inspection Log
Engine room	None	NO	None
Medical facilities	See attachment	NO.	Medical log
Other areas specified – see attached	NA	NA	NA

Control measures applied	Re-inspection date	Comments regarding conditions found

No evidence found. Ship/vessel is exempted from control measures.

~~Control measures indicated were applied on the date below.~~

Name and designation of issuing officer

Sally Gates, Health Protection Officer

Signature and seal

MINISTRY OF HEALTH
MANATŪ HAUORA
Port of Wellington
Date 5 May 2016
Signature

Date (dd/mm/yyyy)

0	5	0	5	2	0	1	6

(1) (a) Evidence of infection or contamination, including vectors in all stages of growth; animal reservoirs for vectors; rodents or other species that could carry human disease, microbiological, chemical and other risks to human health; signs of insanitary measures.
(b) Information concerning any human cases (to be included in the Maritime Declaration of Health).

(2) Results from samples taken on board. Analysis to be provided to the ship's master by the most expedient means and, if re-inspection is required, to the next appropriate point of call coinciding with the re-inspection date specified in this certificate.

Sanitation Control Exemption Certificates and Sanitation Control Certificates are valid for a maximum of six months, but the validity period may be extended by one month if inspection cannot be carried out at the port and there is no evidence of infection or contamination.

Attachment rendered (tick applicable box)

☑ Yes ☐ No

HP 6233
October 2015

Sample 2

SHIP SANITATION INSPECTION EVIDENCE REPORT FORM

MINISTRY OF HEALTH
MANATŪ HAUORA

This form supports the ship sanitation certificate (SSC) and provides a list of evidence found and control measures to be performed.
When attached to the SSC, each page needs to be signed, stamped and dated by the competent authority.
If this document is used as an attachment to a pre-existing SSC, this attachment must be noted on the SSC (eg, by using a stamp).

Name of ship or IMO number or registration: MV Brown Owl IMO 9455373.

Name and signature of the responsible onboard ship officer: Vladamir Yuritov

Name of issuing authority: Ministry of Health, New Zealand

Actual inspection date (dd/mm/yyyy): 05052016

SSC issued at the port of: Wellington

Date of referred SSC (dd/mm/yyyy): 05052016

Indicate areas that **have not** been inspected:

- [ ] Quarters
- [ ] Medical care facilities
- [ ] Potable water
- [ ] Other (laundry, lifeboats, etc)
- [ ] Galley, pantry, service area
- [x] Swimming pools/spas
- [ ] Sewage
- [ ] Stores
- [ ] Solid and medical waste
- [x] Ballast water
- [x] Childcare facilities
- [ ] Engine room
- [x] Cargo holds

Detected health events on board: [ ] Yes [x] No

Area code	Evidence found (brief description according to WHO checklist)	Measure to be applied	Required	Recommended	Measure successfully performed (stamp and signature of reinspecting authority)
3.2.1	Blood spillage onto floor of Chiller 2 from stored meats.	Clean Chiller 2	[x]	[ ]	

Name (issuing inspector): Sally Giles

Signature (issuing inspector):

Stamp (issuing inspector): MINISTRY OF HEALTH MANATŪ HAUORA Port of Wellington. Date 5/5/2016 Signature

Page 1 of 1

Area code	Evidence found (brief description according to WHO checklist)	Measure to be applied	Required	Recommended	Measure successfully performed (stamp and signature of reinspecting authority)
5.3.2	Expired medicines found in medical chest.	Remove and replace all expired medicines	☐	☑	
5.2.3	Absence of sharps container in medical room	Provide UN certified sharps container.	☐	☑	
			☐	☐	
			☐	☐	

MINISTRY OF HEALTH
MANATŪ HAUORA
Port of Wellington

Name (issuing inspector)	Signature (issuing inspector)	Stamp / Date (issuing inspector)	Page
Sally Giles		Date 5/5/2018	Page 2 of 2
		Signature	

HP 6231
October 2015

Areas (systems and services inspected)	Evidence found (1)	Sample results (2)	Documents reviewed	Control measures applied	Re-inspection date	Comments regarding conditions found
Sewage	None	None	ISPP	None	None	None
Ballast tanks	Not inspected	None	None	None	None	None.
Solid and medical waste	None	None	Garbage management Plan.	None	None	None.
Standing water	Yes - see evidence report form	Results pending.	Sanitary inspection log.	Yes - see (13.2.1) evidence report form.	10 May 2016	Larvae found in standing water on deck.
Engine room	None	None	None.	None	None	None
Medical facilities	Yes - see evidence report form.	None.	Medical log, Medicines inventory	Yes - See evidence report form( )	10 May 2016.	Crew returning to work before symptom free for 24hr.
Other areas specified – see attached	None	None	None	None	None	None

~~No evidence found. Ship/vessel is exempted from control measures.~~

Control measures indicated were applied on the date below.

Name and designation of issuing officer

Sally Giles, Health Protection Officer

MINISTRY OF HEALTH
MANATŪ HAUORA
Port of Wellington.
Date 5 May 2016
Signature

Signature and seal

Date (dd/mm/yyyy)

0	5	0	5	2	0	1	6

(1) (a) Evidence of infection or contamination, including vectors in all stages of growth; animal reservoirs for vectors; rodents or other species that could carry human disease, microbiological, chemical and other risks to human health; signs of insanitary measures.
(b) Information concerning any human cases (to be included in the Maritime Declaration of Health).

(2) Results from samples taken on board. Analysis to be provided to the ship's master by the most expedient means and, if re-inspection is required, to the next appropriate point of call coinciding with the re-inspection date specified in this certificate.

Sanitation Control Exemption Certificates and Sanitation Control Certificates are valid for a maximum of six months, but the validity period may be extended by one month if inspection cannot be carried out at the port and there is no evidence of infection or contamination.

Attachment rendered (tick applicable box)

☑ Yes ☐ No

HP 6233
October 2015

SEE ATTACHMENT
A document has been attached to this certificate by the Competent Authority at the Port of:
Wellington NZ
The attachment consists of 2 pages
Date & Signature: 5/5/2016
NZ MINISTRY OF HEALTH

NEW ZEALAND ~~SHIP SANITATION CONTROL EXEMPTION CERTIFICATE~~/ SHIP SANITATION CONTROL CERTIFICATE

MINISTRY OF HEALTH
MANATU HAUORA

Port of Wellington Date 5 May 2016

This certificate records the inspection and ~~(1) exemption from control or~~ (2) control measures applied.

Name of ship or vessel MV Brown Owl Flag Panama ~~Registration~~ / IMO no 9455373

At the time of inspection the holds were ~~unladen~~/laden with 15600 tonnes of containerised cargo.

Name and organisation of inspecting officer Sally Giles Regional Public Health

~~1. Ship sanitation control exemption certificate~~

Areas (systems and services inspected)	Evidence found (1)	Sample results (2)	Documents reviewed
Galley	Yes - See evidence report form	Temps O.K	Food Safety Plan
Pantry	None	Temps O.K.	Cleaning log
Stores	None	None.	Ships stores Declaration
Hold(s) / cargo	None - partially inspected	None	None
Quarters	None	None	Sanitary inspection log.
Crew	None	None	Sanitary inspection log
Officers	None	None	Sanitary inspection log.
Passengers	N/A	NIA	NIA
Deck	None	None	Sanitary inspection log.
Potable water	Yes - see evidence report	None	Microbiological results

Indicate when the areas listed are not applicable by marking N/A.

2. Ship sanitation control certificate

Control measures applied	Re-inspection date	Comments regarding conditions found
Yes - See evidence report form (2.1.3) (2.1.2)	10 May 2016	Significant cockroach infestation
None	None	None
None	None	None
None	None	None
None	None	None
None	None	None
None	None	None
NIA	NIA	NIA.
None	None	None
Yes - See evidence report form (9.19.2)	10 May 2016	Unsafe water sourced, Gastro outbreak in crew

PTO to complete

Sample 3

SHIP SANITATION INSPECTION EVIDENCE REPORT FORM

MINISTRY OF HEALTH
MANATŪ HAUORA

This form supports the ship sanitation certificate (SSC) and provides a list of evidence found and control measures to be performed.
When attached to the SSC, each page needs to be signed, stamped and dated by the competent authority.
If this document is used as an attachment to a pre-existing SSC, this attachment must be noted on the SSC (eg, by using a stamp).

Name of ship or IMO number or registration: MV Brown Owl.

Name and signature of the responsible onboard ship officer: Vladamir Yurtov

Name of issuing authority: Ministry of Health, New Zealand.

Actual inspection date (dd/mm/yyyy): 05052016

SSC issued at the port of: Wellington

Date of referred SSC (dd/mm/yyyy): 05052016

Indicate areas that **have not** been inspected:

- ☐ Quarters
- ☐ Medical care facilities
- ☐ Potable water
- ☐ Other (laundry, lifeboats, etc)
- ☐ Galley, pantry, service area
- ☑ Swimming pools/spas
- ☐ Sewage
- ☐ Stores
- ☐ Solid and medical waste
- ☑ Ballast water
- ☑ Childcare facilities
- ☐ Engine room
- ☑ Cargo holds

Detected health events on board: ☑ Yes ☐ No

Area code	Evidence found (brief description according to WHO checklist)	Measure to be applied	Required	Recommended	Measure successfully performed (stamp and signature of reinspecting authority)
2.1.2	Medical logs indicate crew with diarrhoeal illness returned to work before being symptom free for a minimum of 48hrs.	Food handlers or galley staff with gastro-intestinal illness must not perform any food related work until symptom free for a minimum of 48hrs.	☑	☐	MINISTRY OF HEALTH MANATŪ HAUORA Port of Wellington

Name (issuing inspector): Sally Giles

Signature (issuing inspector): SG

Stamp (issuing inspector) Date 5 May 2016 Signature SG

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Area code	Evidence found (brief description according to WHO checklist)	Measure to be applied	Required	Recommended	Measure successfully performed (stamp and signature of reinspecting authority)
2.1.3.	Insanitary condition of galley. Cockroach infestation in galley.	Develop and implement policies for hygiene, cleaning and maintenance procedures.	☑	☐	
9.19.2	water has been bunkered from unsafe sources	Test for micro-organism contamination.	☑	☐	
13.2.1.	Evidence of live vectors or their larvae	Eliminate standing water and apply vector control measures	☑	☐	
			☐	☐	

Name (issuing inspector)	Signature (issuing inspector)	Stamp (issuing inspector)	Page
Sally Giles		Date 5 May 2016 Signature	2 of 2

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APPENDIX 22: DUTIES AND RESPONSIBLITIES OF BORDER AGENCIES

Role	Primary Agency	Supporting Agencies
Monitor baggage, cargo, containers, conveyances, goods, postal parcels and human remains departing and arriving from affected areas, so that they are maintained in such a condition that they are free of sources of infection or contamination, including vectors and reservoirs	Ministry for Primary Industries	• NZ Customs Service (illicit and prohibited goods) • Environmental Protection Authority (hazardous substances) • Ministry of Health Office of Radiation Safety (ionising radiation sources) • DHB public health units (public health risks)
Ensure facilities used by travellers are maintained in a sanitary condition and are kept free of sources of infection or contamination, including vectors and reservoirs	Port and airport companies	• Territorial authorities (insanitary or hazardous buildings, registered premises, nuisance complaints) • DHB public health units
Supervise any deratting, disinfection, disinsection or decontamination of baggage, conveyances, goods, postal parcels and human remains or sanitary measures for persons	Ministry for Primary Industries	• DHB public health units (conveyances except for aircraft disinsection, sanitary measures for persons) • Ministry of Health Office of Radiation Safety (ionising radiation sources and contaminated articles)
Advise conveyance operators of intent to apply control measures including written information concerning methods to be employed	Ministry for Primary Industries	• DHB public health units (conveyances other than aircraft disinsection, sanitary measures for persons) • Ministry of Health Office of Radiation Safety (ionising radiation sources and contaminated articles)
Supervise removal and safe disposal of any contaminated food, water, human or animal waste wastewater and any other contaminated matter from a conveyance	Ministry for Primary Industries	
Monitor and control discharge by ship of sewage, refuse, ballast water and other potentially disease-causing matter	Ministry for Primary Industries	
Supervise service providers for services concerning travellers, baggage, cargo, containers, goods, postal parcels, and human remains at points of entry including the conduct of inspections and medical examinations as necessary	Ministry for Primary Industries	• NZ Customs Service (illicit and prohibited goods) • Environmental Protection Authority (hazardous substances) • Ministry of Health Office of Radiation Safety (ionising radiation sources) • DHB public health units (public health risks)
Have effective contingency arrangements to deal with an unexpected public health event	DHB public health units	• Port/airport companies • Border agencies • Shipping agents • Airlines • Ground handlers

Communicate with the National IHR Focal Point, ie the Office of the Director of Public Health in the Ministry of Health	DHB public health units	
Ensure health measures recommended by the WHO and endorsed or otherwise approved by the Ministry of Health are applied or reapplied to travellers, baggage, cargo, containers, conveyances, goods, postal parcels, and human remains arriving from an affected area as required	DHB public health units	• Port/airport companies • Border agencies • Shipping agents • Airlines • Ground handlers
Ensure disinsection, deratting, disinfection, decontamination and other sanitary procedures are carried out to avoid, so far as possible, injury and discomfort to persons, damage to the environment and damage to goods	Ministry for Primary Industries	• DHB public health units (conveyances other than aircraft disinsection, sanitary measures for persons) • Ministry of Health Office of Radiation Safety (ionising radiation sources and contaminated articles)

Key operational activities undertaken by public health units at the border

The following core activities are undertaken regarding ships and aircraft undertaking international travel:

- receiving requests for pratique and, subject to statutory requirements, granting pratique to arriving vessels
- receiving notifications of cases with symptoms of concern or reports of evidence of a public health risk on aircraft and vessels
- obtaining information from the pilot in command of an aircraft or the pilot's agent as to health conditions on board and any health measure applied to the aircraft
- receiving the completed Maritime Declaration of Health and obtaining any further information from the master of a ship (or the ship's surgeon if one is carried) as to health conditions on board
- administering the Ship Sanitation Certification system (see Procedure 5.3, above)
- receiving communications from a suspect or affected aircraft or ship that arrives at a port or airport different to that than planned, and applying appropriate health measures (in consultation with the Ministry of Health). Issuing pratique to authorise travellers to leave the conveyance and the removal of cargo, etc. Allowing the conveyance to depart when all required health measures have been completed
- receiving communications from the officer in command of a suspect or affected aircraft or ship communicating any emergency measures necessary for the health and safety of travellers on board
- ensuring programmes are in place to control vectors that may transport an infectious agent that constitutes a public health risk to a minimum distance of 400 metres from those areas of point of entry facilities that are used for operations involving travellers and conveyances with extension of the minimum distance if vectors with a greater range are present.

The following core activities are undertaken by public health units regarding the application of health measures to suspected or affected travellers:

- receiving communications about suspect travellers who, while under public health observation, have been permitted to continue an international voyage, and enable the traveller to report to them on arrival
- requesting travellers to complete contact information forms and questionnaires on the health of travellers
- undertaking screening and medical examination of suspected or affected travellers
- offering/arranging vaccination or prophylaxis to suspected or affected travellers
- subject to powers under the Health Act 1956 and Health (Quarantine) Regulations 1983, denying entry to a traveller in possession of a certificate of vaccination or other prophylaxis because of verifiable indications and/or evidence that the vaccination or other prophylaxis was not effective
- taking into account any opinion provided by a supervising clinician that a vaccination or prophylaxis is contraindicated on medical grounds, including the reasons. Informing such persons of any risk associated with non-vaccination and with the non-use of prophylaxis
- immediately informing the Ministry of Health of any significant public health risks identified or measures taken in relation to arriving craft or travellers.

Key activities undertaken by MPI officers

- taking all practicable measures, including carrying out inspections, to assess the sanitary condition of container loading areas and containers when the volume of international container traffic is sufficiently large, in order to ensure that the containers are free of sources of infection or contamination, including vectors and reservoirs
- ensuring appropriate vector control programmes are in place at places of first arrival.

APPENDIX 23: POINT OF ENTRY RISK ASSESSMENT TOOL

This tool has been developed to support public health units to undertake a risk assessment of their international airports and ports.

The tool is intended as an aid or input for priority setting only. It provides a framework in which local knowledge and professional judgement can be applied and documented to support discussions leading to risk management decisions. It does not provide a quantitative basis for establishing the relative risks of different hazards.

The framework may be applied using an 'all hazards' approach or individually for each identified hazard. The tool is comprised of three sections. These consider:

- factors influencing the likelihood of hazards occurring
- potential population exposure
- the adequacy of existing infrastructure to support initial response measures.

A qualitative rating scale is applied to each parameter using local knowledge and professional judgement:

0 no risk or not relevant
1 low risk or likelihood
2 medium risk or likelihood
3 high risk or likelihood.

An overall rating is made of low, medium, or high risk.

I. **Hazard Likelihood**
Factors influencing the probability that an event will take place
Note whether all hazards or specific hazard such as communicable disease or human disease vector incursion

Parameter	Note	Rating	Comment
Volume of passengers (or crew)	Larger volumes of international travellers increase the likelihood of an adverse event.		
Origin of passengers (or crew)	This is likely to be more important for air travel because of short travel times in relation to incubation periods.		
Volume of cargo	Larger volumes of international cargo increase the likelihood of an adverse event.		

Origin and nature of cargo	Particularly in relation to disease vectors.		
Other issues:			

II. **Likely Population Exposure**

Factors influencing the probability that an event will affect the wider population

Parameter	Note	Rating	Comment
Potential for passengers (or crew) to disperse widely	Travellers dispersal patterns will influence potential disease spread.		
Proximity of urban population	Travellers or workers returning to larger populations increase the likelihood of rapid spread with greater difficulty to contain.		
Physical environment of POE (in regard to establishment of disease vectors)	A physical environment that has a diverse mosquito breeding habitat will increase the likelihood of establishment.		
Local climate conditions (in regard to establishment of disease vectors)	A mosquito breeding climate will increase the risk of establishment of a disease vector.		
Other issues:			

III. **Capacity and Capability for Initial Response**

Port and health infrastructure for initial response – assessed in proportion to likelihood of hazard and population exposure

Parameter	Note	Rating	Comment
Infrastructure at POE	Includes adequacy of public health contingency plans plus the size and characteristics of the facilities in regard to containment.		
Availability of health resources	Includes public health and personal health resources e.g. access to primary care, hospital services and diagnostic services.		
Provision for multi-agency response	Consider level of stakeholder engagement, and training for multi-agency responses.		
Other issues:			

Summary

Provide a statement of the overall assessment (low, medium or high risk) plus comment and any recommendations.

APPENDIX 24: GUIDANCE ON APPLYING IHR CORE CAPACITIES

This Appendix provides operational guidance on how core public health capacities can be implemented at international points of entry (airports and ports) in New Zealand.

Such capacities are required for designated points of entry under the International Health Regulations 2005 (the IHR). The IHR aim to bring a co-ordinated global approach to preventing, and responding to, the international spread of disease.

This guidance will support public health officers when they undertake public health risk assessments, provide advice to develop core public health capacities at points of entry, and respond to public health events.

The guidance does not cover post-border surveillance and responses within countries. Its focus is ensuring core capacities are in place at the border.

1. Routine point of entry measures

Public health units should ensure that the core capacities (listed in Annex 1B.1 of the IHR) are in place at all times for their designated points of entry. Further guidance is provided below, which:

- identifies the core capacities required 'at all times' that are the most critical in dealing with an emergency response (see **section 1.1,** below)
- provides a quick overview of the basic measures that public health units should ensure exists when assessing whether a port or airport meets the 'at all times' IHR core capacities (see **section 1.2,** below)
- provides further operational guidance to meeting the 'at all times' IHR core capacities (see **section 1.3,** below).

1.1 Critical measures

The core capacities that are critical to have in place when responding to a public health emergency include being able to:

- assess ill travellers detected on board conveyances (such as aircraft and vessels) and at entry
- communicate information on ill travellers between conveyance and points of entry as well as between points of entry, public health units, and the Ministry of Health
- safely transport symptomatic travellers to hospitals or designated facilities for clinical assessment and treatment.

Providing these critical capacities will ensure the basic requirements are in place so that additional supportive measures can be implemented to respond to public health risks.

To ensure core capacities are maintained, public health units needs to maintain communications with stakeholders, agencies, and service providers at their points of entry. This should include regular formal meetings and ongoing informal liaison. There should be a formal verification of core capacities via annual audits and careful maintenance of documents (standard operating procedures, plans, records, etc).

1.2 Overview of the basic measures that should be in place 'at all times'

When assessing whether the core capacities required at all times are in place at a point of entry, public health units should focus on the following key issues and should ensure that:

- trained public health staff are available to inspect port and airport facilities and conveyances (aircraft and vessels)
- key amenities are provided including potable water, sanitary public washrooms, appropriate solid and liquid waste disposal services, fresh air (or appropriate ventilation), and safe food
- an on-call capability is in place so that a public health officer is available *at all times* to respond to public health events at the point of entry (within at least 30 minutes)
- a public health leader (e.g., a medical officer of health) is available at all times who can lead a public health response at the point of entry)
- there is a point of contact at the point of entry who is available *at all times* and can implement the directions of the public health leader during a public health response
- first responders trained in first aid, or paramedic staff, are available to treat an ill or injured traveller
- the public health officer and first responders can access the aircraft or vessel and assess the person(s) concerned
- ambulance or other emergency services can transport ill travellers (in isolation if necessary) to a nearby local medical facility or hospital
- there is a room or space that can be used for health assessments (e.g., a first aid room)
- there is equipment for health and medical assessments stored nearby the health room or in a storage area if there is no dedicated health room, or is such equipment readily accessible if needed
- medical staff and medical facilities or a hospital are available nearby to receive and treat an ill or injured traveller (with isolation facilities if required)
- a hotel or other accommodation is available near the port or airport that can be used as a quarantine facility if needed
- arrangements exist with local funeral directors to handle any deceased (if not already included in the point of entry's emergency response plan)
- arrangements exist for disposing of animal carcasses (NB: this is the responsibility of MPI)
- vector surveillance and control programmes are being applied at the port or airport in question
- there are established relationships and regular interactions between public health officers, other point of entry stakeholders, agencies, service providers, emergency services and organisations such as owners and operators of ports or airports.

Unless specified otherwise, for the assessment of the core capacities, it is assumed that the number of passengers carried by the largest aircraft scheduled to land at the designated airport, or the largest cruise vessel scheduled to berth at the designated port, can be managed.

1.3 More guidance on core capacities required at all times at IHR points of entry

Implementation of measures	Application	Discussion
These core capacities are required for responding to events that may constitute a public health emergency of international concern (PHEIC). However, from a technical point of view, they are core capacities that should be available "at all times".	• **Public health contact available at all times** for health emergencies • **Person in charge of public health operations** for health emergencies • **Point of entry coordinating contact** for the public health service • **Contact points** for other relevant agencies and services • **Communications.**	For more information see section 2: Point of Entry Measures During Public Health Events or PHEICs.

Medical services including diagnostic facilities	Application	Discussion
Paragraph 1(a) of Annex 1 B of the IHR requires the capacity to provide access at all times to appropriate medical services including diagnostic facilities located so as to allow the prompt assessment and care of ill travellers; and adequate staff, equipment and premises.	If a traveller suffers an injury or health event then there must be a capacity to provide medical stabilisation, support and quick transportation to a health facility. Facilities may not necessarily be located at the point of entry but at a medical facility in the near vicinity. The first responders on site might be first aiders or paramedics with medical back up available from the local hospital.	In defining the appropriate level of service, in principle, an international traveller should expect to receive the same level of medical support as local New Zealanders. This means treatment facilities need not be located at the point of entry but the traveller can be given first aid and taken to hospital in an ambulance.
Key information relating to medical services, including diagnostic facilities, is available at the point of entry.	Ensure availability of an up to date list of services and facilities, including emergency contact details (address, telephone number, fax, email) for the on-site first aiders or paramedics and the nearest hospital or medical facility.	It may be useful to have a map showing the route and distance from the point of entry to the medical facility and/or hospital.
Medical services at the point of entry.	Medical services should be available to ensure an ill or injured traveller can receive basic treatment before being transported to a medical facility. First responders must be available at all times and have already obtained permission for authorised access to restricted access areas and security restricted areas in the event of an emergency. The first responder must be able to reach ill persons on or at the aircraft or vessel within 15 minutes of notification.	These services should be proportionate to the risk. They could be provided via appropriate emergency service (e.g. fire/ambulance) personnel located at the point of entry or trained first aid responders at the point of entry.
Medical assessment on or near the aircraft or vessel.	Ensure arrangements and written agreements are in place for unrestricted access to conveyances by public health officers and medical services (first responders, also ambulances, fire engines, buses, etc).	This means that responders can have ready access to the aircraft or vessel to be able assess, treat and evacuate ill travellers.

Health assessment within the point of entry.	Ensure arrangements and written agreements are in place for appropriate premises to interview people and examine ill travellers. It may include: • examination and care area • water supply • toilet (and shower if possible) adjacent or accessible • adequately large waiting area • ability to restrict access of non-authorised persons • ventilation and/or air conditioning system that prevents the spread of an airborne disease • technology and infrastructure for temporary isolation of ill traveller • access for emergency vehicles, buses, vehicles for transporting travellers to be isolated.	This should be a room that is either permanently available or can be quickly made available (e.g., a first aid room). There may be a separate area for people waiting to be interviewed or examined. If the room is not permanently available, there may need to be a separate storage area for equipment required for a response.
Equipment	Equipment should be readily available to: • provide personal protection • support physical examinations • provide emergency care • communicate (e.g. personal computers, telephone, and printer) • take samples • package samples for transport.	This may be stored in the health assessment room or stored with other equipment if a permanent health assessment room is not available.
Medical staff	Ensure arrangements and written agreements are in place for a medical service (e.g., emergency physicians) to support the point of entry. This will include access at all times to trained physicians and medical staff for the prompt examination, questioning, medical care and, if necessary, isolation of affected persons.	In practice, this can be appropriate medical staff at a local hospital or medical centre and such staff need not be actually located at the point of entry. First responders located at the point of entry can conduct an initial assessment of a traveller, provide stabilisation measures, and initiate transport to a medical facility.
Medical Assessment Centre	Ensure arrangements and a written agreement is in place for access to a medical assessment centre for affected persons**.**	In practice, this can be a local nearby hospital or medical centre that is not actually located at the point of entry.
Quarantine facility	Ensure arrangements and written agreements are in place for the operation of a quarantine facility. Arrangements must include access at all times to trained personnel qualified to identify symptoms of illness, and who are familiar with initial control measures for persons at risk of infection. There also needs to be a defined and documented procedure for communication with the operators of the quarantine facility and for the assignment, transport and handover of persons.	This may be an arrangement with a hotel or other accommodation facility near the point of entry. Quarantine facilities are provided for well travellers who may have been in contact with a suspected case or have had a high-risk exposure. Arrangements should include the provision of catering, cleaning and security services.

Transport of ill persons	Application	Discussion
Paragraph 1(b) of Annex 1 B of the IHR requires the capacity to provide access at all times to equipment and personnel for the transport of ill travellers to an appropriate medical facility.	Ensure arrangements and written agreements are in place for access at all times to trained personnel who can transport ill persons to suitable medical facilities. These arrangements must include provision of the necessary personal protective equipment, and vehicles suitable for the secure and hygienic transport of ill persons to appropriate medical facilities.	These services should be proportionate to the risk. They could be provided via emergency service (ambulance) personnel located at the point of entry or readily available by phone.

Trained inspection staff	Application	Discussion
Paragraph 1(c) of Annex 1 B of the IHR requires the capacity to provide trained personnel for the inspection of conveyances.	Ensure arrangements and written agreements are in place for access to public health officers for the inspection of conveyances to check for contamination, conduct ship sanitation inspections, etc These arrangements should include provision of necessary personal protective equipment and equipment needed for inspections to be competently performed.	Public health officers should be appropriately trained to undertake inspections and provide advice on any control measures required. For officers conducting ship sanitation inspections, completion of the WHO on-line ship sanitation training is a minimum prerequisite. Other agencies (e.g., MPI) have inspection responsibilities that should be considered.

Safe port environments	Application	Discussion
Paragraph 1(d) of Annex 1 B of the IHR requires the capacity to ensure, at all times, a safe environment for travellers using point of entry facilities, including potable water supplies, eating establishments, flight catering facilities, public washrooms, appropriate solid and liquid waste disposal services and other potential risk areas, by conducting inspection programmes, as appropriate.	Ensure arrangements are in place to provide general assistance and support to travellers and to persons waiting for them and relatives (including information, help with their onward journey, changing reservations, informing relatives, access to telecommunications).	This support and assistance may be provided by port staff, border officials, and service providers at the point of entry.
Training and appointment of inspection staff to ensure a safe environment at the points of entry	Public health officers must be appropriately trained and experienced to work with point of entry stakeholders, agencies and service providers, and conduct of inspection programmes at the point of entry. Officers undertaking the inspections may not always be health officials, but	Public health officers may not be always located at a point of entry but should ensure they maintain relationships with point of entry stakeholders, agencies and service providers. Public health officers should make regular visits to the point of entry to maintain relationships with point of entry

	from other government agencies.	stakeholders, agencies and service providers and check the core capacities are maintained.
Potable water supplies	Water supplied to the point of entry, and to conveyances, must meet drinking-water guidelines or standards and any legal requirements. Hoses and connections must be stored to prevent contamination. Backflow prevention must be in place.	Water suppliers should be able to demonstrate that the water meets drinking-water standards. Bunkering of vessels should be undertaken in a manner to avoid any contamination of the water supply.
Eating establishments and catering facilities.	Ensure arrangements are in place to ensure food premises and catering facilities provide safe food.	Food premises and catering establishments should be operating under a registered Food Control Plan (either custom or template) or relevant National Programme under the Food Act 2014 overseen by MPI. Public health officials should be aware of how this is occurring.
Public washrooms	Confirm arrangements are in place to ensure public washrooms are clean and hygienic.	There should be a regular cleaning and maintenance programme that the point of entry has in place.
Solid and liquid waste disposal.	Ensure arrangements are in place for the treatment and disposal of solid and liquid waste.	Quarantine waste will be dealt with by the relevant authority. Hazardous waste (ie chemical or radioactive) should be disposed of by councils or the port authority according to national legislation and protocols. General sewage and waste can be disposed of via the local waste management systems.
Fresh air supply and air conditioning.	Ensure arrangements are in place for the provision of fresh air and/or air conditioning.	This can be wall openings or open windows that allow air flow.
Deceased Persons	Ensure arrangements are in place for handling deceased persons and body parts.	The point of entry may have included this in its emergency plan. Management of the deceased is usually undertaken by the funeral director once the certification of death has been made. If the person has died of a communicable disease public health officials can provide advice on any disease transmission. Ambulance services or public health units may have organised a medical assessment. The DHB in conjunction with local funeral directors generally arrange for bodies to be removed from the point of entry.
Animal Carcasses	A defined and documented procedure for handling dead animals, in accordance with legal provisions, should be in place.	MPI is responsible for this activity.

Control of vectors and reservoirs	Application	Discussion
Paragraph 1(e) of Annex 1 B of the IHR requires the capacity to provide, at all times and as far as practicable, a programme and trained personnel for the control of vectors and reservoirs in and near points of entry.	Ensure arrangements are in place for surveillance of point of entry environments for vectors and reservoirs/habitat. Inspection of aircraft, baggage, cargo, containers, goods, mail, etc., depending on the epidemiological situation.	In most cases public health units undertake mosquito surveillance at points of entry. In some cases, the port/airport authority commission providers to do this work, and the public health unit has an audit role to check this is being undertaken. The point of entry authority will also arrange for a pest control programme that covers rodents and bird controls. Inspection of conveyances and cargo etc will be undertaken by other border agencies but supported by public health officers when required.
Training of inspection staff (for vectors and reservoirs).	Ensure those undertaking vector surveillance (and audits of surveillance) are appropriately trained. Officers undertaking the inspections may not always be health officials, but from other government agencies.	Staff should be trained in identifying the presence of vectors such as mosquitoes and rodents, and in measures to remove or control potential habitat and to control vectors that may be present.
Equipment	Ensure those undertaking vector surveillance have access to the equipment required for the control of vectors and reservoirs. Regularly check equipment (including service life, stock).	Equipment will include personal protective equipment, sampling and trapping equipment, and pesticides.
Control Measures	Ensure arrangements are in place, including appropriate legislation, to remove or control potential habitat and to take measures to eliminate vectors detected at points of entry.	Staff need to be able to require the point of entry to remove or control habitat that may enable vectors to breed. Staff may also need to take action to eliminate vectors found on site (e.g. by trapping or spraying).

2. Point of entry measures during public health events or PHEICs

The WHO monitors public health events throughout the world and provides updated risk assessments for any outbreak or incident. The WHO will provide recommendations in response to a public health event and public health emergency of international concern (PHEIC), including the application of any travel or trade restrictions or other point of entry measures. The Ministry of Health will advise public health units if emergency measures need to be implemented in New Zealand.

Public health units should ensure that the core capacities (listed in Annex 1B.2 of the IHR) exist for their designated points of entry to enable them to respond to a PHEIC. This guidance:

- identifies the core capacities required at all times that are the most critical in dealing with an emergency response (see **section 2.1**, below)

- provides a quick overview of the key measures that every public health units should ensure exists when assessing whether a port or airport meets the IHR PHEIC response core capacities (see **section 2.2**, below)
- provides further operational guidance to meeting the PHEIC response core capacities (see **section 2.3**, below).

2.1 Critical core capacities for public health events or PHEICs

The core capacities that are critical to have in place when responding to a public health emergency include being able to:

- assess ill travellers detected on board conveyances (such as aircraft and vessels) and at entry
- communicate information on ill travellers between conveyance and points of entry as well as between points of entry, public health units, and the Ministry of Health
- safely transport symptomatic travellers to hospitals or designated facilities for clinical assessment and treatment.

To ensure health and other border point of entry stakeholders, agencies and service providers understand their roles and responsibilities and the importance of ensuring the core capacities are maintained, there should be training of staff (individually and collectively), exercises conducted, debriefs and post-activity reporting for exercises and responses and regional workshops to share information, best practice, and encourage consistency and coordination.

2.2 Overview of the key measures needed for public health events or PHEICs

When assessing whether the core capacities required to respond to a PHEIC are in place at a point of entry, public health units should focus on the following key issues and should ensure:

- the core capacities required at all times are maintained (as highlighted above in **section 1**, above)
- the public health unit has a public health emergency contingency plan and the point of entry emergency plan includes a public health response (and these two plans are interoperable)
- suitable space is available for interviewing passengers and crew from aircraft or vessels
- arrangements can be made to clean, disinsect, fumigate or decontaminate vessels, aircraft and areas within the point of entry if required
- entry and exit measures could be implemented if required by the Ministry of Health.

Note: MPI has responsibility for the care of affected animals.

Unless specified otherwise, for the assessment of the core capacities, it is assumed that the number of passengers carried by the largest aircraft scheduled to land at the designated airport, or the largest cruise vessel scheduled to berth at the designated port, can be handled.

2.3 More guidance on the measures needed for public health events or PHEICs

Public Health Emergency Contingency Plan	Application	Discussion
Paragraph 2(a) of Annex 1 B of the IHR requires the capacity, for responding to events that may constitute a PHEIC, to provide appropriate public health emergency response by establishing and maintaining a public health emergency contingency plan, including the nomination of a coordinator and contact points for relevant point of entry, public health and other agencies and services.	Ensure a public health emergency contingency plan and standard operating procedures are in place. The point of entry's emergency response plan also needs to include a section for responding to a public health emergency response. For airports, this plan needs to be integrated into the airport's overall contingency planning in accordance with ICAO rules.	The public health emergency contingency plan enables the public health authority to respond to a PHEIC.
Public health emergency contingency plan	Ensure a public health emergency contingency plan and standard operating procedures are in place. The public health emergency contingency plan should include provisions for: • the identification of persons suspected of being infected or ill persons • the provision of medical, social and organisational assistance to them • documenting directives, response activities, etc • access to security restricted areas of the point of entry • revision in line with the most recent findings on health and legal issues.	Every point of entry should have a public health emergency contingency plan to deal with accidents and emergencies. Public health units need to check the point of entry's own emergency plan includes provision for responding to public health emergencies (ill travellers, pests and vectors, hazardous substances and radiation incidents). The point of entry emergency plan and the public health emergency contingency plan must be inter-operable. The plans should be reviewed annually and exercised at least partially every 1-2 years. Public health officers should participate in any exercises the point of entry holds to test its plans – as observers for incidents that do not have public health relevance – so they are familiar with the point of entry response practices.
Public health contact available at all times for health emergencies	Ensure arrangements and written agreements are in place for a public health officer to be available at all times for health emergencies. Ensure contact details (address, telephone number, fax, email) are available and up to date. The public health officer must have already obtained permission for authorised access to restricted	This core capacity is required for events that may constitute a PHEIC. However, from a technical point of view, it is a core capacity that should be available "at all times". There must be a clearly identified public health contact. This officer need not be always present at the point of entry but should be able to arrive within 30 minutes. The public

	access areas and security restricted areas in the event of an emergency. The public health officer must be able to reach the point of entry within 30 minutes of notification.	health officer may be a public health officer who can then contact an appropriate public health or medical specialist for advice and support if needed.
Person in charge of public health operations for health emergencies	Ensure arrangements and written agreements are in place for a public health leader to be available at all times, who will be in charge of public health operations for health emergencies. Ensure contact details (address, telephone number, fax, email) are available and up to date. The public health leader must have already obtained permission for authorised access to restricted access areas and security restricted areas in the event of an emergency. The public health leader should be able to reach the point of entry within 30 minutes of notification.	This core capacity is required for events that may constitute a PHEIC. However, from a technical point of view, it is a core capacity that should be available "at all times". There must be a clearly identified public health leader, available at all times, who is authorised to manage and lead the health services during emergencies. This may be the public health officer (above) or a more senior public health or medical specialist. If the public health leader might be delayed reaching the point of entry there must be written, agreed and tested arrangements in place to be able to provide an appropriate public health response while the public health leader is *en route* to the point of entry.
Coordinating point of contact for the public health service at the point of entry.	Ensure arrangements and written agreements are in place for a coordinating point of contact at the point of entry who is available at all times, and is familiar with the structures and operations of the point of entry. This coordinating point of contact should be designated by the point of entry and will be responsible for implementing the measures ordered by the public health contact.	This core capacity is required for events that may constitute a PHEIC. However, from a technical point of view, it is a core capacity that should be available "at all times". The point of entry is to nominate a coordinating point of contact. This person to be familiar with the point of entry environment and its response plans. The coordinating point of contact will liaise with the public health contact and ensure coordination of emergency and other responses.
Contact points for relevant point of entry, public health and other agencies and services.	Ensure arrangements and written agreements are in place for contacts at the point of entry from all the relevant border agencies, border workers, airlines/shipping agents, airport/port workers, etc. Contacts need to be available at all times, and be familiar with the structures and operations of the point of entry. These contacts are designated by their agencies or organisation and will be responsible for implementing the measures ordered by the public health contact.	This core capacity is required for events that may constitute a PHEIC. However, from a technical point of view, it is a core capacity that should be available "at all times". Appropriate contacts from all relevant point of entry stakeholders, agencies and service providers should be identified, along with their roles and responsibilities. The contacts will ensure coordination of emergency and other responses for their organisations.
Communications	Ensure arrangements are in place for communication: • among all agencies involved in the operation of the point of entry including port authorities,	Maintaining relationships with all relevant point of entry stakeholders, agencies and service providers is essential if point of entry responses are to operate effectively.

	border agencies, agents/crew, port workers, other points of entry, health agencies and other relevant agencies and services. • with emergency services (first responders, ambulance), hospitals and medical centres and health practitioners • with travellers, persons waiting for them, and next of kin • with the National IHR Focal Point (the Office of the Director of Public Health in the Ministry of Health).	Attendance at routine meetings of point of entry stakeholders, agencies and service providers, participation in (or observing) point of entry emergency exercises, and regular informal liaison will maintain and enhance relationships. Public health officers should also undertake regular training or updates with stakeholders. Topics could include public health risks and the international context, infection control for stakeholders, ill traveller protocol process, or an IHR overview. Information to travellers may include preparation of multi-lingual handouts and posters that provide information on the event of concern and provide advice to travellers about what to do if they suspect they may have been affected.
Operations room	Ensure arrangements and written agreements are in place for an operations room to be made available for coordinating public health responses, equipped with modern means of communication.	This may be the point of entry's emergency operating centre or a room that can be set up as an emergency operating centre. It would need desks for each response function (preferably set up 'board room' style), computers, telephones, whiteboards. If available, CTV, televisions, and projectors can add to the functionality of the room.

Care for affected travellers or animals	Application	Discussion
Paragraph 2(b) of Annex 1 B to the IHR require the capacity, for responding to events that may constitute a PHEIC, to provide assessment of and care for affected travellers or animals by establishing arrangements with local medical and veterinary facilities for their isolation, treatment and other support services that may be required	Ensure the core capacities at all times are in place for travellers (as described in section 1 above). Ensure arrangements and written agreements are in place for access at all times to a veterinary authority. The veterinary authority will provide professional advice and decide how to proceed with any affected animals. The veterinary authority will need access to an isolation and examination room for affected animals, and to a veterinary facility (usually a veterinary hospital). This will also require procedures to be in place to transport affected animals from the point of entry to the veterinary facility.	While this core capacity is required for events that may constitute a PHEIC, from a technical point of view, it is a core capacity that should be available "at all times. Meeting the core capacities at all times will ensure the provision of assessment of and care for affected travellers, including their isolation, treatment and other support services that may be required. MPI is responsible for the care of affected animals.

Separate interview Space	Application	Discussion
Paragraphs 2(c) of Annex 1 B to the IHR require the capacity, for responding to events that may constitute a PHEIC, to provide appropriate space, separate from other travellers, to interview suspect or affected persons.	Ensure arrangements and written agreements are in place for access at all times to an appropriate area for interviews of passengers and crew.	The space needs to be large enough to comfortably hold all passengers from an aircraft to enable contact tracing and communications. This may be the arrival gate, a space in the arrival hall, or (if necessary) an area such as a hangar. It should be able to be secured so passengers cannot leave until released by health officers. A screened area or separate room(s) needs to be available for health officers to interview passengers. Interviewing passengers and crew from cruise vessels may be more readily undertaken on the vessel so that passengers and crew can await interviews in the comfort of their cabins or ship's lounges. Interview room(s) should be made available on the vessel.

Assessment and quarantine	Application	Discussion
Paragraphs 2(d) of Annex 1 B to the IHR require the capacity, for responding to events that may constitute a PHEIC, to provide for the assessment and, if required, quarantine of suspect travellers, preferably in facilities away from the point of entry.	Ensure the core capacities at all times (described in section 1, above) are in place.	Meeting the core capacities at all times will ensure the provision of quarantine facilities.

Treatment of conveyances and goods	Application	Discussion
Paragraphs 2(e) of Annex 1 B to the IHR require the capacity, for responding to events that may constitute a PHEIC, to apply recommended measures to disinsect, derat, disinfect, decontaminate or otherwise treat baggage, cargo, containers, conveyances, goods or postal parcels including, when appropriate, at locations specially designated and equipped for this purpose.	Ensure arrangements and written agreements are in place for access to trained personnel within 30 minutes for the appropriate and prompt implementation of recommended measures (i.e., cleaning, disinsection, deratting. disinfection, decontamination or any other necessary treatment), in consultation with the public health authorities. The implementation of control measures may be required on • vessels/aircraft, vehicles, • waiting and examination rooms, medical assessments centre • baggage, cargo, containers,	Public health units may require responsible organisations (e.g. airline, shipping agents, air or port operator or others as applicable) to carry out or arrange for disinsection, deratting, disinfection, decontamination or any other necessary treatment. For example the Health Act has provision for issuing of cleansing orders. The measures may be conducted by specially trained airport or private industry staff (e.g., for fumigations or pest control or aircraft cleaning) and in some instances, the aircraft or vessel may need to be directed to another point of entry to enable the required measures to be implemented.

	goods or postal parcels • at the point of entry and within a radius of at least 400 metres.	MPI is responsible for management of goods and cargo. If a PHEIC has been declared public health units should liaise with MPI regarding any additional public health implications for the treatment of goods and conveyances.
Premises	Ensure arrangements and written agreements are in place for the provision of premises for the safe storage, decontamination or destruction of objects.	This may be a secure room or hangar or warehouse at the point of entry. It must also ensure any loss or unnecessary damage to conveyances and goods is avoided.
Equipment	Ensure arrangements and written agreements are in place for the provision of infrastructure, equipment and chemicals for the implementation of recommended measures.	This ensures the availability of appropriate materials and equipment for any necessary treatments of contaminated goods or conveyances when directed by the health officer. It must also avoid unnecessary damage to conveyances and goods.

Exit and entry measures	Application	Discussion
Paragraphs 2(f) of Annex 1 B to the IHR require the capacity, for responding to events that may constitute a PHEIC, to apply entry or exit controls for arriving and departing travellers.	The public health emergency contingency plan should outline entry and exit measures that may be implemented when required at the point of entry. Ensure the core capacities at all times are in place.	Ensure the public health emergency contingency plan and the point of entry health response plan is in place and is regularly exercised. Meeting the core capacities at all times will ensure that appropriate personnel and systems are available to support entry and exit measures.

Safe transport of suspected cases	Application	Discussion
Paragraphs 2(g) of Annex 1 B to the IHR require the capacity, for responding to events that may constitute a PHEIC, to provide access to specially designated equipment, and to trained personnel with appropriate personal protection, for the transfer of travellers who may carry infection or contamination.	Ensure the core capacities at all times are in place.	Meeting the core capacities at all times will ensure the provision of safe transport of suspected cases (including in isolation if required).

APPENDIX 25: BORDER HEALTH RETURN FOR IHR-DESIGNATED POE

Border Health Return for IHR-Designated Points of Entry
For the period 1 January 20XX – 31 December 20XX.

To be submitted to the Ministry of Health by 31 January 20XX.
Please email to: suz_halligan@moh.govt.nz

Part 1 : Verification checklist for IHR-Designated Points of Entry

Name of Point of Entry		**Dates of Visits**		**Verifier(s)**	
PHU					

Core Capacities required *"at all times"* -Items required and explanatory notes	**Verifier Comments:** (Include detail of progress from previous year and current years status)	**Adequately Maintained Yes/No**	**Relevant Reference Docs**
1. Access to medical services			
• Medical services (including diagnostic services) are in place or readily available 24/7.			
• First responders are available 24/7 e.g., ambulance or first responders with back up from local hospital.			
• Medical service personnel (e.g., ambulance staff, first responders) are familiar with POE operations.			
• Public Health Staff including (HPOs & MOoH) are available 24/7.			

• Arrangements are in place for unrestricted access to conveyances for medical personnel.			
• There is restricted access to POE for non-authorised persons.			
• Adequate facilities available at POE for interviewing/examining ill passengers.			
• Equipment (including PPE) is readily available – i.e., stored on site or with first responders.			
• Are arrangements in place with local medical facilities for the isolation, treatment and other medical support services that may be required? (*Note this requirement applies for capacities required in an emergency but for verificationr purposes fits best here*)			
2. Access to appropriate transport for ill passengers			
• There is 24/7 access to equipment, personnel, and vehicles for transport of ill passengers from POE to a medical facility (usually provided by DHBs/ambulance services).			
• Trained staff and PPE are available to operate evacuation transport to ensure secure and hygienic transportation.			

3. Trained personnel to inspect conveyances • Access 24/7 to trained staff to conduct inspections (usually for biosecurity contamination). Includes craft, baggage, cargo, containers. MPI are the lead for pests and risk goods. • PHU staff undertaking ship sanitation inspections have completed SSC training.			
4. Safe environment for travellers • Ensuring a safe environment for travellers using POE facilities, including potable water, safe food, public washrooms, solid and liquid waste disposal, air quality. • POE environment is free of public health risks.			
Potable water • Potable water is provided to the POE. • There is a defined and documented procedure for procurement of, storage and distribution of water (if applicable). A full water safety plan is not required for POEs on municipal supplies (if the municipal supply has an appropriate water safety plan). • Water quality is monitored at regular intervals.			
Safe food • POE is providing safe food.			

• Food premises and catering facilities are inspected/approved and considered satisfactory by relevant authority (TA or MPI). • Flight catering facilities operate HACCP systems and are approved by MPI.			
Waste disposal • POE has documented waste management procedures (including management of solid, liquid and hazardous waste) that ensure public health risks are mitigated.			
• Biological, chemical and radiological waste is collected, contained and treated in accordance with documented procedures (MPI manage quarantine waste airside).			
5. Routine inspections of the POE environment			
• Regular inspections of the environment are undertaken by the POE, PHU and relevant regulatory authorities to ensure it remains risk free			
6. Control of medical vectors or reservoirs of disease			
• Mosquito surveillance is undertaken routinely in and around the POE (up to 400 meters).			
• POE has a documented plan for vector and reservoir control			
• Vector control staff have 24/7 access to POE.			

• MPI undertakes inspection of conveyances and cargo to detect vectors.			
• Documented plans in place for response to interception of mosquitoes/unwanted pests.			
• Procedures in place to assess, monitor and apply aircraft disinsection and other vector control measures if required. *(Note in the 14 point checklist this is included as one of the emergency core capacities but for verifier purposes fits best here)*			
Core Capacities for responding to emergency events **-Items required and explanatory notes**	**Verifier Comments:**		
7. Public health emergency contingency plan			
• Documented plans and procedures in place, familiar to and trained by all border agencies for the management of any public health contingencies at the POE.			
• Plan/procedures must cover the management of ill or suspected to be ill persons transiting the POE, and events such as a chemical, biological or radiological contamination.			
• Plans/procedures need to be multi-agency and have the commitment of the POE operators, regulatory agencies, public health services and commercial stakeholders.			

• Plans/procedures are to be exercised and evaluated regularly.			
8. Co-ordination arrangements/Key contacts			
• Contact lists for border agency contacts are accurate, kept up to date and distributed to all parties.			
• Documented procedures are in place (and familiar to all) for communication amongst all agencies in an emergency event.			
9. Treatment & care of ill animals (MPI lead)			
• 24/7 access to veterinary authority.			
• Access to appropriate veterinary facilities including isolation and examination areas for affected animals.			
• Documented procedures for assignment, transport and handover of affected animals.			
• Documented plans in place and familiar to all parties for the handling of dead animals *(note this is included in 4D of the 14 point checklist but for verifier purposes fits best here).*			

10. Appropriate space/s to manage ill or suspected unwell passengers			
• A facility or access to a space at the POE for the assessment of suspected or affected travellers.			
• Appropriate space should be provided for assessment and/or interview purposes. Requirements for a space include: a water supply (handwashing facilities), access to toilet and ideally a shower, the ability to clean the space, appropriate security, adequate waiting areas, adequate ventilation, and a means of communication.			
• Ready access of emergency vehicles to the space and the ability to remove travellers under secure conditions if needed.			
11. Quarantine of suspected passengers away from the POE			
• 24/7 access to a quarantine facility (preferably off site from POE). PHUs have developed agreements with facility providers.			
• Defined and documented procedures for communication with the operators of the quarantine facility for the assignment, transport and handover of persons.			

12. Capability to apply recommended measures			
• MPI is responsible for aircraft disinsection and will arrange treatment of risk goods when required.			
• PHU staff are competent and capable to order the implementation of cleaning, disinsection, disinfection, fumigation, deratting, decontamination and other necessary treatment if required within a reasonable timeframe.			
• Implementation may be on aircraft, vehicles, vessels, cargo, baggage, waiting/examination areas.			
• Control and surveillance should be out to a radius of at least 400 meters for medical vectors.			
• Trained Public health staff (HPOs & MOoH) available 24/7 and airport systems robust regarding training of staff.			
13. The ability to impose entry & exit controls			
• Border agencies can undertake routine entry/exit controls			
• 24/7 access to designated staff at POE to take, coordinate and enforce key decisions to implement orders issued by the competent authority.			

• PHUs may be required to implement additional border controls – surge capacity for this needs considering.			
• Management of medical entry and exit controls.			
• Defined and documented procedure exists that is familiar to and trained by all parties for medical entry and exit controls.			
14. Access to equipment and trained personnel for transfer of travellers who may be infected			
• Confirm agreements with ambulance service. Infection control needs to be ensured. 24/7 access to equipment, personnel, and vehicles for transport of ill passengers to a medical facility is required.			
• Trained staff and PPE available to operate evacuation transport to ensure secure and hygienic transportation.			
• Staff are aware of when and how to use PPE			
• Transportation plans/procedures should be evaluated and exercised regularly.			

Part 2 : Border Health Activity Return

Pratique	Public Health Unit Response
Aviation	
Total number of times an aircraft was met ON ARRIVAL.	
Provide brief reason for meeting aircraft on arrival issuing (e.g., arrival of non-scheduled aircraft)	
Maritime	
Total number of maritime pratiques issued	
Total number of times pratique ON ARRIVAL issued for a maritime vessel?	
Provide brief reason for issuing on arrival.	

Ship Sanitation Certification	Public Health Unit Response
Total number of Ship Sanitation Control **EXEMPTION** Certificates issued.	
Total number of Ship Sanitation **CONTROL** certificates issued. Provide brief reason for issuing.	
Total number of Ship Sanitation **EXTENSIONS** issued. Provide brief reason for issuing.	

Other comments
Please describe any issues, trends, recurring non compliances, or notable events observed during the implementation of your border health work over the year.

Thank you for your assistance. Please email the completed form to suz_halligan@moh.govt.nz by 31 January 20XX.

APPENDIX 26: BORDER HEALTH RETURN – PLACE OF FIRST ARRIVAL

BORDER HEALTH RETURN FOR PLACE OF FIRST ARRIVAL
For the period 1 January 20XX – 31 December 20XX.

To be submitted to the Ministry of Health by 31 January 20XX.
Please email to: suz_halligan@moh.govt.nz

Name of Public Health Unit:	
Name of port(s):	
Name of airport(s):	
Name of verifier(s):	

Part 1 – Verification for Place of First Arrival:

Item	Notes	Public Health Unit Response
1. PoFA Progress from previous verification	What action has been taken to implement recommendations from the previous year's verification? List any actions outstanding? What is being done to progress outstanding actions?	
2. Ill Traveller Protocol	Status of the Ill Traveller Protocol • When was the protocol last reviewed? • Have stakeholders been involved in the development of/signed off the protocol? • Does the protocol align with the national template? • When was the protocol last exercised? • When will the protocol be next exercised?	
3. Public Health Contingency Plan (complete this section if a PH contingency plan is required)	Status of the PoFA Public Health Contingency Plan. • When was the plan last reviewed? • Have stakeholders been involved in the development of/signed off the plan? • Does the plan align with the national template? • When was the plan (or parts of it) last exercised? • When will the plan (or parts of it) be next exercised?	

4. Stakeholder Engagement (Includes relationship management and training)	List the key relationship management activities undertaken with PoFA stakeholders. Activities could include meetings, training (i.e., PPE), exercise planning, regular email updates, debriefs on responses, global health updates. When was the PoFA Points of Contact list last updated? How are updated lists circulated to stakeholders?	
6. Vector Control	Briefly describe any vector surveillance and suppression programmes. List PoFA vector Interception responses (if any) including date, location, & species identified.	
7. Border Health Responses at PoFA (if any)	Please list any border health responses that occurred at the PoFA and summarise the actions undertaken This should include: • Ill passenger incidents • Vessel outbreak responses • Contamination incidents • Any other incident/activity that reflects on the public health response at the PoFA.	

PART 2 – Other border health activities

Pratique	**Public Health Unit Response**
Aviation	
Total number of times an aircraft was met ON ARRIVAL.	
Provide brief reason for meeting aircraft on arrival issuing (e.g., arrival of non-scheduled aircraft)	
Maritime	
Total number of maritime pratiques issued	
Total number of times pratique ON ARRIVAL issued for a maritime vessel?	
Provide brief reason for issuing on arrival.	

Ship Sanitation Certification	**Public Health Unit Response**
Total number of Ship Sanitation Control **EXEMPTION** Certificates issued.	
Total number of Ship Sanitation **CONTROL** certificates issued. Provide brief reason for issuing.	
Total number of Ship Sanitation **EXTENSIONS** issued. Provide brief reason for issuing.	

Other comments
Please describe any issues, trends, recurring non compliances, or notable events observed during the implementation of your border health work over the year.

Thank you for your assistance. Please email the completed form to suz_halligan@moh.govt.nz by 31 January 20XX.

APPENDIX 27: STATEMENT ON UNWANTED ORGANISMS

Introduction

This document sets out the Ministry of Health's (MoH) policy on circumstances in which chief technical officer (Health) (CTO (Health)), appointed by the Director-General of Health, may declare that an organism is unwanted. Criteria for determining an organism to be an unwanted organism will help to ensure that the decisions of the CTO (Health) are transparent and consistent. The criteria set out in this policy are intended to complement the provisions of the Biosecurity Act 1993.

Interpretation

Unless the context otherwise requires, terms used in this policy have the same meaning as those in the Biosecurity Act 1993 (the Act). Section 2(1) of the Act provides that:

'*Organism*' means:
(a) Does not include a human being or a genetic structure derived from a human being
(b) Includes a micro-organism
(c) Subject to paragraph (a) of this definition, includes a genetic structure that is capable of replicating itself (whether that structure comprises all or only part of an entity, and whether it comprises all or only part of the total genetic structure of an entity)
(d) Includes an entity (other than a human being) declared by the Governor-General by Order in Council to be an organism for the purposes of this Act
(e) Includes a reproductive cell or developmental stage of an organism
(f) Includes any particle that is a prion.

'Unwanted organism' means:
'…any organism that a chief technical officer believes is capable or potentially capable of causing unwanted harm to any natural and physical resources or human health; and
(a) Includes -
  (i) Any new organism, if the Authority [Environmental Protection Authority] has declined approval to import that organism; and
  (ii) Any organism specified in the Second Schedule of the Hazardous Substances and New Organisms Act 1996; but
(b) Does not include any organism approved for importation under the Hazardous Substances and New Organisms Act 1996, unless -
  (i) The organism is an organism which has escaped from a containment facility; or
  (ii) A chief technical officer, after consulting the Authority and taking into account any comments made by the Authority concerning the organism, believes that the organism is capable or potentially capable of causing unwanted harm to any natural and physical resources or human health.'

In this policy, unless the context otherwise requires:
'*Escaped restricted organisms'* are restricted organisms as defined in section 2(1) of the Biosecurity Act 1993 (are permitted in New Zealand only under a containment approval granted in accordance with the Hazardous Substances and New Organisms Act 1996) and which have escaped from a containment facility.

'Import health standard' means a document issued under section 22 of the Act. An import health standard specifies the requirements to be met in order to manage the risks associated with the importation of a risk good before those goods may be imported, moved from a biosecurity control area or a transitional facility, or given a biosecurity clearance.

'Notifiable organisms' will be declared notifiable under section 45 of the Act in Biosecurity (Notifiable Organisms) Orders. The Biosecurity Act does not define the term 'notifiable

organism', therefore, under the Biosecurity Council's policy, all notifiable organisms will be unwanted organisms, and will be limited to those organisms which cause serious harm to natural and physical resources or human health.

'Organisms specified in import health standard' are all organisms specified in import health standards are unwanted organisms.

'Pest management strategy' means a strategy, made under Part V of the Act, for the management or eradication of a particular pest or pests.

'Principal officer' means the principal administrative officer of a regional council. In relation to a regional council, it refers to the principal officer of that council, or, in relation to a region, it refers to the principal officer of the region's regional council.

'Reportable organisms' are those organisms which are reportable to a specified person or body by a rule under a national pest management strategy, or which are the subject of a national pest management strategy notified prior to the implementation of this policy. Organisms reportable under a regional pest management strategy are not included in this category.

'Small-scale management programme organisms' are those organisms that the relevant CTO has, following a request from the principal officer of a regional council, determined to be an unwanted organism, therefore, enabling a small-scale management programme to be carried out in the region under section 100 of the Act. An unwanted organism will have that status throughout New Zealand, however, there is no obligation on a regional council to take action against any such organism.

Declaration of unwanted organism

In the context of the Biosecurity Act 1993, the MoH is particularly concerned with organisms capable of causing, or of contributing substantially, to

- the introduction or wider distribution of a serious human disease
- the epidemic spread of a serious human disease

To declare an organism unwanted, the CTO (Health) must:

- confirm that they are a CTO appointed under section 101(2) of the Biosecurity Act 1993
- advise that the organism does not include a human being or a genetic structure derived from a human being
- advise that the organism is an organism by virtue of the fact that it:
  - includes a genetic structure (i.e. DNA) that is capable of replicating itself (which structure comprises only part of the genetic structure of the entity); or
  - includes an entity (other than a human being) declared by the Governor-General by Order in Council to be an organism; or
  - includes a reproductive cell or developmental stage of an organism; or
  - includes any particle that is a prion.
- believe that the organism is capable, or potentially capable, of causing unwanted harm to human health
- declare the organism an unwanted organism for the purposes of the Biosecurity Act 1993.

An unwanted organism declared unwanted by the CTO (Health) may also be an organism that is capable or potentially capable of causing unwanted harm to any natural and physical resources (although the CTO (Health) would not declare an organism unwanted on this basis). Should the organism be capable or potentially capable of causing unwanted harm to any natural and physical resources, the responsibilities of another CTO will be affected

and the CTO (Health) should consult with other affected CTOs before making the determination.

The criteria for declaring an unwanted organism

An unwanted organism is an organism that meets the criteria in at least one of the following categories:

- declared as an unwanted organism by the CTO
- is a notifiable organism under the Biosecurity Act 1993
- described in this policy as:
  - an escaped restricted organism
  - a reportable organism
  - a small-scale management programme organism
  - an organism specified in an import health standard.

Organisms that are established in New Zealand and are subject to voluntary controls (such as industry quality assurance programmes) are not unwanted organisms under this policy.

Consequence of declaring an organism unwanted

The reason for determining an organism to be unwanted is so that compulsory powers under the Biosecurity Act 1993 can be exercised against those organisms as and when necessary.

Where an organism has been declared an unwanted organism under the Biosecurity Act 1993, officers under Part VI of the Act (such as inspectors and authorised persons) can exercise compulsory powers (such as powers to search premises) in relation to such organisms.

An unwanted organism will have that status throughout New Zealand. An organism cannot be an unwanted organism only within a region or other locality.

Communication

The CTO (Health) shall determine whether an organism is unwanted because of its impact or potential impact on public health. Where the responsibilities of another CTO are, or potentially are affected, the CTO (Health) shall consult with other affected CTOs before making the determination. If there is disagreement on such a determination, this will be discussed by the Biosecurity Council.

After any organism is declared to be unwanted or determined to no longer be unwanted, the MoH will inform the Director-General of the MPI as soon as is practicable, as required by section 164C of the Biosecurity Act 1993. This advice shall include a copy of the declaration and shall provide the necessary information for the register of unwanted organisms, established and maintained by MPI.

This policy will be reviewed in light of any amendment to the Biosecurity Act 1993 or at such other time as a CTO considers appropriate.

APPENDIX 28: VECTOR DETECTION/INTERCEPTION RESPONSE STEPS

Step One

The identification and location of exotic mosquitoes of public health significance should be reported to the CTO (Health), or the Deputy CTO (Health), within one hour of such report or identification being received.

Step Two

Identification by the Ministry's mosquito identification experts will be undertaken. A result should be received within 24 hours. Independent verification will be obtained and reported when available (this may take hours if digital images are satisfactory or days if the actual specimen needs to be sent to the expert).

Role of the public health units

In the meantime, public health units must not wait for the confirmation to be received but should immediately implement the following guidelines:

1. Commence an Activity Log (refer Appendix 33)
2. Advise the CTO (Health), public health manager and MPI
3. If not already done, collect samples and send to New Zealand BioSecure for identification as soon as possible. Advise NZ BioSecure laboratory of shipment details (refer Appendix 34)
4. Advise the port/airport company/or Transitional Facility and stakeholders (if the incident has occurred at a port) or the landowner/occupier if elsewhere
5. Visit the interception site: urgently undertake a delimiting survey of the port and any vessel including checking all traps in place, inspecting and treating, mitigating or eliminating potential habitat, installing additional traps and maintaining enhanced monitoring for three weeks
6. Organise immediate treatment of risk goods (via MPI's Quarantine Service staff (MQS)) and interception site (refer role of MQS, below)
7. Identify the owners of the risk goods
8. Confirm availability of treatment material, equipment and sampling gear
9. Assess human resources requirements
10. Respond appropriately depending on mosquito life stages present (see below)
11. Complete an interception situation report (refer Appendix 32 for the report template) and send to the Environmental and Border Team via notifyenvhealth@moh.govt.nz within 24 hours of the initial finding
12. Contact the shipping agent and obtain voyage details including transit ports and onward destinations (domestic and foreign) and advise any public health units where the vessel is berthing and/or unloading risk goods
13. If no additional exotic mosquitoes are found following three weeks of enhanced monitoring, this would indicate that a population is either absent or below the levels of detection. At this time, the response would be terminated and routine surveillance resumed.

Late instar larvae and/or evidence of pupae or adult mosquitoes

In this situation, an exotic mosquito is detected on arrival in New Zealand or soon after. For example, exotic mosquito larvae, pupae and/or adults being found during an inspection of imported risk goods at the border (port, airport, or importer's premises). In this scenario, one or more adults may have escaped into New Zealand during the time between arrival and inspection.

Components of a response where adult mosquitoes may have been present include:

- Treatment of risk goods
- Ultra-low volume adulticide treatment of area where risk goods have been transported and/or disembarked and surrounding adult resting sites
- Delimiting survey and larviciding (with slow release or residual products) of all habitats at an appropriate distance from find.

Enhanced trapping specific for species for 3 generations if no further evidence of establishment. Three generations which can vary depending on current climate conditions, a minimum of four weeks is recommended. Seek further advice from NZB laboratory regarding suitable enhanced monitoring if required.

Eggs or larvae only detected - no evidence of pupae or adults

When eggs or larvae only have been detected and there is no evidence of pupae or adults, and the biological profile and shipping information indicates adults unlikely to have been present, the components of the response are:

- Treatment of risk goods
- Delimiting survey and larviciding (with slow release or residual products) of all positive habitats at an appropriate distance from find considered
- Enhanced trapping specific for species for 3 generations with no further evidence of additional life stages detected.

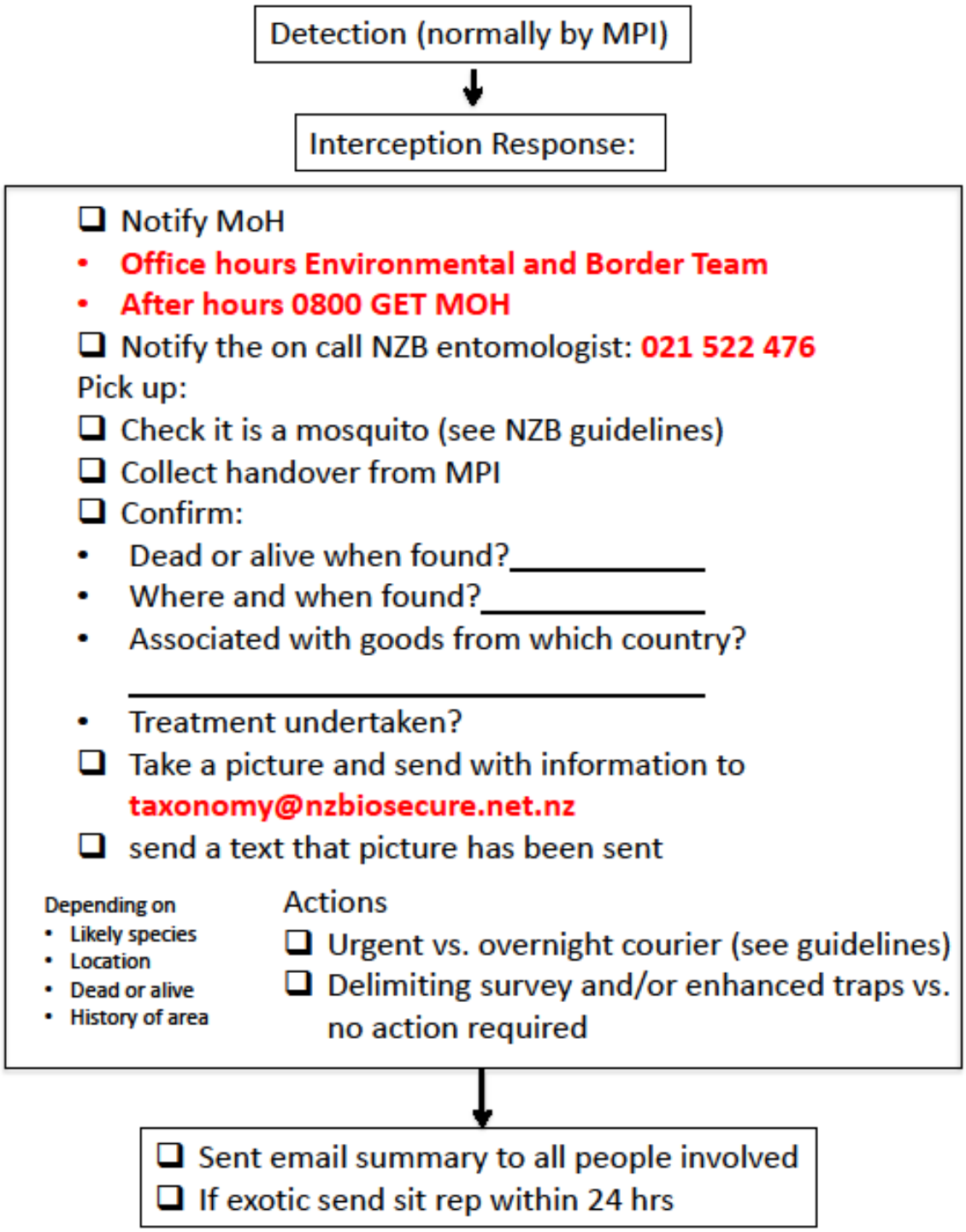
Role of the MPI's Quarantine Service (MQS)

- MQS staff will inform the public health unit of any suspected exotic mosquitoes identified on vessels or risk goods
- MQS staff will hold specimens for public health units to forward to NZ BioSecure for identification (or may forward specimens directly in some rare circumstances)
- MQS will arrange for the urgent treatment of the risk goods
- MQS will inspect risk goods which may be contaminated, including the treatment of risk goods where appropriate.

MQS will arrange for the recall and reinspection of released risk goods where appropriate.

APPENDIX 29: CHECKLIST FOR SUSPECTED MOSQUITO DETECTION

Checklist for HPOs in the event of a suspected mosquito detection



APPENDIX 30: TASK TABLE FOR A RESPONSE TO AN EXOTIC MOSQUITO

Table 1: Exotic Mosquito Interception Response
HPO/PHU Task Table

Task Ref	PHASE 1	Notification & Pre-Deployment Activity	X Ref to
HP1	PHU is notified of a mosquito detection at a POE or TF. Notification may occur 24/7.	On Call HPO takes facts of finding including notifier's details, location, risk goods, flight number or Vessel name, life stage detected, dead/alive, sample status i.e. as much intel as possible	
HP2	Contacts and informs other key parties	• Notifies PHU Manager/MOH • Notifies Environmental and Border Team within two hours by phone • Notify the on-call NZB entomologist mob phone **021 522 476**	**M1** **L1**
HP3	Prepares to visit index site, conduct equipment checks	• Ensures he/she has the required items incl: ○ PPE ○ PHU Standard operating procedures ○ Traps, adult & larval (+CO2 cyls Gas fitting tools) ○ S-methoprene granules ○ Knock Down Insecticide Spray Canister ○ Sample Collection Kit ○ Smart phone with Macro Lens	
HP4	Deployment	Travels to Index site asap	
Task Ref	**PHASE 2**	**Responders Deployed to Index Site**	X Ref to
HP5	Enter site. Contact the Notifier or their representative. Make contact with MPI. Ensure access to Authorised Person.	• Report to Owner/Operator • Gather intel from the site operator or the MPI officer • Complete Handover Certificate with MPI (use Handover certificate – see EMIS	
HP6	Secure Sample and send data to NZ BioSecure Lab	• **Secure & Check Sample:** • Dead or alive when found?_____ • Where and when found?_____ • Associated with goods from which country? _____ • Take a picture and send with information to taxonomy@nzbiosecure.net.nz • **Sending Physical Sample to Lab -Actions** • Urgent vs. overnight courier (see guidelines)	**L2**
HP7	Lab Confirms initial Screen	**Either** • Probable Exotic/unwanted species • Probable established species	**L2**
HP8	Contact CTO (Health) /DCTO (Health) 24/7	• Discuss initial findings – options confirmed	**M2**
HP9	Develop the Course of Action (COA). Decision point will be the initial screening report	• Examine the site/risk goods and make an appreciation of what has occurred. • Contact/consult Environmental and Border Team	

	from the Lab	if necessary for advice on COA • Receive Screening result – notify Environmental and Border Team of results • If positive screen result then- • Consider if treatment of risk goods may be necessary • Contact PHU for additional resources if they are needed, (staff, material or equipment) • Consider risks/benefits of Delimiting survey and/or enhanced traps vs no action required	
HP10	Implement COA	• Arrange fumigation of risk goods or risk conveyance • Execute delimit survey • Apply containment treatment (S-methoprene or BTI) to mosquito breeding habitat	
HP11	Concurrent activity	• Update CTO/DCTO on response activity • Complete Handover Certificate with MPI (use Handover certificate)	
HP12	An Exotic ID has been made by Lab. Implement COA.	• Delimit Survey to be completed • Surveillance system deployed (Adult & Larval traps) • Treatment of habitat (S-methoprene) • Fumigation of Risk Goods • Issue (if necessary) directives for cleansing and disinsection • Updates Environmental and Border Team on activities • Update PHU Manager on actions taken, (by txt, email or phone) • Brief occupier on measures taken and follow-up action	
HP13	Lab confirms is an exotic organism but not a mosquito and not of human health significance	• Check if this discovery will be of concern to MPI, i.e is the organism a Biosecurity Risk	**L3**
HP14	Recovery	• Clears site and recover to PHUs offices	
	PHASE 3	Post Deployment Administration	**X Ref To**
HP15	Responders return to PHU location	• Brief Manager • Check equipment and material, and service, replenish and replace as necessary • Assemble data and write post event report (according to template) • Conduct planning to sustain the Response Surveillance programme (if an exotic was detected) On return to PHU draft full SITREP, (use Template) and send to MoH on the first working day unless requested to expedite this report and send it earlier	

	Phase	Monitoring Programme	
HP16	Post Incident Surveillance (Interception Event only)	• Conduct routine checks of the traps, collect any samples and dispatch them for ID • Maintain surveillance for three 'life cycles' of the species (21 – 28 Days) • Maintain ongoing reports to Environmental and Border Team of activity at Interception site including nil returns • Internal review of Response – lessons learned	**M10** **L7**

Table 2: Exotic Mosquito Interception Response CTO/DCTO Task Table

Serial	Phase 1 Notification	Notification Phase	X Ref
M1	Receive Notification of possible exotic mosquito interception	• From on-call HPO if in working hours- remain close to desktop – start draft log • If off site or silent hours log on remotely to the MoH system.	**HP 2**
	Phase 2	**Responders Deployed to Index Site**	
M2	Receive initial brief from HPO i/c Index Site	• Note the intel – proffer advice if requested • Discussion with lab if needed	**HP8**
M3	Conduct Assessment based on information to hand (HPOs brief)	• Is this an Interception or is it an Incursion? • If Incursion commence planning for operational control of the site to be transferred to MPI • Draft revised Health Report for Minister's Office • Assist Comms with media release(s) • Review HIA for arboviruses	
M4	Index Site HPO contacts MoH	• Review possible containment plan	**HP8**
M5	Lab Screen indicates probable Interception	• Enter into Data Base of Exotic Interceptions • Advice to agencies and stakeholders drafted • Comms updated and assisted with preparing media release • Ensure relevant MoH officials are advised • Confirm Stakeholder (POE) advised • Health Report Drafted for Minister's Office	**L3**
M6	Confirm COA	• Discuss Options with HPO i/c Index Site • Confirm what actions will be taken	**HP 11**
M7	Lab confirms Screening ID	• If Exotic, proceed to Task M8 • If established, not a health threat - stand down	**L4**
M8	Assessment of Risk – teleconference, (incl consulting Australian Experts)	• Is this an Interception or an Incursion? • If Interception what are: • Resource requirements? (HR, material, equipment, training) • Technical Support from Lab • If an incursion, develop future intentions COA • Receive Full Response Report	**L4** **HP13**

	Phase 3	**Post Deployment**	
M9	Assessing the potential impact of the finding	• If novel species, what are the Health Impacts? • If novel species & of health significance, declare it an Unwanted Organism • Review relevant response reports	**HP14** **L4**
	Phase 4	**Monitoring Programme**	
M10	Overwatch of Index Site	• Collate monitoring reports & sample data	**HP14** **L6**
M11	Review	• Conduct review of Response if necessary	**L7**

Table 3: Exotic Mosquito Interception Response Laboratory Task Table

Serial	Phase 1 Notification		X Ref
L1	Notification	NZ BioSecure Laboratory notified of possible Exotic Interception (same data as MoH gets)	**HP 2** **M1**
	Phase 2	**Responders Deployed to the Index Site**	
L2	Digital Image received by on call Lab Staff	• Screened to see if it is endemic or a possible exotic • Inform the Response HPO of screening result and info Environmental and Border Team	**HP6**
L3	Physical Sample received at Lab. (this may be between 6 – 36hrs after collection).	• On call Lab Tech conducts ID process and then: • Informs Environmental and Border Team and HPO of ID results IMMEDIATELY by phone (if exotic) txt & email	**HP7** **M4**
L4	Confirm initial ID	• With Australian Lab (NZ BioSecure Laboratory will arrange) • Provide technical advice to operational staff on the surveillance plan • Provide Technical Training support (if requested)	**L4** **M5**
L5	Ongoing Assistance to Interception	• Lab continues to support interception by • Conducting IDs of any further samples that might be collected • Conducts literature search if it is a novel species and briefs MoH and PHU staff on the characteristics of that species	**M9**
	Phase 3	**Post Interception Administration**	
L6	Review	• Assemble data sets, analyse findings and provide commentary to MoH	**HP14**
	Phase 4	**Monitoring Programme**	
L7	Support Monitoring Phase	• Continue IDs of samples from index site • Be prepared to provide tech support incl training for monitoring programme • Participate in Response Review	**HP15** **M10** **M11**

APPENDIX 31: BIOSECURITY HANDOVER CERTIFICATE

Ministry for Primary Industries
Manatū Ahu Matua

MINISTRY OF HEALTH
MANATU HAUORA

BIOSECURITY HANDOVER CERTIFICATE

Event Type			
Date	/ /	Time	
Location of Intercept			
After hours contact details at location of intercept (Transitional Facility, Port Of First Arrival, etc)			
Organism is assumed to be			
MPI Office		PHS Office	
MPI POC (Point Of Contact) responsible for handover		PHS POC responsible for takeover	
Contact Tel:		Contact Tel:	
Time interception notified to MPI		Time interception notified to PHS	

Outgoing Agency Release of Responsibility

I _____ (print name) of the _____ MPI office

certify that the interception site is clear for the PHS to take over responsibility for the site. In doing so it is acknowledged that:

- all relevant data acquired during the initial phase of the interception has been made available to the PHS;
- all information regarding treatment activities initiated and completed by MPI staff has been made available to the PHS;
- all samples and specimens of suspected exotic organisms have been transferred to the PHS for formal identification.

Signed _____ Date/Time / /

Incoming Agency Acknowledgement of Assuming Responsibility

I _____ (print name) of the _____ PHS office

certify that the interception site is ready for handover of responsibilities from MPI to PHS. In doing so I acknowledge that:

- the Public Health Service Biosecurity response team has sufficient assets in place to manage the interception effectively;
- the MPI POC has provided a comprehensive briefing of all the relevant activities of the interception conducted by MPI as at this point in time.

Signed _____ Date/Time / /

Interception/Incursion Event

Biosecurity Handover Certificate - Notes

1. Introduction

The purpose of the Handover Certificate is to record the relinquishing of the operational responsibility for the conduct of an interception of an exotic organism of public health significance (such as mosquitoes) from MPI to the relevant public health unit for the port or airport concerned.

Note: It is **not** relinquishing full biosecurity authority for risk goods and it is acknowledged that not all MPI functions may have been completed at time of handover of responsibility for the organism.

2. General

The handover of operational responsibility should occur as part of the following sequence:

I. MPI detect or are advised of the presence of an unwanted organism of public health significance within the port/airport or transitional facility.

MPI immediately advise the relevant public health unit for the port or airport concerned of the interception and as part of concurrent activity carry out whatever actions are necessary to contain and control the organism. This activity may include:

a. Securing of samples/specimens so they can be passed to the public health unit
b. Immediate treatment of the risk goods that might still be harbouring the organism (including authorising fumigation of containers)
c. Identification of (and notification to if necessary) stakeholders such as TFs, freight forwarders, importers, port/airport companies, shipping agencies, etc.
d. Containment of risk cargo – e.g., movement restrictions on risk goods
e. Capture of all relevant information so that it can be recorded and passed on to the RPHS Response Team Leader

II. If at any time treatment of the goods/container is undertaken MPI will notify the public health unit of the date, type of treatment and chemicals used.

III. The public health unit will mount an immediate response that will include:

a. Collection of and dispatch of any specimens for formal identification
Note: If identification shows the interception is not a mosquito then the lab will inform MPI as the interception may still have biosecurity implications
b. Delimitation of the incident site in accordance with 'best practice' protocols
c. Initiation of continuation of treatment procedures that may be deemed necessary to ensure control, containment and eradication
d. Notification of the incident to:
    - Chief Technical Officer or Deputy Chief Technical Officer
    - NZ BioSecure Lab
    - Stakeholders – Port Company, TAs, shipping agents, freight forwarders, etc.

IV. Once the public health unit has deployed the necessary resources and has its assets in place and is prepared to carry out the necessary procedures efficiently and in a timely manner the responsibility for the interception will pass from MPI to the public health unit.

3. Handover

At the point in time when the public health unit controller has assets in place then the handover of responsibility will occur. The MPI Inspector in charge of the site will complete two copies of the Handover Certificate, sign them off and give them to the public health unit Controller for countersigning. Each agency will retain one copy of the certificate. Once the certificate is signed off then responsibility for the interception is formally transferred to the RPHS.

Where the interception occurs at a transitional facility (TF) in the Auckland Region the physical handover of the form and the specimen may be conducted through a third party which is to be the TF Operator only.

If the estimated time of arrival of the HPO is greater than 1 hour then handover may be conducted via the TF Operator. If the HPO expects to arrive within the hour then the MPI Inspector will wait and make the handover.

If third party facilitation is agreed the contact details of the TF operator must be provided to the RPHS.

4. Transition Phase

There will be a transition phase when it is anticipated that MPI and public health unit staff will be working side by side until MPI elements can make a “clean break” from the incident site. This transition phase needs to be managed with care by the parties involved.

It is extremely important that the disengaging agency does not leave the site prematurely without ensuring that the processes described above are completed.

Note: There must be designated Points of Contact (POC) for both agencies who have executive authority to sign over the transfer of responsibility.

APPENDIX 32: TEMPLATE FOR A SUMMARY REPORT

SUMMARY REPORT ON VECTOR INTERCEPTION RESPONSE (MOSQUITO/RODENT/OTHER)

This report summarises PHU response actions and control measures for a vector interception response. Submit following a confirmed exotic mosquito (Laboratory ID) or pest of public health significance interception ***within 24 hours of initial notification.***

Send to: *notifyenvhealth@moh.govt.nz*

Date/Time submitted: *xxxxxxxxxxxx*

Person Submitting Report*:* *xxxxxxxxxxxxxx*, Health Protection Officer

Organisation: *xxxxxxxxxxxxxxxx* Public Health Service

Appointment: Health Protection Officer/Biosecurity Authorised Person

Contact Tel Number: *XXXXXXXXXX*

Findings ***(complete sections that apply)*** *Where information is not available or does not apply note this in the relevant space.*		
	Item	**Comments**
1	**Notification received from** Name and occupation Company/organisation. Contact details	
2	**Details of vector discovered** Date/Time notified to PHU, Vector type (mosquito (adult, larva, pupae) or rodent. Number. Dead or alive.	
3	**Circumstance of discovery** Location (point of entry, transitional facility, craft, other). When & how found	
4	**Risk assessment** Craft arrival date into NZ. Last port/s of call Origin and type of goods, owner of the goods, distribution Treatment Vector management activities (IPM, SSC) Current surveillance activity	
5	**Sample-collection and despatch** Date/Time collected/despatched, sample number	

6	**Laboratory initial identification** Date/Time	
7	**Delimit Survey-** Brief outline of your survey response. Date/Time survey conducted (attach map/sketch) of interception site if possible, Outline the survey area Findings from the survey Risk assessment outcome	
8	**PHU Actions** Enhanced surveillance/trapping (attach map or plan if available). Trapping Plan-locations Recommendations to site Consider management (including treatment) of goods, craft, port airport, wider area, surrounding area	
9	**MPI Actions** Name of treatment agent applied Other MPI controls implemented	
10	**Notifications (where relevant) – who and when** ☐ MoH Environmental and Border Team ☐ Own PHU staff ☐ MPI ☐ Port/Airport Authority ☐ Local Authority ☐ Other PHUs for follow-up	
Additional Comments		

APPENDIX 33: ACTIVITY LOG TEMPLATE

	Date/time	*From*	*To*	*Activity*	*Comment/description*
		Name	Name(s)	E.g., email, phone call, letter	Subject matter, action and any further action required
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

APPENDIX 34: NATIONAL MOSQUITO SAMPLE SHEET

To access the mosquito services of Southern Monitoring Services Ltd (SMS-NZB).

Sample – Trap Sheet

Organisation:_____ **Collector:**_____
Date:_____ **Time:**_____ **Location:**_____
Site Ref No./Name:_____ **Trap Number:**_____
GPS E:_____**GPS N:**_____ **Sample Number:**_____

Surveillance type:	Port	◯	Airport	◯	Other:	
Reason:	Response	◯	Routine	◯	Other:	
Sample type:	Larvae	◯	Adult	◯	Other:	

Habitat category: (Circle)

1. Flowing Stream
2. Ponded Stream
3. Lake Edge
4. Swamp / Marsh
5. Permanent Pond
6. Temporary Pond
7. Intermittent ephemeral puddle
8. Natural container
9. Artificial Container
10. Subterranean habitats- natural
11. Subterranean habitats- artificial
12. Other:

Trap type (circle):	CO_2	Light	BG	GAT	Tyre	Other:
Dip Numbers:	+ve dips:		-ve dips:			Temp (^oC):
Trap nights:						Salinity (ppt.):
Treatment:						
Attractant:						

Background Information: (**Habitat description, weather, water event triggering hatch e.t.c)**

RESULTS- TO BE COMPLETED BY TAXONOMIST

	Larvae–Instar				Pupae		Adults	
Species	**1**	**2**	**3**	**4**	**Female**	**Male**	**Female**	**Male**
Other native:					**Other exotic:**			

APPENDIX 35: INFORMATION TO BE PROVIDED TO NFP IF AN EMERGING DISEASE THREAT IS SUSPECTED

Summary of the event

PROVIDE A CONCISE OVERVIEW OF THE EVENT, INCLUDING KEY CHARACTERISTICS AND EVOLUTION (with dates), AND MEASURES IMPLEMENTED.

To the extent possible, (*and where relevant*) provide information on the following:

Case definitions…

Laboratory results…

Source and type of risk…

Numbers of cases and deaths…

Conditions affecting spread…

Public health measures implemented…

Any other information considered relevant… (eg, projections, additional response measures being planned, further information expected to be available shortly etc)

APPENDIX 36: HEALTH ADVICE CARDS

The health advice cards are passport size.

The card is also available in the following languages:
Arabic, Czech, Dutch, English, Farsi, French, German, Greek, Hebrew, Hindi, Indonesian, Italian, Japanese, Korean, Malay, Portuguese, Punjabi, Russian, Samoan, Chinese (traditional and simplified), Spanish, Tongan, Thai, Vietnamese.

The English translation and 6 other commonly used translations are on the Ministry of Health website
http://www.health.govt.nz/our-work/border-health/health-advice-cards-people-arriving-new-zealand

PDF versions of all translations are available on EMIS (see Environmental Health Guidelines and Advice, Border Health, Health advice cards).

If additional copies of the posters, or stocks of health advice cards are required contact an Advisor in the Environmental and Border Health Team who can arrange printing.

APPENDIX 37: TEMPLATE – ILL TRAVELLER PROTOCOL (AVIATION)

Introduction

The effective management of Ill Travellers suspected to be suffering from a communicable disease on aircraft first porting into New Zealand is considered essential under the International Health Regulations (2005), which New Zealand is a signatory to.

The Ministry of Health requires an Ill Traveller Protocol to be in place at every aviation point of entry that has direct international aircraft arrivals. This protocol provides the minimum expectations of the Ministry for what each PHUs Ill Traveller Protocol should contain.

Scope and objectives

This document contains four resources to guide the expected process when the pilot of an arriving aircraft reports ill passengers and/or crew who may be suffering from a communicable disease. The resources are a flow chart, an initial notification recording form, key contact list and a matrix of agency responsibilities.

This Protocol is designed to assist public health, airport, and border agencies staff in planning for and responding to an Ill Traveller notification.

The objectives of the Protocol are to:

- ensure prompt, effective and appropriate management of ill travellers/crew notifications from aircraft arriving into New Zealand
- ensure appropriate identification and management of public health risks when passengers/crew may be suffering from a communicable disease.

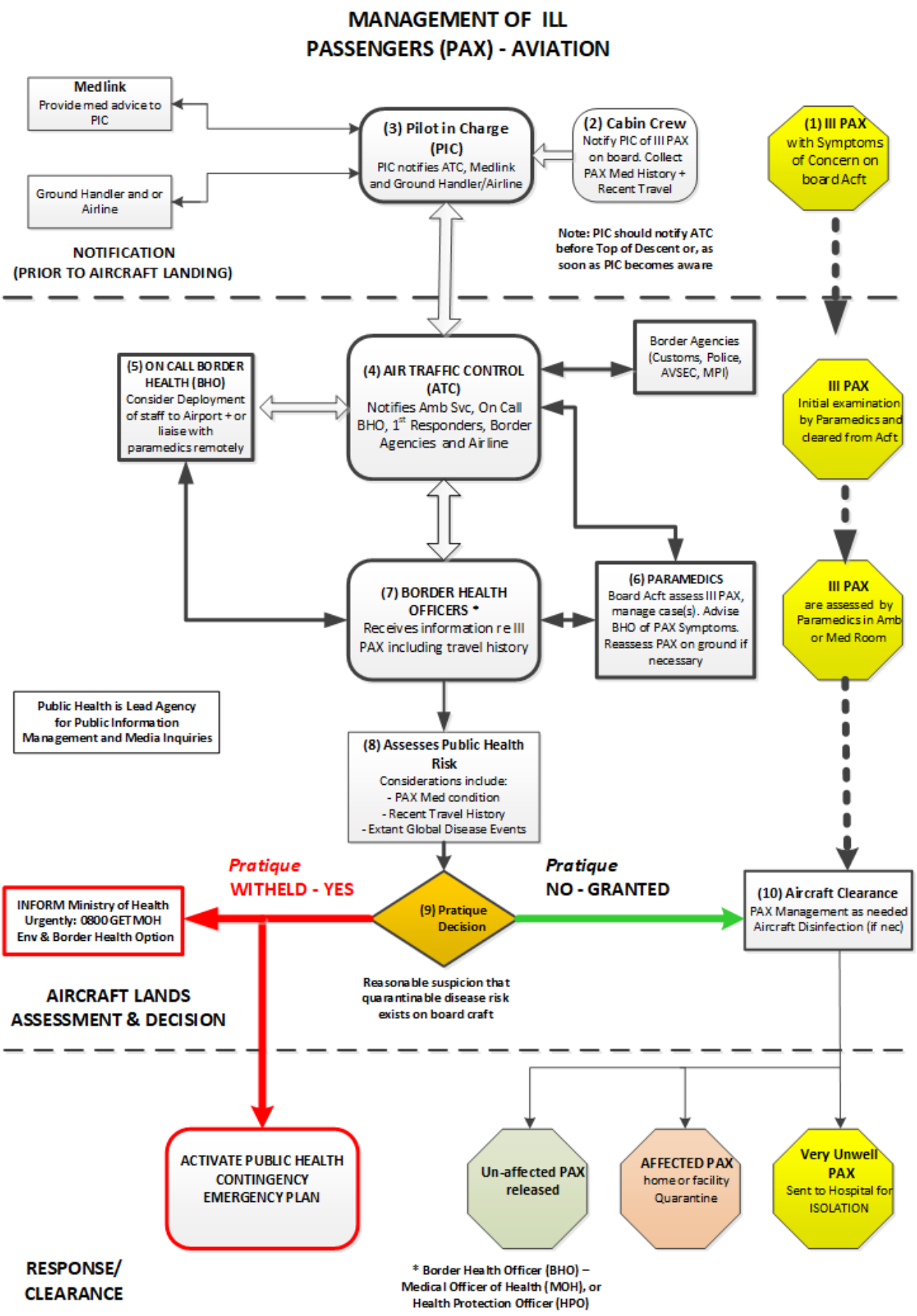
The Protocol links in to the Public Health Emergency Contingency Plan (PHECP). The Plan is expected to be activated if pratique (health clearance) is withheld or in a significant public health emergency event when resources are likely to be overwhelmed

Principles

- International reporting requirements are detailed in the Health part of the International Civil Aviation Organisation Aircraft General Declaration.
- The Health (Quarantine) Regulations 1983 provide the New Zealand legislative framework for reporting and management of persons suspected to be suffering from a communicable disease on an aircraft.
- Health will be the lead agency for an event until a public health risk is deemed not to exist.
- The existence and magnitude of public health risks will be determined by the responding designated officers. Actions to manage public health risks will be commensurate with the assessed magnitude of the risk.
- Minimal disruption of routine operations and travellers' convenience will be the default position unless management of the assessed public health risk requires otherwise.

References

1.World Health Organization; International Health Regulations (2005): http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf
2. Health (Quarantine) Regulations 1983 http://www.legislation.govt.nz/regulation/public/1983/0052/latest/DLM85073.html?src=qs
3.World Health Organization website for current Public Health Emergencies of International Concern http://www.who.int/csr/don/en/index.html


MANAGEMENT OF ILL PASSENGERS (PAX) - AVIATION
Medlink
Provide med advice to PIC
Ground Handler and or Airline
(3) Pilot in Charge (PIC)
PIC notifies ATC, Medlink and Ground Handler/Airline
(2) Cabin Crew
Notify PIC of Ill PAX on board. Collect PAX Med History + Recent Travel
(1) Ill PAX
with Symptoms of Concern on board Acft
Note: PIC should notify ATC before Top of Descent or, as soon as PIC becomes aware
NOTIFICATION (PRIOR TO AIRCRAFT LANDING)
(5) ON CALL BORDER HEALTH (BHO)
Consider Deployment of staff to Airport + or liaise with paramedics remotely
(4) AIR TRAFFIC CONTROL (ATC)
Notifies Amb Svc, On Call BHO, 1st Responders, Border Agencies and Airline
Border Agencies (Customs, Police, AVSEC, MPI)
Ill PAX
Initial examination by Paramedics and cleared from Acft
(7) BORDER HEALTH OFFICERS *
Receives information re Ill PAX including travel history
(6) PARAMEDICS
Board Acft assess Ill PAX, manage case(s). Advise BHO of PAX Symptoms. Reassess PAX on ground if necessary
Ill PAX
are assessed by Paramedics in Amb or Med Room
Public Health is Lead Agency for Public Information Management and Media Inquiries
(8) Assesses Public Health Risk
Considerations include:
- PAX Med condition
- Recent Travel History
- Extant Global Disease Events
Pratique
WITHELD - YES
Pratique
NO - GRANTED
INFORM Ministry of Health Urgently: 0800 GETMOH Env & Border Health Option
(9) Pratique Decision
(10) Aircraft Clearance
PAX Management as needed
Aircraft Disinfection (if nec)
Reasonable suspicion that quarantinable disease risk exists on board craft
AIRCRAFT LANDS
ASSESSMENT & DECISION
ACTIVATE PUBLIC HEALTH CONTINGENCY EMERGENCY PLAN
Un-affected PAX released
AFFECTED PAX
home or facility Quarantine
Very Unwell PAX
Sent to Hospital for ISOLATION
RESPONSE/
CLEARANCE
* Border Health Officer (BHO) – Medical Officer of Health (MOH), or Health Protection Officer (HPO)

ILL TRAVELLER NOTIFICATION FORM

Date / Time Initial of Call ____ / _____ / _20___ _____Hrs MOH/HPO Name _____ _____ File XXXXX

Flight Information: Airline/Flight Number _____ Agent/Caller Name_____ Contact Phone # _____

Ill Passenger(s) / Crew Details:

Initial Information (Required – caller to ascertain and call back)						Subsequent Information		
Seat #	Name	Fever >38°C?	Symptoms reported? And Onset	Country of Embarkation	Countries visited in last 2 -4 weeks	DOB	Ethnicity	NZ address & phone

Date / Time Initial Notification ____ / ____ / _20____ ____Hrs Date / Time Pratique Granted ____ / ___ / _20____ _____Hrs

HPO/MOH's Assessment / Plan (circle appropriate options, write brief plan):

Current international PHEIC? Y / N Likely quarantinable disease? Y / N

Request EOC activation? High / Low / No Need for quarantine? Y / N

Need for Contact tracing? All PAX / _ rows / No Samples requested? Y / N Announcement requested? Y / N

Plan:

KEY CONTACT LIST (INCLUDED IN PROTOCOL OR READILY LOCATABLE ELSEWHERE)

xxx Airport		
Incident Control Room	Emergency (to initiate an ill traveller call Other incidents Duty Operations Shift Manager	
Airport Fire Rescue	Crew Chief	
EOC (once activated)	Shift Manager	
Communications	24/7 Media Service	
General Operations	Business hours	
Ambulance		
Duty Manager	Clinical Control Centre	
Ministry of Health		
		0800 GET MOH
XXX Hospital		
Duty Manager		
Airline contacts		
Media		
Operations		
Chief Medical Officer		
Ground handler		
Other border agencies		
Aviation Security (Avsec)		
Immigration NZ		
MPI		
NZ Customs Service		
NZ Police		
Other		
DHB emergency planner		
Council (EM staff)		
Quarantine Facility Operators		
Transport providers		

MODEL ROLES AND RESPONSIBILITIES MATRIX

Activity	Pilot	Cabin Crew	ATC	Airline	AVSEC	Fire Rescue Svc	Customs	Police	Ambulance Paramedics	HPO	Med Officer Health	MPI	DHB (Hosp)	PH Service	Airport Co	Hotels
Notify ATC	X															
Notify Pilot of Ill Pax		X														
Notify Ground Handler/Airline			X													
Position Acft			X													
Triage Area									X					X	X	
Identify suspect Ill PAX		X				X	X									
Initial PAX Health Check									X							
Cfm Assess											X					
PRATIQUE											X					
Flight Manifest				X			X									
Isolation & Quarantine									X		X		X			X
Security					X			X								
Clinical Assess													X			
Media Releases											X			X		
PAX Baggage												X				
PAX Arrival Cards							X							X		
Fol Up Contacts														X		
PAX to Hospital									X							
Disinfect ACFT				X												

Key

ATC – Air Traffic Control

AVSEC – Aviation Security

Acft –aircraft

PAX – passengers

APPENDIX 38: PUBLIC HEALTH EMERGENCY CONTINGENCY PLAN LIST

Introduction
- Background
- Purpose
- Scope
- Legislation
- References

Activation of Plan
- Establishing the Emergency Operations Centre

Roles and Responsibilities
- Command and Control
- Task Matrix
- Agency responsibilities

Public health risk assessment
- Pratique processes (flow diagrams)
- Suspected case assessment

Management of passengers, crew and craft
- Case management
- Contact tracing and management
- Facilities for holding quarantined passengers
- Infection control and cleaning

Logistics
- Anticipated resources and location

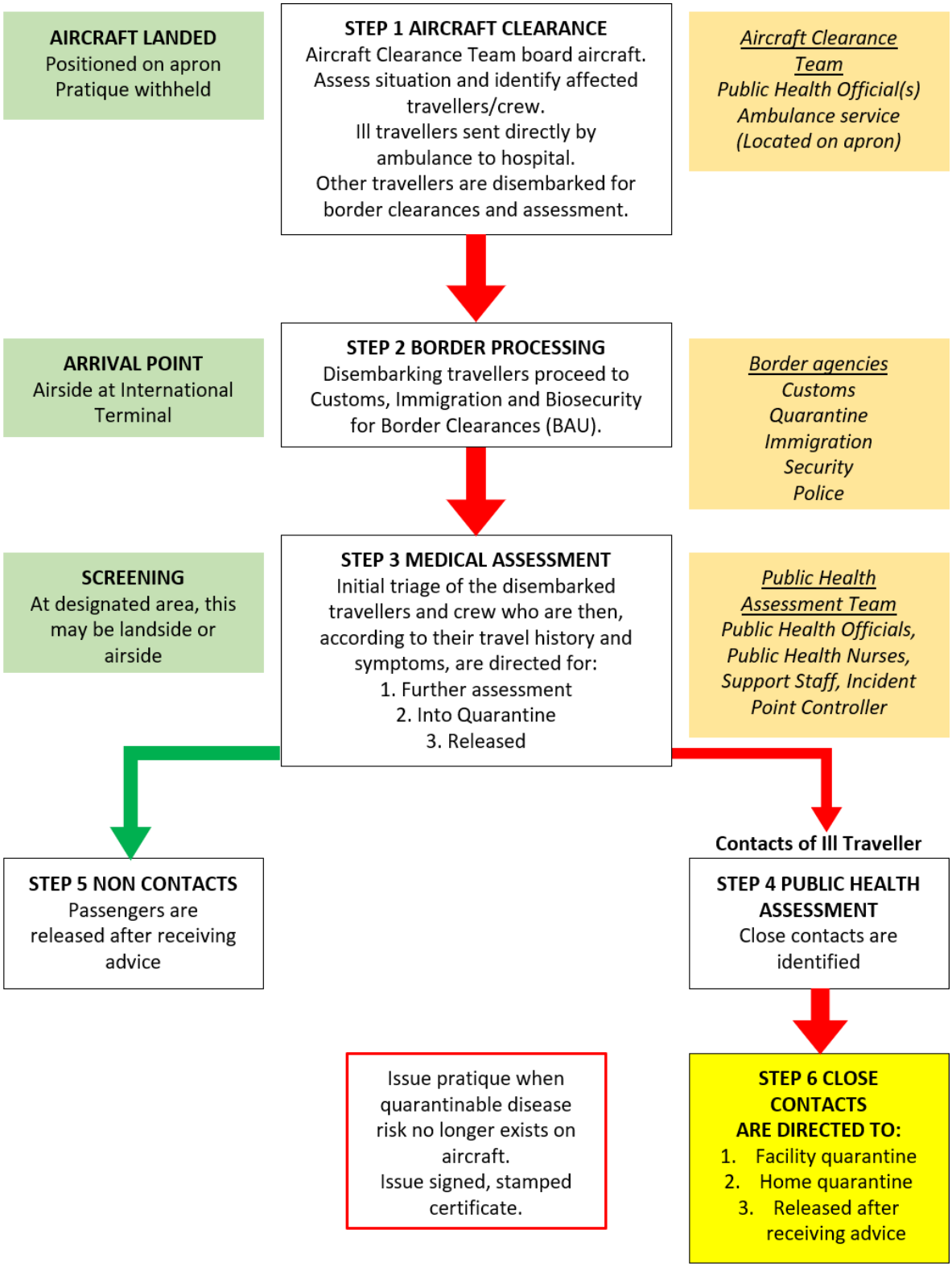
Health and Safety
- Personal Protective Equipment Recommendations

Risk communication
- Key messages and standard messaging
- Media management

Key contact list

Forms/templates

APPENDIX 39: PROCESSING AIRCRAFT WHEN PRATIQUE WITHHELD



Note 1: Quarantine facilities normally located away from the POE.

Note 2: In some circumstances it may be more efficient to disembark the affected passengers/crew prior to conducting medical assessment.

APPENDIX 40: POINT OF ENTRY SCREENING ADVICE TEMPLATE

EXAMPLE ONLY will be amended with disease specific information at the time

Screening of travellers at airports

[DD Month 20YY]

This factsheet helps explain the measures being taken at airports in [insert country or area] and in [insert affected countries] to prevent the spread of [insert disease].

General risk of transmission of [insert disease]

The Ministry of Health considers that it is highly unlikely that anyone with [insert disease] will arrive in [insert country or area], and extremely unlikely that any case of [insert disease] would spread. To get infected, you need to have [type of contact] contact with [eg infected body fluids or heavily contaminated objects]. To date, no one has caught [insert disease] from travelling on an aircraft with an infected person. [delete if not correct]

[Delete this section if not applicable] Exit screening in countries with [insert disease] outbreaks

Since the beginning of [insert month] the World Health Organization has been working with airlines, airports, ministries of health, and other partners to provide technical assistance to countries with [insert disease] outbreaks. The World Health Organization has recommended affected countries screen departing travellers (exit screening). Exit screenings are conducted at airports in these outbreak-affected countries to look for sick travellers or travellers exposed to [insert disease] and to delay them from boarding an airplane until it is safe for them to travel.

Exit screening might look a little different in each country but contains the same basic elements.

All travellers:

- have their temperature taken
- answer questions about their health and exposure history
- are visually assessed for signs of potential illness.

Travellers with symptoms or possible exposures to [insert disease] are separated and assessed further. This assessment determines whether they are:

- allowed to travel
- not allowed to travel on a commercial flight and referred to public health officers for further evaluation.

Entry screening in [insert country or area]

Looking for sick travellers on aircraft flying to [insert country or area]

The captain of an international flight is required to tell public health officers if anyone on board the aircraft has ‘symptoms of concern’. These are an internationally agreed set of symptoms that may indicate a person has a disease of public health concern. The symptoms are a fever (temperature of 38°C or greater) **and** one or more of the following symptoms: persistent

coughing, impaired breathing, persistent diarrhoea, persistent vomiting, skin rash, bruising or bleeding without previous injury, and/or confusion of recent onset.

Once the captain reports an ill passenger, the public health officers will make sure the sick person is assessed and referred for treatment. They will then talk to the people on the aircraft to identify anyone travelling with the ill passenger and anyone else who may have had contact with them.

Looking for sick travellers at [insert country or area] airports

Because of the [insert disease] outbreak, the [insert name of Health authority] and Customs are undertaking additional entry screening of travellers who have travelled from or through [insert affected countries] which are affected by the [insert disease] outbreak. Our staff at all airports remain trained and ready to respond to any reports of ill travellers, and our robust public health system is prepared to respond and assist.

What New Zealand entry screening looks like

Customs officers are checking arrival cards and identifying travellers who list [insert affected countries] as countries visited in the past 30 days. Any travellers identified who have visited the [insert disease]-affected countries will be asked the following questions by Customs officers/will be asked to complete a Public Health Declaration Form [delete as appropriate].

- [insert questions]

If the traveller answers 'no' to all the questions, they will be given a Ministry of Health health advice card.

If the traveller answers 'yes' to any of these questions, the traveller will be isolated and public health officers will undertake a health assessment of the traveller to see if they meet the case definition, may be a contact of a suspected case, or require further public health follow-up. If the Customs officer has any cause for concern, regardless of the responses to these questions, they will seek advice from the public health officer.

People who may have been in contact with [insert disease]

People who may have been in contact with an [insert disease] case in one of the affected countries, or on an aircraft, will be given information about the disease by a public health officer. The travellers will be assessed to see how they may have been exposed and how likely it is that they may get sick. If necessary, they will be asked to take their temperature twice a day, and will be visited or phoned each day by a public health officer to see how they are feeling. Public health officers can also place people in quarantine if needed.

For further background information on [insert disease] see [insert webpage – use relevant MoH or DHB page]

APPENDIX 41: TEMPLATE – POINT OF ENTRY SCREENING QUESTIONNAIRE

The information is being collected as part of the public health response to the increased incidence of [insert disease of concern]. This information will be used by public health authorities in accordance with applicable national laws.

TRAVELLER INFORMATION: [if not collected already]

Flight/ship number/name:..... Seat/cabin:.....
Last (family) name: ..... First (given) name: .....
Passport country: ..... Passport number: .....
Arrival date: Day..... Month..... Year..... Birth date: Day..... Month..... Year.....
Sex: Male..... Female..... E-mail address: .....
Telephone number (include country code or country name): .....
Home address: .....

Addresses for next 21 days: .....

PUBLIC HEALTH INFORMATION:

Today, or in the past 48 hours, have you had any of the following symptoms?	**Yes**	**No**
a. Fever (38°C/100°F or higher), feeling feverish or having chills?		
b. Coughing?		
c. Shortness of breath?		
d. Vomiting or diarrhoea?		
e. [Insert other symptoms of concern (eg skin rash, bruising or bleeding without previous injury, confusion of recent onset)]		

In the past [incubation period] days, have you done any of the following?	**Yes**	**No**
a. Travelled for business or leisure to [insert affected countries]?		
b. Lived in the same household or had other contact with any person ill with a [insert disease or symptoms]?		
c. Space for specific travel or contact question – eg, were you providing medical care to patients?		
d. Space for specific travel or contact question – eg, were you working in a laboratory and having exposure to potentially infectious samples?		
e. Space for specific travel or contact question – eg, have you participated in or attended a funeral?		
f. Space for specific travel or contact question - eg, have you been involved in any capacity with providing humanitarian aid?		
g. Space for specific travel or contact question		
h. Space for specific travel or contact question		
i. Space for specific travel or contact question		

Countries visited: [if not collected already]

List all countries where you have been in the past [incubation period] days (including airports or sea ports, transit ports and where you live) and the dates. List the most recent country first (where you boarded).

Assessment and Actions taken: [to be completed by public health official]

APPENDIX 42: TEMPLATE – HEALTH RISK ASSESSMENT FORM

If a traveller answers 'yes' to the screening questions, a more detailed health risk assessment should be undertaken by a public health officer.

It is recommended that, if at all possible, public health officers arrive at the point of entry at least an hour before a flight with a suspected case or known contacts is due to land. This will enable the officers to ensure appropriate arrangements are in place and to provide advice and reassurance to border officials and point of entry staff who may be concerned about potential exposure risk.

Public health officers should take pre-prepared kits that include the relevant forms and templates, health advice cards and fact sheets. The kits might also need to include an accurate digital sub-lingual or tympanic thermometer, instructions on how to use it and the self-monitoring log (refer to Contact Tracing (section 5.7.10) for further information), and contact details for the public health officer.

The traveller should be interviewed to collect basic demographic, clinical, and epidemiological information.

If a traveller reports symptoms, ensure they are isolated and, if relevant for the disease of concern, provided with a mask and other appropriate PPE. The interviewing officer may also need to wear appropriate PPE. Complete the risk assessment.

Essential basic information

- Full name
- Passport number
- If unwell: date of symptom onset (by symptom, if possible).
- Contact details (e.g. name, home address, home/mobile telephone numbers, email address).
- Demographic information (e.g. date of birth/age, sex).
- Occupation (including specific classification such as healthcare worker, laboratory worker, farm worker etc.)

Exposure Information and travel history

For travellers not experiencing symptoms, possible exposures in the 30 days [or the maximum incubation period for disease of concern] before arrival should be thoroughly explored and described, with special focus on:

- Travel history: Dates, destinations and details of modes of transport for recent travel (local and international); activities during the period of travel (including information on human, animal/vector, food/water and other potential exposure pathways).
- Contact with sick or deceased people: any contact with sick people (eg respiratory illness and/or gastrointestinal symptoms and/or specific symptoms of concern), including people who have been severely ill or have died (indicate the type(s) of contact, frequency, and duration of exposure, and location). Any recent admission in hospital or visit to outpatient treatment facility or visit to traditional healer. Attending deceased and/or participating in funeral rituals.
- Animal (including insect) exposures: presence of animals in or around household area where the case traveller stayed or worked (e.g. pets, rats, other rodents, bats, camels, birds, mosquitoes, ticks and any specific vectors etc.). Any activities that result in animal exposures and type of animals exposed to (e.g. riding or other leisure activities involving animals, keeping livestock, visiting farms, visiting live animal markets or racetracks,

practicing falconry, participating in the slaughter or sacrifice of animals etc.). Any exposures to animal products or products potentially contaminated by animal excreta or body fluids.

- Food exposures: recent consumption of unprocessed, raw foods or drinks. Any recent consumption of raw or undercooked meat, or uncooked blood products. Any recent preparation of fresh meat for consumption. Any sharing of utensils and food containers.
- Other exposures: any use of smoking apparatus such as hookah or shisha (smoking using a water pipe), any exposures associated with the disease of concern.
- Family or friends: any friends or family who may have had high risk exposures (especially if travelling with person being interviewed).

Actions following assessment.

Actions will depend on the outcome of the assessment and may include:

- Suspected case – manage as for suspected case
- No risk contact – no further follow-up required but provided with health advice card. Advised to seek medical attention if symptoms occur.
- Low risk contact – general advice given about low level of risk. Contact public health staff if symptoms develop.
- Medium or high risk contact – additional controls on a case by case basis may be required and will likely include as a minimum daily self-monitoring and reporting.

The Ministry of Health will provide specific guidance during a PHEIC.

APPENDIX 43: TEMPLATE – SUSPECT CASE RISK ASSESSMENT FORM

[Health Authority Logo] **Suspect** [insert disease] **Case Risk Assessment Form**

Name of person …… Contact phone no. in [country]……

Age …… days / months/ years Date of birth ……/……/……. Nationality ……

Flight number …… Seat number …… Date flight arrived NZ ……/……/…….

Date of incident ……/……/…… Time informed ……..…… hrs

Notification Type

Ill traveler notified prior to landing/berthing	☐	National IHR Focal Point	☐
Customs notification on screening	☐	Presentation to Emergency Department	☐
Presentation to a Medical Centre	☐	Specify other:	☐
Other:	☐	Contact Details of Notifier:	
Name of Notifier:			

Risk Assessment in the 21 Days prior to onset of symptoms:

Travel overseas?	Yes / No	If yes which countries, cities, regions, provinces :
For travel in [insert affected country] where and when did you visit?	1.	Dates:
	2.	Dates:
	3.	Dates:
History of contact with any probable or confirmed [insert disease] Cases?	Yes / No	Details of contact:
Did anyone else travel with you?	Yes / No	Names, age, contact details, are they well?
History of exposure to blood or body tissue?	Yes / No	Specify:
History of exposure to [insert risk factor]?	Yes / No	Specify:
History of exposure to [insert risk factor]?	Yes / No	Specify:
History of exposure to [insert risk factor]?	Yes / No	Specify:
Direct contact with others since onset of symptoms?	Yes / No	Details of contact:
Occupation?		State risks identified:
Other activities in [affected country]?		State risks identified:

Major Symptoms	Date of Onset		Duration
Fever (at least 38°C) [especially with chills, rigors or headache]		Persistent diarrhoea	
Persistent coughing		Obviously unwell	
Impaired breathing		Skin rash	
Abdominal pain		Abnormal bleeding	
Persistent vomiting		Confusion of recent onset	
Other (give details)			

Do the symptoms and risk assessment meet the suspected case definition for [insert disease]?
YES NO

Category of Contact:

Casual/No Contact	☐	Contact (Low Risk)	☐
Close Contact (High Risk with no PPE)	☐	Close Contact (High Risk with PPE)	☐
Refer to Ministry of Health (Communicable Diseases team) for guidance on managing contacts			

Public Health action taken:
Advice and information sheet given
Referred to hospital
Referred to GP
On daily monitoring
Other

Comments
……

…..……

…..……

……

……/……/……. Time: …… Hrs

……..……Name Date

APPENDIX 44: CATEGORIES AND MANAGEMENT OF CONTACTS

(EXAMPLE ONLY – WILL BE AMENDED TO BE DISEASE SPECIFIC DEPENDING ON DISEASE RISK)

Category of contact	**Advice /Action**	**Monitoring**
Casual/no contact (no risk)	Provide advice about absence of risk. Provide fact sheet and health advice.	Seek medical attention if symptoms occur and advise health practitioner of recent overseas travel.
Contact (low risk)	Conduct risk assessment. Personal and other relevant circumstances should be considered as part of the risk assessment informing actions and monitoring. Provide advice about likely low level of risk. Provide fact sheet and health advice.	Contact health authority immediately if symptoms develop public health unit staff will make an assessment and arrange clinical assessment and monitoring.
Close contact (high risk) with no PPE	Conduct risk assessment. Personal and other relevant circumstances should be considered as part of the risk assessment informing actions and monitoring. On a case-by-case basis, public health staff may require additional controls or restrictions, and may consider quarantine (home or facility) within 3-5 hours road transport of a referral hospital (for the incubation period since the last high risk contact). Provide support and advice about higher level of risk. Provide fact sheet and health advice. Onward travel should be discouraged.	Twice daily monitoring eg for fever (at least 38°C) and/or other symptoms for XX days from last potential exposure. At least daily contact (with at least one face to face visit early in the monitoring period) from public health unit staff. Contact public health unit staff immediately if symptoms develop, including fever (at least 38°C). Public health unit staff will make an assessment and arrange clinical assessment and monitoring.
Close contact (high risk) with PPE	Conduct risk assessment. Personal and other relevant circumstances should be considered as part of the risk assessment informing actions and monitoring. On a case-by-case basis, public health staff may require additional controls or restrictions, and may consider quarantine (home or facility) within 3-5 hours road transport of a referral hospital (for the incubation period since the last high risk contact). Provide support and advice about higher level of risk. Provide fact sheet and health advice. Onward travel should be discouraged.	Twice daily monitoring eg, for fever (at least 38°C) and other symptoms for XX days from high risk exposure. At least daily contact (with at least one face to face visit early in the monitoring period) from public health staff. Contact public health unit staff immediately if symptoms develop, including fever (at least 38°C). Public health unit staff will make an assessment and arrange clinical assessment and monitoring.

Please see other appendices for examples of assessment forms, monitoring forms and health advice.

Friends or family travelling with a suspected case should be assessed as contacts as they may have been exposed to the same potential source of infection or had direct contact with the suspected case.

APPENDIX 45: FACT SHEETS FOR CASUAL CONTACTS (LOW RISK) OR NON CONTACTS

[Health authority logo]

Information for people who have been on an aircraft with an unwell person

Month 20yy

This information is being provided to you because you have been on an aircraft with someone who has been unwell.

The person who is unwell is receiving medical treatment, and because of their recent travel, is also being tested for [insert disease]. This does not mean the person has [insert disease].

You are not at high risk of catching [insert disease].

There are a lot of diseases you can catch overseas. If you do become unwell within a month of returning to [insert name of country or area], it is important you visit your doctor and tell them you have been overseas, and let them know that you have received this letter.

For further background information on [insert disease] see: [insert website or use WHO website]

APPENDIX 46: DAILY CONTACT MONITORING FORM

DAILY CONTACT MONITORING FORM	PUBLIC HEALTH OFFICER CONTACT No:
Contact's Name:	**Phone Number(s):**

DAY 1	Date:	Time:	Caller's Name:		
Questions			Yes	No	Action Plan
1.) Have you been taking your temperature twice a day?					Remind of importance (See Appendix 1)
2.) Have you developed any symptoms?					If Yes, medical assessment required
3.) Any other household members showing symptoms?					Medical assessment required
4.) Are there any problems?					Welfare assistance required

Add more days as required.

Release from Self Monitoring	Date:	Time:	Advised By:

Comments:

_____
_____
_____
_____
_____
_____

Appendix 1: Reminders to Cases

- **The importance of taking temperature:**
  Fever is mostly likely the first symptom you will develop and as such will give the earliest indication that there is an issue. Early diagnosis and treatment can assist with a good outcome for this illness.
- **The importance of not taking medication before taking temperature:**
  It is important that you do not take medication that may mask a fever (eg paracetamol) for at least 4 hours before taking your temperature.

APPENDIX 47: EXAMPLE MEASURING YOUR TEMPERATURE FORM

[insert disease] Contact Daily Temperature Log

Name:……

You have been asked to record your temperature twice a day for the next …… days. To do this you have been given a thermometer. It is important to use the thermometer properly in order to give a true reading.

To take your temperature, follow the instructions below:

- Remove the thermometer from the plastic container and press the digital button.
- Place the silver bulb under your tongue, where the tongue meets the floor of your mouth. Close your lips around the thermometer making sure it stays under your tongue. You can steady the end of the thermometer with your fingers if you wish, but do not hold the thermometer with your teeth
- After the thermometer has been under your tongue *until it beeps*, remove the thermometer and read the temperature. *Do not hold the silver bulb while reading*.
- Write the date, time and your temperature in the table below.

For children follow the same method but place the silver bulb end of the thermometer high into the child's armpit with the other end protruding forwards. Again, wait until it beeps and then read the temperature. The temperature is best taken when the child is seated on an adult's knee with the child's arms held securely against their side.

Do not measure your oral temperature within five minutes of consuming hot or cold foods or drinks or smoking. Do not take medicine to reduce fever (eg paracetamol, panadol or ibuprofen) for at least 4 hours before taking your temperature.

Remember:

- Please record the date, time and your temperature in the table below.
- Do not allow other people to use your thermometer.

Date	Morning: Time	Temperature (^{o}C)	Evening: Time	Temperature (^{o}C)	Daily Activities*

* brief note of what you did (in case Health authorities need to follow up any significant contact with others) eg home all day, shopping in mall, movie at x cinema, meal at y café, attended wedding

APPENDIX 48: FACT SHEETS FOR CLOSE CONTACTS (HIGH RISK)

EXAMPLE – will be populated at the time of an event by Ministry of Health and provided for use

Information for people who have had direct contact with a suspected case of [insert disease]

Month 20yy

This information is being provided to you because you have been identified by a public health officer as having had close contact with someone who is suspected of having [insert disease].

If the person who is unwell is confirmed as having [insert disease], there is a possibility that the illness could have been passed on to you. We will be in regular communication with you, and once we have confirmed whether the person has [insert disease] or not, will inform you.

What is [insert disease]?

[Insert disease] is a disease caused by a [virus/bacteria/protozoa]. There is/is no vaccine against [insert disease] available. [Insert disease] can cause a serious illness but if the disease is identified and treated early then recovery is more likely.

How is it spread?

- [insert disease] spreads from person to person by [insert text].
- [insert disease] could also be spread through [insert text].
- [insert disease] can also be caught by [insert text].

Am I at risk of catching [insert disease]?

As you have been identified as having contact with a person suspected of having [insert disease]it is important that you are monitored, so that any early symptoms of [insert disease] can be detected and treated.

How is my health monitored and for how long?

Your health will need to be monitored until [insert disease] is ruled out, or until [insert maximum incubation period] days since your last contact with the suspected case or high risk exposure. Monitoring your health involves:

- Having your temperature taken twice daily. Do not take any medicine that may reduce fever (eg Panadol, Paracetamol) for four hours before taking your temperature. If your temperature is elevated, or you begin feeling unwell, limit your contact with people and ring the public health officer.
- A public health officer will make contact with you each day to check on you and answer any questions you might have.

What are the symptoms?

The early symptoms of [insert disease] are [insert symptoms].
Other symptoms can include [insert symptoms].
Note that the early symptoms of [insert disease] are similar to a lot of other illnesses, so having these symptoms does not necessarily mean that you have [insert disease]. However, it is important that you let the public health officer know as soon as you start to feel unwell as although [insert disease] can cause a serious illness, early identification and treatment makes recovery more likely.

Is there anything else I should know or do?

The public health officer will tell you if you should not [insert text eg not return to work or school not meet people, not catch public transport, not go to the shops].

More information

You can find out more information at [insert website or use WHO website]

APPENDIX 49: CLEANING ADVICE FOR AIRCRAFT AND BAGGAGE HANDLERS

The health and safety of airport and airline staff is the responsibility of their respective employers in conjunction with the workplace health and safety authority. However, public health officers can give general advice about communicable diseases and the Health authority's general risk assessment for the disease.

The International Airline Travel Association (IATA) and the WHO have provided advice on aircraft sanitation, as it is imperative that any cleaning products are safe and appropriate to use on aircraft (as well as effective in disinfecting and decontaminating aircraft). This link to IATA's website includes a link to the WHO Guide on Hygiene and Sanitation in Aviation: http://www.iata.org/whatwedo/safety/health/Pages/index.aspx.

For any ill traveller on board an aircraft, the airline's ground and cleaning crews should be notified so that preparations can be made to clean the aircraft after passengers have disembarked.

Guidance for Air Cargo Personnel: There is no risk to baggage handlers from suspected unwell passengers on the aircraft. Handling of baggage should not pose a risk unless it is visibly contaminated. It is good practice for cargo handlers to wash their hands frequently to prevent exposure to other infectious diseases or contamination.

Baggage or packages visibly soiled with blood or body fluids should be handled as little as possible and be set aside in a secure area. PPE (disposable gloves, mask and apron) must be worn by any staff who do handle any soiled packages or baggage. All biohazardous material should be disposed of using infectious waste procedures.

APPENDIX 50: PROCESS FOR CLEANING RESIDUALLY TREATED (DISINSECTED) AIRCRAFT

Where an aircraft has been residually treated for the purposes of disinsection and the certificate is still current, a touch up spray will be required to be applied to areas where the residual insecticide has been removed due to cleaning. Seek advice from New Zealand Ministry for Primary Industries or advise the airline to contact the equivalent agency in their home country if aircraft staff are unsure of the correct procedures.

When specific areas require wet cleaning, (e.g. to sanitise a small section of wall lining, bulkhead, overhead locker or toilet), permethrin must be reapplied to those areas using a permethrin aerosol touch up spray (as is normally carried out for any area subject to repeated substantial cleaning).

Currently there are only two brands of touch up (pre-embarkation) aerosol approved for use in aircraft (Arandee and Callington).

The pre-embarkation aerosol (green top, 2% permethrin) should be directed to the cleaned surface at close range (around 300mm away) so the droplets of spray adhere to the cleaned surface. Food preparation areas, food trays, bench tops and electronic equipment (such as video monitors and controls) should **not** be treated.

When entire walls or sections of carpet are replaced or the aircraft has undergone a deep clean, it will be necessary for the usual treatment applicator to reapply a permethrin coating to those areas.

The steps are as follows:

Step	Action
1	The aerosol can must be directed at the cleaned surface and discharged approximately 30 cm away in a method that ensures that the droplets of the spray cover all cleaned surfaces.
2	Interior cleaning and soiled item replacement of a relatively minor nature are considered negligible in the overall context of the program, and will not require re-spraying during turn around, but should be treated at the first available opportunity to ensure compliance.
3	It will be necessary for the residual spray to be reapplied when fixtures such as entire walls or large sections of carpet are replaced or have undergone a deep clean.
4	Fixtures used for replacement purposes may be treated off aircraft, but these items must be treated either on the same day or on a date after the aircraft disinsection is carried out in order for the certificate to comply.
5	Any non-compliance in procedures should be reported to the intended first port of arrival as soon as possible.

APPENDIX 51: EXAMPLES OF STANDARD MESSAGING

Passengers

Before disembarking and clearing any quarantine area it may be necessary for cabin crew to make a general announcement to advise travellers, as follows:

Standard information:

> *Ladies and gentleman, thank you for your cooperation. As you may know, some passengers on this flight were ill with a condition that may be infectious and subject to the International Health Regulations.*
>
> *Public Health Authorities may need to contact you should there be a need for any further action. Can you please complete your customs arrival cards as thoroughly and accurately as possible? Please ensure your writing is legible. Depending on where you were seated on the aircraft, you may be directed to a separate Immigration and Customs line, and may receive written information. Please follow the directions of airport staff.*

If verbal briefing required:

> *Public Health Authorities will provide a briefing to those of you who could have had direct contact with the unwell passenger. Please follow directions of airport staff and wait for the briefing if required.*

For all passengers:

> *Should you develop an illness with fever in the next month please keep yourself separate from others and contact a health practitioner. Please tell them you have recently returned from overseas, and that there was a sick passenger on your flight*

Public in Arrivals Hall

> *Attention Please. Attention Please. This announcement concerns the arrival of flight {flight number} from {flight origin} scheduled to arrive at {ETA}. Some passengers on this flight have presented with symptoms of ill health. Health authorities are assessing the situation and there may be delays with processing passengers from this flight.*
>
> *We will provide you with regular updates on the status of this flight.*

Media

> *{number of ill PAX} passengers on {flight number} from {flight origin} scheduled to arrive at {…….. Airport } at {ETA} have presented with symptoms of ill health. Health authorities are assessing the situation and are working quickly to process passengers from this flight. We will provide you with more details as soon as reasonably possible, once the initial public health risk assessment is complete.*

Key messages (for media spokesperson)

- *The _____ Health Authority is following its standard protocols and procedures in relation to an incident of this nature. This involves working with and communicating with other appropriate agencies as relevant, including {the airport, airline, etc}*
- *Specific details of the case(s) cannot be disclosed due to patient confidentiality.*
- *For further media enquiries please contact our Media Spokesperson on _____*