Communicable Diseases Network Australia annual report, 2005

Introduction

In Australia, although the surveillance and prevention of communicable diseases is largely the legislative responsibility of the states and territories, a nationally consistent approach to communicable disease management is obviously desirable. This report aims to highlight the communicable disease challenges that Australia faces, and the integral role the Communicable Diseases Network Australia (CDNA) plays in providing a cohesive national response to these threats.

The report describes the activities of the CDNA in 2005. Section two provides some background to the Network and section three outlines the significant changes to the National Notifiable Diseases Surveillance System (NNDSS) and the notable communicable disease activity for 2005. Section four gives examples of other important work that CDNA did in 2005, including its response to particular disease outbreaks and important policy questions, and also outlines some projects that are of strategic importance to CDNA, without CDNA being integrally involved in them. The achievements and challenges of CDNA's working groups and subcommittees in 2005 are highlighted in section five.

The varied and complex work of the Network is evident from this report, as is the increasing demand for CDNA's contributions to communicable disease policy. With the emergence of new infections, the threat of antimicrobial resistance and bio-terrorism, climate change and the re-emergence of infections previously thought to be well controlled, communicable disease has become one of the highest public health priorities both in Australia and overseas. Although vaccination has reduced the morbidity and mortality associated with many diseases, the epidemiology of these diseases and their vaccination coverage require enhanced monitoring, and intensified control efforts are required in the disease elimination phases. CDNA's involvement extends to the international sphere, for example, advising on refugee pre-departure assessments for malaria.

About the Communicable Diseases Network Australia

Introduction

In 1989, as part of a joint initiative of the National Health and Medical Research Council and the Australian Health Ministers' Advisory Council (AHMAC), the Communicable Diseases Control Network was established. This network is now known as the Communicable Diseases Australia Network.

CDNA reports to the AHMAC, formerly through the National Public Health Partnership (NPHP). On 30June 2006, the NPHP was restructured into two committees, the Australian Health Protection Committee (AHPC) and the Australian Health Development Committee. CDNA is now a subcommittee of the AHPC.

Objectives

The CDNA vision statement outlines the role of the network:

> 'The Communicable Diseases Network Australia will provide national public health leadership and co-ordination on communicable disease surveillance, prevention and control, and offer strategic advice to governments and other key bodies on public health actions to minimise the impact of communicable diseases in Australia and the region' (CDNA, 2005).

CDNA's key objectives are to:

- promote best practice prevention and management of communicable diseases;
- develop and coordinate national surveillance programs for communicable diseases;
- develop policy and to provide policy advice on the control of communicable diseases;
- support and strengthen training and capacity building in the communicable disease field;

Correspondence: Dr Charles Guest; Deputy Chief Health Officer, ACT Health, GPO Box 825, CANBERRA ACT 2601. Telephone: +61 2 6205 2108. Facsimile: +61 2 6205 1884. Email: charles.guest@act.gov.au

- provide a resource for the investigation and control of outbreaks of communicable disease; and
- liaise with and support other communicable disease control agencies and programs in the region.

Representation

The Network includes representatives from the Australian Government, state and territory governments, key organisations in the communicable diseases field, representatives from New Zealand and the Secretariat of the Pacific Community (as observer members) and other individuals with relevant experience.

Network meetings

CDNA conducts fortnightly teleconferences to share and evaluate the latest developments in communicable disease surveillance and holds additional teleconferences, as required, to obtain specialist assistance and coordinate actions when outbreaks or potential outbreaks occur.

Subcommittees and working groups

Increasingly, CDNA receives requests to provide comment on national policies or surveillance and control issues that have national implications, and issues public statements when appropriate.

To ensure this capability, CDNA utilises the skills and expertise of a wide network of people through the formation of subcommittees and working groups that produce policies, practice guidelines and other outputs. The achievements of these committees and working groups in 2005 are presented in section five of this report.

Highlights from the National Notifiable Diseases Surveillance System

In 2005, there were significant improvements in the NNDSS. Most states and territories began daily transmission of data to NNDSS through the Data Acquisition System (DAS), whilst the remainder transmitted data three times per week. DAS is an automated system which provides a quality check on all incoming data.

- In addition, the National Surveillance Committee (NSC), a subcommittee of CDNA, worked towards obtaining complete and consistent reporting of data through NNDSS. During 2005 the completeness and quality of data improved, particularly in the reporting of influenza type and meningococcal serogroups. The improvement in the timeliness and completeness of NNDSS data has enabled CDNA to review national data each fortnight at CDNA teleconferences since January 2005. (See also the report from the NSC on page 312).

In 2005, NNDSS reported on 61 diseases and conditions. Only three diseases were not notifiable in all jurisdictions—campylobacteriosis (New South Wales), incident hepatitis C (Queensland) and in South Australia influenza was not notifiable, although reports were made to NNDSS. Syphilis notifications were reported by all jurisdictions in two categories—less than two years duration and greater than two years or unknown duration. The bioterrorist agents, tularaemia and smallpox, were made notifiable in all jurisdictions and added to the NNDSS. A list of the diseases that are currently nationally notifiable can be found on the Australian Government Department of Health and Ageing's (DoHA) website at: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/cda-surveil-nndss-casedefs-distype.htm

The major disease activities detected by NNDSS in 2005 were increases in *Chlamydia* and gonococcal infections, continuing a trend evident for some years. There were high rates of pertussis in New South Wales and an increase in notifications of cholera, and hepatitis E acquired overseas. Analysis of NNDSS data also demonstrated a decline in notifications of meningococcal C disease, following the introduction of a meningococcal C vaccination program in January 2003.

Enhanced (or additional) data collections in NNDSS for tuberculosis and invasive pneumococcal disease continued in 2005. Most states and territories were able to send enhanced data on these two diseases directly to NNDSS by the end of 2005. The reporting and analysis of these data were improved by greater data timeliness and consistency. During 2005, CDNA approved, in principle, the collection of enhanced data on three sexually transmitted infections: gonococcal infections, syphilis (of less than 2 years duration) and donovanosis. Enhanced surveillance data collection on meningococcal infections has also been proposed for 2006.

The DoHA website provides access to NNDSS data via a set of user defined queries which allow aggregated data to be viewed by disease, state and time period.

Selected challenges

The following section gives examples, listed in alphabetical order, of the issues that CDNA dealt with in 2005, outside of its subcommittees and working groups. Some of the topics are CDNA's core business (for example, responding to changes in the epidemiology of pertussis and developing policy for

the management of health care workers infected with bloodborne viruses). Others are mentioned because the topics themselves are of strategic importance to CDNA even though CDNA may only be involved on the periphery (for example, antimicrobial resistance and the Biosecurity Surveillance System).

Antimicrobial resistance

The Joint Expert Technical Advisory Committee on Antibiotic Resistance (JETACAR) was established by the then Minister for Health and Aged Care, the Hon. Dr Michael Wooldridge and the then Minister for Primary Industries and Energy, the Hon. John Anderson MP, in April 1998. The JETACAR report, *The use of antibiotics in food-producing animals: antibiotic-resistant bacteria in animals and humans*[1] (1999) was presented to the Ministers in September 1999. The JETACAR report itself proposed an antibiotic resistance management program encompassing human and animal use of antibiotics.

Progress has been made in addressing the recommendations of the JETACAR report. Major areas of concern continue to include: healthcare associated infections caused by bacteria such as 'golden staph' (usually methicillin resistant *Staphylococcus aureus),* vancomycin resistant enterococci and multi-resistant gram negative organisms such as *Acinetobacter* species; community acquired infections with resistant organisms; the use of antibiotics in animals, particularly in stock feeds; and the possibility of resistant bacteria being transmitted from animals to humans, and contributing to resistant infections in humans.

CDNA and the Public Health Laboratory Network (PHLN) have continued to provide advice and feedback on antimicrobial resistance activities to the DoHA. CDNA and PHLN are also represented on antimicrobial resistance related committees such as the Expert Advisory Group on Antimicrobial Resistance, and via these channels, maintain a watching brief on this important issue.

Avian and pandemic influenza

The increasing number overseas of human cases of highly pathogenic avian influenza (H5N1) since December 2004 and the threat of an influenza pandemic has prompted the Australian Government to ensure effective planning and response at a national level.

The CDNA has been providing specific policy advice to the Australian Government relating to planning and response processes, which includes management of human cases of avian influenza. CDNA has been working closely with the National Influenza Pandemic Action Committee (NIPAC) and the then Australian Health Disaster Management Policy Committee (AHDMPC) and has contributed to the development of the *Australian Management Plan for Pandemic Influenza* – June 2005.[2] Together, these groups provide comprehensive national leadership and international linkage for the coordination of planning and response to an influenza pandemic.

CDNA has specifically assisted in the following areas:

- epidemiological and disease control advice to the Australian Government Chief Medical Officer, NIPAC and the AHDMPC for the management and containment of avian influenza to prevent a pandemic;
- advice on methods, definitions and protocols for national surveillance of human cases of avian influenza and contacts of cases;
- advice on situational management according to global and Australian phasing, and assistance with the development of public health protocols and guidelines to address the situation; and
- liaison with other networks such as the Public Health Laboratory Network and infectious diseases sectors of Australia to ensure appropriate clinical guidelines are in place for timely investigation and management of suspected and confirmed cases.

The CDNA provides an operational resource for the investigation and control of suspected and confirmed cases of avian influenza and potential outbreaks of pandemic influenza in Australia.

In late 2005, the CDNA also participated in *Exercise Eleusis.* This national exercise simulated an outbreak of avian influenza and evaluated the industry and government's national capability to manage a zoonotic disease outbreak.

Biosecurity Surveillance System

In the 2004–05 Budget, the DoHA received funding to improve national communicable disease surveillance through the development and implementation of the following information technology systems, which together, make up the Biosecurity Surveillance System (BSS):

- a secure Outbreak Case Reporting System (OCRS);
- improvements to the NNDSS;
- development of a Sentinel GP Surveillance System; and
- a secure communication system.

In December 2005, the Australian Government provided additional funding for the development of the Syndromic Surveillance System (SSS). The SSS is intended to strengthen national surveillance and provide early warning of an influenza pandemic in Australia. The SSS will build on the infrastructure and protocols developed for the BSS.

Analysis and design of the surveillance systems commenced in 2005. The interim OCRS, NetEpi, was enhanced and trialled by OzFoodNet and the Jurisdictional Executive Group of CDNA, and subsequently implemented in July 2005. NetEpi continues to be used by OzFoodNet and is available for use by jurisdictions and the DoHA National Incident Room.

The Health Alert Network, the 'in-confidence' network allowing communication and collaboration amongst the health surveillance community, is being designed and built in-house and is due for implementation in 2006.

Jurisdictions and CDNA are represented on a number of BSS Special Interest Groups (SIG) such as the Laboratory eNotification and Data and Coding Standards SIG and the Cluster and Outbreak Detection SIG. Both of these SIGs conducted meetings in 2005. The Cluster and Outbreak Detection SIG met with disease surveillance algorithm researchers from the Centre of Epidemiology and Research (New South Wales Health), the Centre for Mathematical and Information Systems (Commonwealth Scientific and Industrial Research Organisation), and the Australian Biosecurity Cooperative Research Centre.

General information about the BSS is available on the DoHA website at: http://www.health.gov.au/internet/wcms/publishing.nsf/content/biosecurity%20surveillance%20system-1

Bloodborne virus infection in health care workers

On 22 September 2005, the *Guidelines for Managing the Issues of Blood-Borne Virus Infection In Health Care Workers*[3] was endorsed by CDNA.

With this endorsement, CDNA adopts the same rights-based, minimum compulsion approach to the problem of health care workers infected with HIV, hepatitis B or hepatitis C that has proved so successful in the containment of the general HIV epidemic since the mid-1980s. The document identifies and supports the equal rights for health workers to privacy as their infected patients.

The *Guidelines for Managing the Issues of Blood-Borne Virus Infection In Health Care Workers* contains the following recommendations:

- Where restriction of a health care worker's practice may be necessary, psychological, financial and other support must be provided to encourage self-presentation to a physician with the necessary knowledge and experience in the field. Also, physicians managing such health care workers should be able to seek the advice of a jurisdictional expert advisory panel. Rather than instating specific discriminatory regulations, including compulsory testing, responsible behaviour by both infected health care workers and their treating physicians, to ensure patient safety, can be enforced through the ordinary legal penalties for unprofessional behaviour that already exist in all the jurisdictions.
- With one exception, the restrictions that should be placed on the practice of a health care worker infected with a bloodborne virus, should depend on the real risk of transmission and should be tailored to each individual case. The relevant risks include the worker's level of viraemia, the nature of the practice (namely whether it involves exposure prone procedures and how invasive they are) and the worker's experience. The exception is HIV infection, which should, at present, be an absolute criterion for exclusion from performing exposure prone procedures, even though the likelihood of transmission from a health care worker with low or undetectable virus during an exposure prone procedure is most probably close to zero.
- It is strongly recommended that anyone entering into any undergraduate or postgraduate training, which involves exposure prone procedures, should be aware of their bloodborne virus status and seek professional advice if infected since it is recognised that training is a high risk time for transmission.
- It is essential to ensure the involvement of the relevant jurisdictional registration boards, in order to provide consistent management of infected health care workers.

Dengue

Outbreaks

Two outbreaks of dengue occurred in 2005, both of dengue type 4. The first occurred in the Torres Strait and involved 56 confirmed cases and the second in Townsville, resulting in 18 confirmed cases.

The Torres Strait outbreak, affecting Thursday, Darnley and Murray Islands, was controlled using the *Dengue Fever Management Plan 2005–2010*[4] (*DFMP*) developed the previous year. This required the rapid mobilisation of a large 'dengue intervention force' (comprising 20 health staff sourced from

Queensland Health's Tropical Public Health Unit Network (TPHUN) and Torres Strait) for a two week period. Important factors contributing to the success of this operation included:

- increased levels of awareness and cooperation of residents and other government agencies;
- the Queensland Health funded campaign to remove rubbish that may act as mosquito breeding sites on Thursday Island in 2004; and
- comprehensive repair of screening on rainwater tanks on Thursday Island in 2004.

The Dengue Fever Management Plan 2005–2010

The *DFMP* was revised and distributed by Queensland Health to guide and coordinate the management of dengue fever by local and state government in north Queensland.

The *DFMP* focuses on three central components of dengue management: disease surveillance; mosquito control and surveillance; and education.

There are three levels of dengue activity:

- ongoing prevention: where there is no current dengue activity in the zone;
- response to sporadic cases: where there is no current dengue activity in the zone, but the TPHUN is notified of an imported case of dengue or a possible locally-acquired case; and
- outbreak response: where one or more locally-acquired cases occurs concurrently in the zone.

The *DFMP* also outlines ongoing research into dengue transmission and control. The *DFMP* is available on the Queensland Health website at: http://www.health.qld.gov.au/dengue/managing_outbreaks/default.asp or the *Dengue in North Queensland* website at: http://www.health.qld.gov.au/dengue/default.asp

Dengue prevention campaign

In June 2005, Queensland Health's TPHUN developed a new dengue fever prevention campaign, after a survey revealed only one-third of Townsville and Cairns residents took steps to get rid of dengue mosquito breeding sites. The 'Stop mozzies breeding' awareness campaign features posters, post cards, brochures, bin stickers and fridge magnets.

Dengue and CDNA

The CDNA contributes to dengue control primarily through advice from the National Arbovirus and Malaria Advisory Committee (NAMAC). During 2005, NAMAC was involved in the *Aedes albopictus* delimiting survey and subsequent surveillance and control activities in the Torres Strait and the Tennant Creek *Aedes aegypti* eradication program. The possible spread or introduction of *Aedes aegypti* from its present distribution in Queensland is being closely monitored. Although the *Aedes albopictus* mosquito is not as good a vector as *Aedes aegypti*, the prevention of the introduction and establishment of *Aedes albopictus* remains a high priority because this mosquito has the potential to spread widely over Australia, including southern areas (see report from the NAMAC on page 310).

Gastrointestinal and foodborne diseases

Foodborne disease is an important part of the CDNA's work, as contaminated food often causes multi-state outbreaks and requires a coordinated response. OzFoodNet—Australia's system for enhanced foodborne disease surveillance—and Food Standards Australia New Zealand are both members of CDNA. In addition, all states and territories have responsibility for investigating and controlling foodborne and gastrointestinal diseases.

Each fortnight at their teleconference, the CDNA reviews notifications of potentially foodborne diseases to the NNDSS and reports of outbreaks in jurisdictions. This allows CDNA to monitor the status of foodborne diseases and detect multi-state outbreaks. OzFoodNet conducted several multi-state outbreak investigations during 2005, under the auspices of CDNA. These included outbreaks of *Salmonella* Hvittingfoss, *Salmonella* Havana, *Salmonella* Typhimurium 44, and *Salmonella* Typhimurium 135a.

CDNA considered papers on food safety and foodborne illness, including illness associated with chicken meat and eggs, and efforts to improve national outbreak coordination. At the CDNA 2005 Communicable Disease Control conference two sessions on foodborne and enteric diseases highlighted the work that states and territories conduct through CDNA.

The recent *Exercise Eleusis* on avian influenza involved CDNA and touched on many food-related issues. CDNA made use of the membership of Food Standards Australia New Zealand to prepare advice relating to consumption of egg and poultry products.

Investigation into an outbreak of desquamating rash among clients in treatment for opioid dependence

In late 2004, the NSW Health Department received several reports of a desquamating rash among clients of the methadone program. In response, NSW

Health, in collaboration with the CDNA, initiated a series of investigations to identify the likely cause, including active surveillance for cases, a survey of dosing points and a case control study.

Over 380 cases were identified across Australia, largely in New South Wales. Almost all cases were identified among clients prescribed one form of methadone. No abnormality or contaminant was identified on testing suspected batches of methadone. While the exact cause of the outbreak could not be determined, batches of methadone temporally associated with the outbreak were quarantined from use, and the outbreak subsided.

This investigation highlighted the importance of a coordinated approach to the investigation and response to national disease outbreaks.

Pertussis

Background

Pertussis was first notifiable in South Australia in 1909 and in most jurisdictions from the early 1930s. National compilation of pertussis data ceased in 1949 and did not recommence until 1979.[5] The current case definition allows for reporting of both laboratory-confirmed cases and clinical cases (with or without an epidemiologic link), although the majority of cases are laboratory-confirmed only.[6]

Diphtheria-tetanus-pertussis vaccine was introduced in 1953 and childhood immunisation programs have included pertussis vaccine since that time. Pertussis is a cyclic disease. Epidemics occur every 3–5 years, although rates of notifications in current peak periods correspond with the troughs of pre-immunisation days. In 2004, Western Australia experienced an outbreak of pertussis in which notification rates slightly exceeded 100 cases per 100,000 population. In 2005, the cyclic epidemic affected South Australia (95.1/100,000), New South Wales (86.6/100,000) and the Australian Capital Territory (96.3/100,000).[6]

Control strategies

In the early to mid-1990s, a National Pertussis Working Party was convened to develop strategies to control pertussis in Australia. The *Guidelines for the control of pertussis in Australia*[8] were developed and became an authoritative document on notification, investigation, case management and public health management of pertussis.

Whilst information contained in the Guidelines is no longer current, the practice of supporting vaccination programs, appropriate case management, chemoprophylaxis for defined contacts and other outbreak control measures remains a priority of CDNA. The objective of public health management of pertussis is to reduce outbreaks of disease and reduce morbidity and mortality, especially in infants who are at high risk of severe disease and adverse outcomes. Priorities for management of pertussis are also now contained in *The Australian Immunisation Handbook.*[9] Public health authorities in most jurisdictions have inadequate resources to investigate all notifications of pertussis, but follow regularly reviewed practices in an aim to identify high risk contacts and identify and manage potential outbreaks. CDNA is also a focal point for scrutinising responses to the cyclical epidemic, and to provide support to general and specific outbreak control measures, such as those implemented during 2005.

Vaccination

Since 1999, the funded childhood schedule has included an acellular pertussis vaccine that is considerably less reactogenic than its whole-cell predecessor. In January 2004, the 15-year-old diphtheria-tetanus (dT) booster was replaced by dTpa, which includes an acellular pertussis component. It is anticipated that increasing uptake of this booster will reduce transmission of pertussis by reducing disease in adolescents and young adults, who are recognised as a significant reservoir of infection. This vaccine is also recommended for adults who have contact with infants and young children – including parents, carers and child care workers. CDNA continuously advocates and promotes uptake of this vaccine among these groups.

Challenges

Aspects of pertussis control remain a challenge. Members of the CDNA have in recent years conducted research to improve the efficiency of pertussis investigation and follow-up. During outbreaks, information alerts to clinicians and settings such as child care have been shown to increase detection of disease during the infectious period, enhancing the window of opportunity to identify and manage vulnerable contacts.[10]

Highlights from the subcommittees and working groups

The following section describes the achievements and challenges of CDNA's working groups and subcommittees in 2005, in alphabetical order.

Case Definitions Working Group

Background

The Case Definitions Working Group was convened in 2001 to revise or develop standard surveillance case definitions for all nationally notifiable diseases for reporting to the DoHA. The Working Group comprises members representing all states and territories, the DoHA, the PHLN, OzFoodNet, the National Centre in HIV Epidemiology and Clinical Research (NCHECR), the National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases (NCIRS) and other communicable disease experts. Laboratory definitions previously developed by the PHLN formed the basis for the Surveillance Case Definitions, with clinical and epidemiological elements added, as appropriate.

Major activities

At the beginning of 2005 the Working Group was presented with 17 case definitions for which review had been requested. The definitions for review were:

- *Chlamydia;*
- cholera;
- Creutzfeldt-Jakob disease – classical (cCJD);
- Creutzfeldt-Jakob disease – variant (vCJD);
- hepatitis E;
- human immunodeficiency virus (HIV) – newly acquired;
- HIV – unspecified;
- influenza;
- Japanese encephalitis virus infection;
- Kunjin virus infection;
- meningococcal – invasive disease;
- pertussis;
- severe acute respiratory syndrome (SARS);
- syphilis – infectious (primary, secondary, and early latent), less than 2 years duration;
- syphilis – more than 2 years duration;
- syphilis – congenital; and
- tularaemia.

The Working Group met three times, by teleconference, through 2005 and has submitted to CDNA final recommendations on all but three definitions from the review list. The recommended changes are unlikely to have a significant impact on the number of cases notified.

Case definitions still under review include cCJD, vCJD and SARS.

Communicable Disease Control Conference Organising Committee

The 2005 Communicable Diseases Control Conference, convened by the CDNA and the PHLN was held at the Convention Centre, Sydney on 2–3 May 2005. Because effective disease control and prevention demands close collaboration among experts in many different fields, and the conference aimed to bring these people together, the theme was *Piecing Together the Jigsaw.*

Dr John Watson from the United Kingdom Health Protection Agency and Dr David Butler from the Canadian Public Health Agency were among the keynote speakers. Along with presentations (both oral and poster) from those who submitted abstracts, panel discussions were held on 'Avian influenza', 'Current and future challenges and opportunities in communicable diseases control in Australia' and 'Public health issues from the Asian tsunami disaster'.

The conference was a great success with the highlights being the oral presentations and keynote speakers.

Improving Indigenous Identification in Communicable Diseases Reporting Project Working Group

Background

In late 2004, the DoHA received a report titled *Improving Indigenous Identification in Communicable Diseases Reporting.*[11] The CDNA was requested to provide input to the DoHA response and consequently established the Improving Indigenous Identification in Communicable Diseases Reporting Project (IIICDRP) Working Group to prepare a written report.

Improving the quality of Indigenous identification in communicable disease reporting will make a contribution to better health for Aboriginal and Torres Strait Islander peoples. Benefits identified arise from improved data collection leading to enhanced quality data and a clearer picture and understanding of communicable diseases in Aboriginal and Torres Strait Islander populations. This enables appropriate actions to address the identified issues and allows the measurement of change over time. One of the major contextual challenges to these identified benefits, especially for Indigenous people with communicable diseases, is diagnosis and data capture at the outset. *Improving Indigenous Identification in Communicable Diseases Reporting* aims to provide some insight into how Indigenous identification can

be improved in communicable disease reporting and recommends a number of short, medium and longer term strategies.

Standardising the process of collecting and reporting Indigenous identification for all communicable diseases in all jurisdictions is the highest order recommendation made in the report.

Major activities

The IIICDRP Working Group will focus primarily on those recommendations which will be implemented by jurisdictions. The aim of the working group is to categorise the recommendations into those that:

- are able to be implemented immediately without the need for further funding;
- could be implemented with further funding; and
- are not feasible for implementation by jurisdictional health authorities.

The Working Group expects to have a written report for the CDNA's endorsement finalised in 2006. This report will provide an analysis of the recommendations in the original discussion paper and focuses on key recommendations which are likely to lead to maximum improvements in the Indigenous notification system.

Infection Control Guidelines Working Group

Background

The Infection Control Guidelines Working Group was established to review components of the *Infection Control Guidelines for the Prevention of Transmission of Infectious Diseases in the Health Care Setting*[12] (ICGs) relating to CJD (Chapter 31 and Appendix 9) and the section on autoclaving of asthma spacers (Section 17.6.2 and 17.6.3). The Working Group is comprised of national experts from the fields of clinical infectious diseases, health care associated infection prevention and control units, infection management services, with representation from the Australian National CJD Registry and CJD Incident Panel, state and territory governments and the DoHA.

Major activities

The Working Group conducted two face-to-face meetings in 2005, which achieved the following outcomes.

1. An approach to the review of the CJD components of the ICGs was established, including;
   - major revision of the CJD chapter to exclude non-essential information;
   - consolidation of the CJD components into a single chapter;
   - inclusion of evidence for recommendations made in the guidelines;
   - development of risk levels arising from possible exposure to CJD;
   - inclusion of risk assessment tools and action items for practitioners to use in the health care settings; and
   - recommendations on the infectivity of the tissues from the anterior eye.
2. Following consultation with the Therapeutic Goods Administration, advice was provided to the National Asthma Council regarding reprocessing of single patient use spacers.

The following activities are planned for the 2006:

- link the revised cCJD infection control document to separate infection control guidelines for vCJD;
- seek input from dentists and maxillofacial surgeons with regards to procedures considered high risk in their profession and infection control;
- consider management practices for surgical instruments used during and after the diagnostic and therapeutic procedures;
- agree on a clearance process for the updated chapter on cCJD; and
- develop timetable for the revision of the remaining ICG chapters.

Inter-Governmental Committee on HIV/AIDS, Hepatitis C and Related Diseases

Background

The Inter-Governmental Committee on HIV/AIDS, Hepatitis C and Related Diseases (IGCAHRD) is the key advisory body to the NPHP, through the CDNA, on policy and program issues and activities related to the response to HIV/AIDS, hepatitis C and sexually transmissible infections (STIs). The committee comprises representatives from all states and territories, the DoHA, and community-based organisations which represent people affected by HIV, hepatitis C and STIs. Three subcommittees, which aim to improve data standardisation nationally and develop methods to improve national surveillance for HIV, viral hepatitis and STIs, also report to IGCAHRD.

Major activities

During 2005, the IGCAHRD was involved in the development and endorsement of the *National HIV/AIDS, STI and Hepatitis C Strategies 2005–2008*[13–15] and the *National Aboriginal and Torres Straits Islander Sexual Health and Blood-Borne Virus Strategy 2005–2008*.[16] All four of these strategies were officially launched by the Minister for Health and Ageing in 2005. Subsequent to the strategy launches, the IGCAHRD played a key role in the development and endorsement of Implementation Plans for each of the strategies.

During 2005, representatives of the IGCAHRD were also involved in the following activities:

- participation in the planning and implementation of World AIDS Day 2005;
- the review of the national anti-retroviral guidelines for treatment of HIV;
- co-chairing the review of the national HIV Testing Policy;
- the process the National Pathology Accreditation Advisory Council is undertaking at the request of IGCAHRD to develop accreditation standards for laboratories which perform HIV and hepatitis C virus testing;
- the development of evidence-based guidelines for hepatitis C treatment, care, support education and prevention in correctional settings;
- the revision of national projections for hepatitis C;
- the Hepatitis C Surveillance Strategy Review Subcommittee;
- the reference group for the economic evaluation of hepatitis C in Australia;
- the review of the work plans, terms of reference and governance arrangements for the viral hepatitis, HIV and STI surveillance subcommittees of IGCAHRD;
- the development of a framework for mapping of HIV, hepatitis C and STI-related prevention and education activities;
- the Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis C (MACASHH) Research Round Table;
- observer at MACASHH and its three subcommittees; and
- the National *Chlamydia* Screening Pilot Program reference group.

In addition:

- The STI Surveillance Subcommittee has contributed toward the establishment of a minimum national dataset for enhanced (or additional) surveillance for STIs and conducted a national review of laboratory testing data collected for *Chlamydia.*
- The National Viral Hepatitis Surveillance Committee has been likewise preparing a draft dataset for newly acquired hepatitis B and has also prepared an information sheet, which has been used to promote enhanced surveillance of newly acquired hepatitis C among GPs; and
- the National HIV Surveillance Committee is working toward the establishment of surveillance of HIV subtypes among cases of newly diagnosed HIV infection, is carrying out an assessment of the completeness of AIDS notification through linkage to the National Death Index and is reviewing the content of national HIV/AIDS notification forms.

During 2005 the IGCAHRD developed the *Infrastructure Benchmarks for the Design, Implementation and Evaluation of HIV/AIDS, STI and Hepatitis C Health Promotion Programs*[17] and submitted the document to CDNA for endorsement prior to release.

IGCAHRD members continue to be involved in the on-going analysis of HIV, STI and hepatitis C notification and social research data; and the program response to the increases in HIV, gonorrhoea, *Chlamydia* and syphilis. The IGCAHRD will continue to work with all key stakeholders and DoHA to progress activities identified in the *National Strategy Implementation Plans 2005–2008.*[18]

Inter-pandemic Influenza Working Group

Background

The Inter-pandemic Influenza Working Group was formed in 2004 to develop guidelines for the management of influenza outbreaks in residential care facilities (RCFs). The Working Group consists of public health representatives from all Australian states and territories, with support from the DoHA.

RCFs are considered to be high-risk environments for influenza due to communal living arrangements and the continual close proximity of residents. Nursing homes and hostels catering for the elderly are especially high-risk environments due to the older age of residents and high prevalence of chronic medical conditions.[19,20]

Major activities

In 2005, the Working Group developed the *Guidelines for the Prevention and Control of Influenza Outbreaks in Residential Care Facilities in Australia.*[21]

The purpose of the Guidelines is to provide national best practice guidelines for staff of public health units for preventing, defining and managing outbreaks of influenza in RCFs in Australia during inter-pandemic periods.

The main strategies emphasised in the Guidelines to prevent and manage outbreaks are vaccination prior to the influenza season and during an outbreak, the use of antiviral therapy for treatment and prophylaxis, infection control measures including restriction of movement between affected and unaffected areas and minimising contact between affected and unaffected persons during an outbreak, and maintaining good surveillance in RCFS so that appropriate interventions can be promptly instituted.

The Guidelines will be distributed to all public health units in Australia in 2006 and copies will be available to residential care facilities on request. They are also available on the DoHA website at: http://www.health.gov.au/internet/wcms/publishing.nsf/content/cda-pubs-other-flu_guidel.htm

Meningococcal Disease Working Party

Background

The terms of reference for the Meningococcal Disease Working Party are to consider current evidence in the epidemiology and management of meningococcal disease and submit recommendations to CDNA as appropriate, which may include the following activities:

- revisions to the *Guidelines for the early clinical and public health management of meningococcal disease in Australia;*[22]
- consideration of issues relating to the implementation of the National Meningococcal C Vaccination Program; and
- provision of advice on the management of outbreaks of meningococcal disease to health authorities.

The Working Party is comprised of national experts from the fields of clinical infectious diseases, microbiology, surveillance, and public health; and representation from public health units, state governments, the DoHA and the NCIRS. Ms Maureen Watson, representing the National Immunisation Committee, provides the important link with the routine vaccination program. The Working Party has also benefited from the insights provided by Dr Diana Martin as the New Zealand representative, on the issues faced in the New Zealand situation of hyperendemic group B disease, and the specific vaccination program being rolled out in response.

Major activities

In 2005, the Working Party continued its review of the current guidelines, which commenced in 2004. The group has met regularly by teleconference, and has almost completed draft changes to the Guidelines, mostly in relation to the use of the conjugate meningococcal C vaccine for contacts of cases, and for cases. Further consideration of new available evidence for the definition of contacts requiring clearance antibiotics has also been undertaken, along with updates of the case definition to take account of new technologies and new routine protocols in laboratories, and of the national surveillance dataset. It is expected that a draft will be ready for consideration by CDNA in 2006.

The Working Party has noted, with pleasure, the excellent coverage attained for children 12 months of age with the meningococcal C conjugate vaccine, and the reasonable coverage achieved in children aged 2–6 years from the 'catch up' program, based on the Australian Childhood Immunisation Register. Parallel with these achievements, the overall incidence of meningococcal disease in Australia has fallen from 3.5 cases per 100,000 population in 2001 to 2.0 cases per 100,000 population in 2004. During this period, the incidence of serogroup C isolates has decreased by 45 per cent.

National Arbovirus and Malaria Advisory Committee

Background

The National Arbovirus and Malaria Advisory Committee, reporting through the CDNA, makes recommendations on arbovirus and malaria surveillance, strategic arbovirus and malaria disease management and vector control. The Committee provides expert technical advice on malaria and arboviruses to assist in the detection, management and control of real or potential outbreaks of arboviral disease. The NAMAC includes individuals with expertise in surveillance, vector virology control, quarantine and clinical care, representing agencies with a substantial interest in this area.

Major activities

The NAMAC has been developing national flavivirus outbreak management guidelines (dengue virus, Japanese encephalitis virus, West Nile virus, Murray

Valley encephalitis virus). The *Interim National Guidelines for the Prevention, Management and Control of Murray Valley Encephalitis Virus*[23] was completed by NAMAC and endorsed by CDNA in 2005. Work on the guidelines for dengue, Japanese encephalitis and West Nile is progressing.

During 2005, the International Organisation for Migration (IOM) and the Department of Immigration and Multicultural Affairs sought NAMAC clarification on the pre-departure malaria treatment requirements for refugees. The new requirements were clarified and CDNA endorsed the *Recommendations for refugee pre-departure assessment/treatment for malaria* prepared by the IOM.

The NAMAC is also assisting the DoHA and Australian Quarantine Inspection Service in the development of a memorandum of understanding (MOU). The MOU will detail Commonwealth and state and territory co-operative arrangements in relation to vector control and surveillance at Australian borders. The NAMAC provided advice on vector control and surveillance according to the *Quarantine Act 1908*.

A delimiting survey of *Aedes albopictus* (dengue mosquito vector) in the Torres Strait and adjoining northern Cape York Peninsula was carried out in collaboration with NAMAC in May 2005. To address the *Aedes albopictus* mosquito incursion in north Queensland that was detected in the survey and the associated human health implications, a NAMAC working group, which included members of the Island Coordinating Council, met on June 2005. Subsequent recommendations which included '*that intensive control and surveillance in the Torres Strait begin immediately to make use of the dry season and be continued for 3 years'* were subsequently endorsed by the full NAMAC on 16 June 2005 and then CDNA. Australian Government funding assistance is being provided to Queensland Health to conduct a mosquito elimination program in the Torres Strait

The Tennant Creek *Aedes aegypti* Eradication Project continues to progress. This is a joint Northern Territory Government Department of Health and Community Services and DoHA project.

Mosquito incursions are a recurring problem in northern Australia. The DoHA held a meeting in December 2005 with the Australian Government Department of Agriculture, Fisheries and Forestry (DAFF) and northern Australian jurisdictions to discuss issues concerning mosquito and disease control in northern Australia and strategies to address these emerging problems. It is anticipated that this will lead to longer term planning to respond to mosquito incursions.

National Enteric Pathogen Surveillance Scheme Steering Committee

Background

Membership of the National Enteric Pathogen Surveillance Scheme (NEPSS) Steering Committee includes representatives from all state and territory health departments, the DoHA, and DAFF, OzFoodNet and Food Standards Australia New Zealand.

The primary task of the NEPSS Steering Committee is to ensure that the agreed key performance indicators in the contract with the University of Melbourne Microbiological Diagnostic Unit (MDU) Public Health Laboratory are met. This process is performed electronically, and if issues arise a teleconference is convened.

The agreed key performance indicators for 2004–05 related to the:

- quality, amount and timeliness of data collected and inputted into the database by the MDU;
- ease of stakeholders and other approved persons in accessing the data;
- quality of the analyses of the data undertaken by the MDU;
- MDU's compliance with the format for reports and data request reports agreed with the Steering Committee; and
- time and frequency of the reports and data request reports.

Major activities

For the 2004–05 contract period, the NEPSS Steering Committee acknowledged that the agreed key performance indicators were met.

In addition, the DoHA funded Dr Diane Lightfoot of the MDU to attend the Enter-net Workshop and International Collaboration on Enteric Disease meetings in Madrid, Spain, from 1–4 June 2005.

The CDNA Joint Executive Group endorsed the project proposal *External review of the National Enteric Pathogens Surveillance Scheme* in July 2005. The NPHP agreed to fund the project proposal for $30,000 in November 2005. The review will occur in 2006.

National Immunisation Committee

Background

The National Immunisation Committee (NIC) was first established in 1993 and is the peak body responsible for overseeing the development, implementation and delivery of the National Immunisation Program (NIP).

Membership of the NIC during 2005 comprised of representatives from the Australian Government, the states and territories, the Australian Divisions of General Practice, the Royal Australian College of General Practitioners and the Australian Local Government Association. At the end of 2005 it was agreed to expand the membership of the NIC and invite additional representatives from the Rural Doctors Association of Australia, the Consumers Health Forum and the Australian Medical Association.

Major activities

During 2005 the NIC oversaw the implementation and delivery of both the National Childhood Pneumococcal Vaccination Program and the National Pneumococcal Vaccination Program for Older Australians which commenced on 1 January 2005. Take-up for the National Childhood Pneumococcal Vaccination Program has been greater than anticipated with 76.6 per cent of children eligible for the catch-up component of the program up-to-date for pneumococcal vaccination as at 31 December 2005 and approximately 97 per cent of babies born in January 2005 having had their first scheduled dose of Prevenar, according to data from 31 December 2005.

Vaccine supply shortages, including influenza, were also managed by the Committee during 2005 to ensure continuity of supply to immunisation providers and doctors.

The NIC was also involved in the rollout of the National Varicella (Chickenpox) Vaccination Program, the replacement of oral polio vaccine with inactivated polio vaccine which commenced on 1 November 2005, and the introduction of hepatitis A vaccine for Indigenous children under 5 years of age living in Queensland, the Northern Territory, Western Australia and South Australia.

The *National Vaccine Storage Guidelines – Strive for 5*[24] was finalised and released by the NIC. The document is aimed at Australian vaccination service providers and gives them a concise, practical and user-friendly guide to vaccine storage as well as outlining the basic principles for safe vaccine management. *Understanding Childhood Immunisation*[25] was also revised and released. *Understanding Childhood Immunisation* is given to all new parents at the birth of their baby, and contains easy to understand information on vaccines funded under the NIP, the diseases that are protected against, and side effects caused by the vaccines and what to do about them. Both of these documents were sent to all general practices during 2006 and are available from the Immunise Australian Program website at: http://immunise.health.gov.au/

During 2005, the NIC convened a workshop to review vaccine safety and the reporting of adverse events following immunisation. The *National Vaccine Safety Workshop* made several recommendations which will be pursued by NIC in 2006.

National Surveillance Committee

Background

The role of the National Surveillance Committee is to:

- develop policy and processes relating to national reporting of notifiable diseases;
- work toward national consistency in reporting of notifiable diseases;
- identify and address deficiencies in current surveillance processes; and
- advise and respond to the CDNA, including the subcommittees, on issues relating to strategic planning and processes for the national surveillance of communicable disease.

The membership of the NSC consists of epidemiologists and data managers from each state and territory and the Australian Government and representatives from OzFoodNet, the NCHECR and the NCIRS.

Major activities

Over the course of four meetings in 2005 the Committee agreed upon a nationally consistent process for dealing with cross-border issues in relation to disease notifications. The implementation of enhanced (or additional) STI and invasive meningococcal disease surveillance also commenced. Furthermore, NNDSS core data revisions have been completed and a new version of the data specifications is ready for endorsement by CDNA.

National Tuberculosis Advisory Committee

Background

The terms of reference for the National Tuberculosis Advisory Committee (NTAC) in 2005 were to provide strategic and expert advice to the CDNA on a coordinated national and international approach to

tuberculosis (TB) control and to develop and review nationally agreed strategic and implementation plans for the control of TB in Australia.

The current membership of NTAC includes jurisdictional representation from those responsible for the TB programs in their respective jurisdictions. This representation includes nurse managers with TB expertise, public health physicians, clinicians practising in TB clinics, thoracic physicians, infectious diseases physicians, a microbiologist and the DoHA secretariat.

Major activities

In 2005, the NTAC continued to push the TB agenda forward by endorsing a number of national guidelines as part of their key strategies under the *National Strategic Plan for TB Control in Australia Beyond 2000.*[26]

To date, NTAC has endorsed the following guidelines:

- *The BCG vaccine: information and recommendations for use in Australia;*[27]
- *Guidelines for Australian Mycobacteriology Reference Laboratories;*[28]
- *Procedures for Health Assessments of Unauthorised Fisherpersons Apprehended of the North Coast of Australia;*[29] and
- *National Guidelines for Overseas Travel for Patients with Pulmonary Tuberculosis.*[30]

In 2006, NTAC is working to revise its strategic plan and agenda for action for the next three years. The new draft strategic plan outlines the minimum requirements and resources for all jurisdictional TB services. Under the proposed plan, NTAC have identified the following issues for 2006–2009:

- maintaining political commitment to eliminating TB in Australia;
- maintaining current high level of diagnostic and management services for TB;
- ensuring the free availability of drugs for first and second line treatment;
- improving the management of latent TB;
- ensuring adequate pre-migration screening, in particular, of health workers entering Australia from countries with a high risk of TB; and
- encouraging research to improve diagnostic tools.

The role of the NTAC committee has become increasingly important over recent years as issues relating to the prevention and control of TB have emerged, including the recruitment of healthcare providers from high incidence TB and multidrug-resistant TB areas. Also, there has been considerable concern over the reduced availability of human tuberculin purified protein derivative for tuberculin skin testing and TB drugs for the treatment of cases. NTAC continues to play an important role in ensuring that effective treatment is made available.

Norovirus Guidelines Working Group

The CDNA Norovirus Working Group was established in 2004 and to date has shared the guidelines that have been developed in each state and territory for the management of infectious gastrointestinal illness or viral gastroenteritis. The Working Group has recommended a project officer be contracted to develop national norovirus guidelines. A part-time project officer has been appointed (located in South Australia) to develop the first draft of these guidelines for discussion by the Norovirus Working Group in 2006.

Pneumococcal Working Party

Background

The Pneumococcal Working Party is a joint initiative of the CDNA and the Australian Technical Advisory Group on Immunisation formed in 2000, along with a number of subgroups. In 2005 the active subgroup was the Enhanced Invasive Pneumococcal Disease Surveillance Working Group (EIPDSWG).

The EIPDSWG's role is to continue and improve national enhanced (or additional) surveillance of pneumococcal disease, including the review of what should be included in the dataset and to provide reports on the status of pneumococcal disease in Australia and guidelines for control.

The Working Group's membership consists of representatives from the CDNA, the Surveillance Policy and Systems Section of the DoHA and each state and territory. A representative from the Immunisation Section of DoHA attends as required and the PHLN provides laboratory surveillance when needed.

Major activities

One of the EIPDSWG's major achievements in 2005 was that enhanced surveillance is now available nationally for all children aged less than five years. There have also been ongoing improvements in the amount and type of data collection including agreement to collect additional risk factor information on child care attendance and repeat episodes of IPD. In addition, more than 90 per cent of all isolates are serotyped in most jurisdictions.

During 2005, the EIPDSWG prepared the 2004 annual report titled *Invasive pneumococcal disease in Australia, 2004,*[31] for publication in *Communicable Diseases Intelligence* (*CDI*) and submitted an abstract for the *5th International Symposium on Pneumococci and Pneumococcal Diseases* in Alice Springs to be held in 2006.

Concerns raised and identified through the EIPDSWG have contributed to the development of a proposal by NCIRS to examine the efficacy of the 23-valent vaccine in Australia, particularly in Indigenous adults and those with underlying conditions. Data collected through the EIPDSWG will be used in the analysis.

One of the challenges faced by the EIPDSWG is that although the Australian Government has negotiated individual contracts with the jurisdictions to assist in the collection of enhanced invasive pneumococcal disease surveillance data, the funds are inadequate for the amount of resources required to collect comprehensive data in all jurisdictions. The importance of enhanced data has been highlighted in a recent NCIRS draft position paper on conjugate vaccine failures in Australia and the need for serotype and antibiotic resistance pattern information is well accepted.

Public Health Laboratory Network

Background

The PHLN is a collaborative group of laboratory representatives from all jurisdictions in Australia. The aim of the PHLN is to provide strategic advice and share expertise at the national level in order to enhance the national capacity for the laboratory-based detection and surveillance of agents and vectors of communicable diseases in Australia. This is achieved by the sharing of knowledge and expertise within the PHLN; consultation with other laboratories, organisations and individuals with specialised expertise; and communication with other public and private laboratories in the jurisdictions.

The PHLN was established in 1996 as part of the implementation of the *National Communicable Diseases Surveillance Strategy* to complement the CDNA. PHLN holds monthly teleconferences and has at least one face-to-face meeting per year.

Major activities

In 2005, the PHLN met monthly by teleconference to discuss ongoing issues surrounding laboratory diagnostics. Some key areas of discussion included laboratory biosafety, laboratory capacity (particularly in relation to dealing with a pandemic) and laboratory biosecurity. The PHLN worked to develop standard protocols and guidelines such as the *Laboratory precautions for samples collected from patients with suspected viral haemorrhagic fevers.*[32]

In March 2005, the PHLN hosted a *Neisseria gonorrhoeæ* Workshop to:

- review the current status of gonococcal nucleic acid detection test in Australia;
- evaluate the accuracy of the existing tests;
- advise on further assessment of tests; and
- develop guidelines for monitoring of antibiotic susceptibility.

A paper titled *Guidelines for the use and interpretation of nucleic acid detection tests for* Neisseria gonorrhoeæ *in Australia: a position paper on behalf of the Public Health Laboratory Network*[33] was published in *CDI*.

During 2005, the DoHA engaged the services of Dr Janice Lanser to focus on completing and revising the Laboratory Case Definitions (LCDs). This work continues to progress.

The DoHA provided a range of equipment and test kits to allow the rapid detection (within 30 minutes) of biological agents and toxins, including anthrax, ricin and botulinum toxin. This equipment was distributed to state and territory PHLN laboratories in June 2005 and have already proved valuable for the Australian Capital Territory public health laboratory which used the kits to rapidly discount the presence of anthrax in 'white powders' received by foreign embassies in early to mid-June 2005.

PHLN held their annual face-to-face meeting on 5–6 September 2005. The first day consisted of workshops on 'white powders'/suspicious substances plus a session on eNotification. The second day consisted of discussion on issues ranging through counter terrorism, laboratory capacity, classification of physical containment facilities, and molecular diagnosis of gonococcal infection.

A bioterrorism workshop on laboratory capacity was held on 6 December 2005, which outlined a plan for public health pathology services and their capacity to handle health emergencies. In addition, laboratory capacity planning for pandemic influenza, SARS and biosecurity continued in 2005.

The major challenge for PHLN in 2006 is to work with the Australian Government and relevant committees such as CDNA to establish the Network as

a subcommittee under the new AHPC. In accordance with AHPC's governance structure, PHLN has developed terms of references and a work plan which will maintain the collaborative network of pathology and microbiology laboratory leaders and continue to provide strategic advice to enhance the national capacity for the laboratory-based detection and surveillance of agents and vectors of communicable diseases in Australia.

Through the agreed work plan and strategies, PHLN will continue to:

- communicate and consult widely with government, microbiologists and other public health professionals in public and private sector laboratories and to identify any need for additional essential resources;
- ensure early warning of communicable disease outbreaks through laboratory data sharing via laboratory reporting systems and regular teleconferences; and
- provide a first point of contact for all jurisdictional and national issues relating to laboratory diagnosis or surveillance of communicable diseases by identifying and utilising additional specialised expertise as needed.

Trachoma Steering Committee

Background

The CDNA Trachoma Steering Committee was established in September 2003 to develop guidelines to improve consistency in trachoma screening and treatment programs.

Major activities

During 2005, the Committee continued to prepare the guidelines. Comments were sought from CDNA members and key interest groups and all submissions received during the consultation were taken into consideration in finalising the guidelines. The CDNA endorsed the *Guidelines for the Public Health Management of Trachoma in Australia,*[34] in September 2005.

The Guidelines establish a minimal best practice approach for trachoma screening, diagnosis and treatment. They recommend that state and territory population health units collect trachoma data in accordance with a minimal national trachoma dataset and report these to a national trachoma database. Monitoring of antibiotic resistance to treatment (azithromycin) is also recommended.

In support of the trachoma management guidelines, the Minister for Health, the Hon. Tony Abbott MHR, announced in December 2005, a government commitment of $920,000 over the next three years to try to reduce the incidence of trachoma.

A proportion of this funding will be allocated to establish a surveillance unit to monitor trachoma prevalence and control measures in regions where trachoma control activities are currently undertaken. Remaining funding will be allocated towards essential training for health care workers to identify, treat and report incidences of trachoma.

The CDNA will have continued involvement in the management of trachoma through membership of advisory groups that will oversee implementation of the Guidelines.

Future directions

With reporting lines having changed in 2006, CDNA will work closely with the new AHPC and related committees to ensure that suitable governance arrangements are in place for the Network to provide national public health leadership and co-ordination on communicable disease surveillance, prevention and control, and offer strategic advice to governments and other key bodies on public health actions.

As well as the ongoing surveillance of communicable diseases, identified priorities for 2006–07 include:

- finalising the revision of the *Guidelines for the early clinical and public health management of meningococcal disease in Australia;*
- developing national norovirus, pertussis, seasonal influenza and measles guidelines;
- progressing harmonisation of public health legislation across Australian jurisdictions;
- further contributing to the development of the BSS; and
- continuing to contribute to pandemic influenza planning, including participating in *Exercise Cumpston* in October 2006.

Experience with SARS and avian influenza has highlighted that international collaboration is essential for the prevention and control of communicable diseases. Projects with international linkages that CDNA has planned for 2006 include the development of pre-departure health screening for refugees from South Asia and the Middle East and protocols for people being deployed to disaster areas.

Due to issues such as the emergence of new infections and bio-terrorism, and the intensified efforts required for the monitoring and elimination of vaccine preventable diseases, CDNA's workload continues to grow. One of its greatest challenges for the future will be ensuring workforce capacity for the consideration and progression of crucial communicable disease policies to enhance Australia's communicable disease capability.

Acknowledgements

Members of the CDNA Editorial Team and contributors were *(in alphabetical order)*: Mark Bartlett, Bernadette Bernasconi, Andrew Black, Allison Bloxham, Jenny Byron, Scott Cameron, John Carnie, Heather Cook, Catherine Corvisy, Geoff Davis, Sandra Gebbie, Rod Givney, Charles Guest, Farah Haq, Geetha Isaac-Toua, Martyn Kirk, Vicki Krause, Kishen Lachireddy, Rosemary Lester, Gary Lum AM, Jeremy McAnulty, Ian McKay, Valerie Mercer, Moira McKinnon, Melanie Middleton, Megan Morris, Bronwyn Morrish, Irene Passaris, Kate Robinson, Paul Roche, Linda Selvey, Jackie Steele, Julie Toms, Cassandra Walker, John Walker, Kim Wight, Phil Wright, Clare Wylks, and Margaret Young.

References

1. Joint Expert Advisory Committee on Antibiotic Resistance. *The use of antibiotics in food-producing animals: antibiotic resistant bacteria in animals and humans.* Canberra: Commonwealth of Australia, 1999.

2. Australian Government Department of Health and Ageing. *Interim Australian Management Plan for Pandemic Influenza* – June 2005. Canberra: Commonwealth of Australia, 2005.

3. Communicable Disease Network Australia. *Guidelines for Managing the Issues of Blood-Borne Virus Infection In Health Care Workers* (2005, publication pending).

4. *Dengue Fever Management Plan 2050–2010.* Tropical Population Health Network, Queensland Health, Cairns, 2005

5. Hall R. Notifiable Diseases Surveillance, 1917 to 1991. *Commun Dis Intell* 1992;17:226–236.

6. Communicable Diseases Australia. Pertussis case definition. Available from: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/cda-surveil-nndss-casedefs-cd_pertus.htm Accessed on 30 March 2006

7. National Notifiable Diseases Surveillance System. Available from: http://www9.health.gov.au/cda/Source/Rpt_4.cfm Accessed on 30 March 2006

8. Communicable Diseases Network Australia New Zealand. *Guidelines for the Control of Pertussis in Australia.* November 1997. Technical Report Series No. 1. Canberra: Commonwealth of Australia, 1997.

9. Australian Technical Advisory Group on Immunisation. Pertussis. In: *The Australian Immunisation Handbook.* 8th Edition. Canberra: Commonwealth of Australia; 2003. p. 205–217.

10. Hiam R, Guest C, Isaac-Toua G. An evaluation of public health interventions during a pertussis outbreak in the ACT 2003. *Aust N Z J Public Health* 2005;29:552–554.

11. Improving Indigenous Identification in Communicable Disease Reporting Project Steering Committee. *Improving Indigenous Identification in Communicable Disease Reporting.* Canberra: Commonwealth of Australia, 2004.

12. Australian Government Department of Health and Ageing. *Infection control guidelines for the prevention and transmission of infectious diseases in the health care setting.* Canberra: Commonwealth of Australia, 2004.

13. The National HIV/AIDS Strategy: *Revitalising Australia's response 2005–2008.* Australian Government Department of Health and Ageing, June 2005.

14. *The National Hepatitis C Strategy 2005–2008.* Australian Government Department of Health and Ageing, July 2005.

15. *The National Sexually Transmissible Infections Strategy 2005–2008.* Australian Government Department of Health and Ageing, June 2005

16. *The National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008.* Australian Government Department of Health and Ageing, October 2005.

17. *Infrastructure Benchmarks for the Design, Implementation and Evaluation of HIV/AIDS, STI and Hepatitis C Health Promotion Programs.* (2005, publication pending).

18. *National Strategy Implementation Plans 2005–2008.* (2005, publication pending).

19. Public Health Division and Long Term Care Homes Branch. Ontario Ministry of Health and Long-Term Care. *A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2004.*

20. McGeer A, Sitar DS, Tamblyn SE, Kolbe F, Orr P, Aoki FY. Use of antiviral prophylaxis in influenza outbreaks in long term care facilities. *Can J Infect Dis* 2000;11:187–192.

21. Inter-pandemic Influenza Working Group of the Communicable Diseases Network Australia. *Guidelines for the Prevention and Control of Influenza Outbreaks in Residential Care Facilities in Australia.* 2005.

22. Communicable Diseases Network Australia. *Guidelines for the early clinical and public health management of meningococcal disease in Australia.* Canberra: Commonwealth of Australia, 2001.

23. Broom A, McKinnon M, Miller M, Moran M, Russell R, Whelan P, *et al. Interim National Guidelines for the Prevention, Management and Control of Murray Valley Encephalitis Virus.* Canberra: Commonwealth of Australia, 2005.

24. Grant S, Langley A, Peterson A, Kempe A, Miller N, Bryant V, *et al. National Vaccine Storage Guidelines – Strive for 5.* Canberra: Commonwealth of Australia, 2005.

25. Immunisation Section, Department of Health and Ageing. *Understanding Childhood Immunisation.* Canberra: Commonwealth of Australia, 2005.

26. National Tuberculosis Advisory Committee. *National Strategic Plan for TB Control in Australia Beyond 2000.* Canberra: Commonwealth Department of Health and Ageing, 2002.

27. National Tuberculosis Advisory Committee. The BCG vaccine: information and recommendations for use in Australia. *Commun Dis Intell* 2006; 30:109–115.

28. National Tuberculosis Advisory Committee. Guidelines for Australian Mycobacteriology Reference Laboratories. *Commun Dis Intell* 2006; 30:116–128.

29. National Tuberculosis Advisory Committee. *Procedures for Health Assessments of Unauthorised Fisherpersons Apprehended of the North Coast of Australia.* (2005, publication pending).

30. National Tuberculosis Advisory Committee. *National Guidelines for Overseas Travel for Patients with Pulmonary Tuberculosis.* (2005, publication pending).

31. Roche PW, Krause VL, Bartlett M, Coleman D, Cook H, Davies C, *et al.* Invasive pneumococcal disease in Australia, 2004. *Commun Dis Intell* 2006;30:80–92.

32. Communicable Diseases Network Australia and the Public Health Laboratory Network. *Laboratory precautions for samples collected from patients with suspected viral haemorrhagic fevers.* Canberra: Australian Government Department of Health and Ageing, March 2002/September 2005.

33. Smith DW, Tapsall JW, Lum G. Guidelines for the use and interpretation of nucleic acid detection tests for *Neisseria gonorrhoeae:* a position paper on behalf of the Public Health Laboratory Network. *Commun Dis Intell* 2005;29:358–365.

34. Communicable Diseases Network Australia. *Guidelines for the Public Health Management of Trachoma in Australia.* Canberra: Commonwealth of Australia, 2006.

Abbreviations

AHDMPC	Australian Health Disaster Management Policy Committee
AHMAC	Australian Health Ministers' Advisory Council
AHPC	Australian Health Protection Committee
AIDS	acquired immunodeficiency syndrome
AMRLN	Australian Mycobacterium Reference Laboratory Network
BSS	Biosecurity Surveillance System
cCJD	classical Creutzfeldt-Jakob disease
CDI	*Communicable Diseases Intelligence*
CDNA	Communicable Diseases Network Australia
CJD	Creutzfeldt-Jakob disease
DAFF	Department of Agriculture, Fisheries and Forestry
DAS	Data Acquisition System
DFMP	*Dengue Fever Management Plan 2005–2010*
DoHA	Department of Health and Ageing
dT	diphtheria-tetanus vaccine for use in adults
dTpa	adult/adolescent formulation diphtheria-tetanus-acellular pertussis vaccine
EIPDSWG	Enhanced Invasive Pneumococcal Disease Surveillance Working Group
HIV	Human immunodeficiency virus

ICGs	*Infection Control Guidelines for the Prevention of Transmission of Infectious Diseases in the Health Care Settings*
IGCAHRD	Inter-Governmental Committee on HIV/AIDS, Hepatitis C and Related Diseases
IIICDRP	Improving Indigenous Identification in Communicable Disease Reporting Project
IOM	International Organisation for Migration
JETACAR	Joint Expert Technical Advisory Group on Antibiotic Resistance
MACASHH	Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis C
MDU	Microbiological Diagnostic Unit
MOU	memorandum of understanding
NAMAC	National Arbovirus and Malaria Advisory Committee
NCHECR	National Centre in HIV Epidemiology and Clinical Research
NCIRS	National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases
NEPSS	National Enteric Pathogens Surveillance Scheme
NIC	National Immunisation Committee
NIP	National Immunisation Program
NIPAC	National Influenza Pandemic Action Committee
NNDSS	National Notifiable Diseases Surveillance System
NPHP	National Public Health Partnership
NSC	National Surveillance Committee
NTAC	National Tuberculosis Advisory Committee
OCRS	Outbreak Case Reporting System
PHLN	Public Health Laboratory Network
RCFs	residential care facilities
SARS	Severe Acute Respiratory Syndrome
SIG	Special Interest Groups
SSS	Syndromic Surveillance System
STIs	sexually transmitted infections
TB	tuberculosis
TPHUN	Tropical Public Health Unit Network
vCJD	variant Creutzfeldt-Jakob disease