GOVERNMENT NOTICE

DEPARTMENT OF HEALTH

No. R. 287 **13 April 2010**

NATIONAL HEALTH ACT, 2003 (ACT NO. 61 OF 2003)

REGULATIONS RELATING TO COMMUNICABLE DISEASES

The Minister of Health intends, in terms of section 90(1) (j) of the National Health Act, 2003 (Act No. 61 of 2003), to make the regulations in the schedule.

Interested persons are invited to submit any substantiated comments on the proposed Regulations, or any representations they may wish to make in regard thereto, to the Director-General: Health, Private Bag X828, Pretoria, 0001 – for the attention of the Director: Communicable Disease Control within one month of this notice.

SCHEDULE

Definitions

1. In these regulations, any word or expression to which a meaning has been assigned in the Act shall have the meaning so assigned and, unless the context indicates otherwise:–

'**address**' means a place of ordinary residence, but excludes a post office box number;

'**body**' means human remains, but excludes remains of a body which has been cremated;

'**bury**' means to dispose of a body and where applicable may include the placenta, foetus, any severed part or exhumed human remains;

'carrier' means a person or animal infected with a specific infectious agent but shows no marked symptoms of the disease caused by that infectious agent. It may also be an inanimate object contaminated with a specific infectious agent. A carrier may be a potential source of infection;

'child' means a person under the age of 18 years;

'committee' means the Communicable Diseases Advisory Committee established in terms of regulation 2(1);

'communicable disease' means a disease resulting from an infection due to pathogenic agents or toxins generated by an infection, following the direct or indirect transmission of the agents from the source to the host;

'Director-General' means the Director-General of the Department of Health;

'emerging infectious diseases' means diseases that have newly appeared in a population;

'epidemiology' means the study of the distribution and determinants of disease, injury and other health-related conditions in a defined human population;

'health care associated infection (nosocomial or hospital-associated infection)' means an infection acquired in a health care establishment by a health care user, health worker, or a visitor to a health care establishment, who was in the establishment for a reason other than that infection;

'infectious agent' means an organism or toxin which may cause an infection or communicable disease in a person;

'immune contact' means any person who, owing to his or her having contracted a communicable disease in the past or his or her having been successfully immunised against it, is not likely to contract the disease again on exposure thereto;

'isolation' means the separation of persons who are ill or suspected of having a specific infectious disease from those who are healthy, with the objective of preventing transmission of infection and allowing for specialised care;

'isolation precautions' means procedures, methods or processes used in nursing care to protect health care workers, patients and other persons against

infectious agents transmitted from a patient or patients suffering from a communicable disease;

'local government' means a municipality and includes all municipal entities under the sole or shared control of the municipality within the meaning of the Local Government: Municipal Finance Management Act, 2003 (Act No. 56 of 2003); and all organs of state in that municipality or such municipal entity under the Intergovernmental Relations Framework Act, 2005 (Act No. 13 of 2005);

'National Health Laboratory Service' means the organisation established in terms of the National Health Laboratory Service Act, 2000 (Act No. 37 of 2000), hereinafter referred to as the NHLS;

'National International Health Regulations (IHR) Focal Point' means the national centre, designated by each State Party, which shall be accessible at all times for communications with World Health Organisation's (WHO) IHR Contact Points under the International Health Regulations;

'notifiable medical condition' means a medical condition that must be reported in terms of a statutory obligation;

'official responsible for health at local government' means a person responsible for health at that level;

'poisoning' means to administer poison or an infectious agent/toxin or to contaminate with poison either intentionally or unintentionally;

'public health emergency of international concern' means an extraordinary event which is determined, as provided in the International Health Regulations (2005):—

(i) to constitute a public health risk to other States through the international spread of disease, and

(ii) to potentially require a coordinated international response;

'public health risk' means a likelihood of an event that may affect adversely the health of human populations, with the emphasis on one which may spread internationally or may present a serious and direct danger;

'quarantine' means separation and restriction of movement or activities of "healthy" persons, animals, or goods that have been exposed or are suspected to have been exposed to an infectious agent and may be incubating the disease through:—

(i) the removal, or limitation of freedom of movement of a person or animal; or

(ii) the removal or restriction of movement of vehicles, goods, articles or any other things that have been exposed or are suspected of having been exposed to a communicable disease, until such time the risk of disease transmission no longer exists;

're-emerging infectious diseases' means diseases that have existed in the past, but are rapidly increasing in incidence or geographical range;

'susceptible contact' means a person or animal that is at risk of contracting a communicable disease following contact with an infected person and/or animal;

'the Act' means the National Health Act, 2003 (Act No. 61 of 2003);

'vector' means any agent (living or inanimate) that acts as an intermediate carrier or alternative host for a pathogenic organism and transmits it to a susceptible host;

'World Health Organisation International Health Regulations (IHR) Contact Point' means the unit within the WHO responsible for communications with the National IHR Focal Point; and

'zoonoses' means a disease of animals that can be transmitted to humans.

CHAPTER 1

COMMUNICABLE DISEASE STRUCTURES AND RESPONSIBILITIES OF HEALTH ESTABLISHMENTS

Establishment of Communicable Diseases Advisory Committee

2(1). There is, hereby established a committee known as the Communicable Diseases Advisory Committee, hereinafter referred to as the "Committee".

(2). The Minister appoints the members of the Committee.

Constitution of the Committee

3. The Committee shall consist of not less than fifteen (15) but not more than twenty (20) members. The Committee shall be comprised of the following members:

(a) at least six (6) but not more than nine (9) persons from the Department, provincial department of health and local government;

(b) a representative from the private health sector;

(c) a representative from the National Institute for Communicable Diseases;

(d) two representatives of community groups;

(e) the remainder of the members will be appointed from amongst others the academia and health professionals. The Committee must include at least any six (6) of the following experts:

(i) a medical specialist with extensive experience in the treatment of communicable diseases in adults;

(ii) a medical specialist with extensive experience in the treatment of communicable diseases in children;

(iii) a pathologist with extensive experience in laboratory diagnosis of infectious agents;

(iv) a specialist in public health medicine with skills and experience in the management of outbreaks, epidemics and disasters and the epidemiology and surveillance of communicable diseases;

(v) a health care provider with experience in health information systems, in the employ of a health establishment;

(vi) a person with experience in the management and prevention of environmental hazards conducive to the origin or spread of communicable diseases;

(vii) a health care provider with extensive experience of hospital infection prevention and control programmes;

(viii) a veterinarian with extensive experience in the control of zoonoses;

(ix) an entomologist with extensive experience in the research and control of human disease vectors; or

(x) an occupational health expert;

(f) the appointment of members of the Committee is for a period of three (3) years, but they shall be eligible for re-appointment; and

(g) the Minister, on good cause shown, may terminate the appointment of any member of the Committee or sub-committees.

Chairperson and Vice-Chairperson

4(1) At the first meeting of every newly constituted Committee, the members of the Committee shall elect the chairperson and a vice-chairperson from among themselves.

(2) The chairperson and vice-chairperson shall hold office during the term of office of the members of the Committee, unless the chairperson and the vice-chairperson shall sooner resign or cease to be a member of the Committee.

(3) The vice-chairperson may, if the chairperson is absent or for any reason unable to act as chairperson, perform all the functions and exercise all the powers of the chairperson.

(4) If both the chairperson and vice-chairperson are absent from any meeting, the members present shall elect one of their members to preside at that meeting and the person so presiding may, during that meeting and until the chairperson and/or the vice-chairperson resumes duty, perform all the functions and exercise all the powers of the chairperson.

(5) If both the chairperson and the vice-chairperson have been given leave of absence, the members of the Committee shall elect one of their members to act as chairperson until the chairperson and/or the vice-chairperson resumes duty or vacates office.

(6) If the office of the chairperson and the vice-chairperson becomes vacant, the members of the Committee shall, at the first meeting after such vacancy occurs or as soon thereafter as may be convenient, elect from among themselves a new chairperson and the vice-chairperson, as the case may be, and the member so elected shall hold office for the unexpired portion of the period for which his or her predecessor was elected.

(7) The chairperson and the vice-chairperson may vacate office as such, without such vacation by itself, terminating his or her membership of the Committee.

Objects of the Committee

5. The objectives of the Committee are to:

(a) advise the Minister on the following:

(i) policy and guideline formulation on matters related to communicable diseases control;

(ii) prevention and control of communicable diseases;

(iii) communicable diseases data information flow and/or management;

(iv) strategies for the prevention of nosocomial infections;

(v) strategies to strengthen surveillance and epidemiology of communicable diseases, laboratory analysis of communicable diseases;

(vi) review the list of priority communicable diseases in Annexure A for emerging and re-emerging infectious diseases of public health significance;

(vii) prevention and control of occupational related communicable diseases; and

(viii) any other functions related to communicable diseases.

(b) Provide advise on the management and control of communicable diseases and notifiable medical conditions of public health importance as the Minister may from time to time determine.

Functioning and meetings of the Committee

6(1). For the purposes of performing its functions, the Committee may at its discretion consult or receive representations from any appropriate person, body or authority.

(2). The Committee shall perform any function that may be referred to the Committee by the Minister or Director-General.

(3). The Committee shall perform any other function to further the objects of these Regulations.

(4). Committee meetings must be held on such dates and such times and places as may be determined by the chairperson, but not less than twice per year. The first meeting must be held within three months of the appointment of the full Committee.

(5). The Committee may establish one or more sub-committees such as the malaria advisory sub-committee and infection control sub-committee to advise it on any matter related to the subject matter of such a sub-committee:

(a) the chairperson of such a sub-committee must be a member of the Committee;

(b) the term of office of a person appointed to a sub-committee of the Committee, other than the malaria advisory and infection control sub-committees, will be determined by the task for which the sub-committee was formed, but may not exceed thirty six successive months;

(c) members of sub-committees may be re-appointed; and

(d) notwithstanding paragraphs (b) and (c) above, membership to a sub-committee may be terminated at any time by the chairperson of the Committee on good cause shown.

(6). Travel and accommodation expenses of members of the Committee and sub-committees will be paid by the Department in terms of the Treasury regulations.

(7). The Directorate: Communicable Disease Control, of the Department of Health will function as the secretariat for the Committee.

Quorum and procedure at meetings

7(1). The majority of the members of the Committee shall constitute a quorum at any meeting of the Committee.

(2). A decision of the majority of the members of the Committee present at any meeting shall constitute a decision of the Committee: Provided that in the event of an equality of votes the member presiding shall have a casting vote in addition to a deliberative vote.

(3). No decision taken by the Committee or act performed under authority of the Committee shall be invalid by reason only of an interim vacancy on the Committee or of the fact that a person who is not entitled to sit as a member of the Committee sat as a member at the time when the decision was taken or the act was authorized, if the decision was taken or the act was authorized by the requisite majority of the members of the Committee who were present at the time and entitled to sit as members.

Responsibilities of the National Department of Health

8. The Department's responsibility shall be to promote adherence to norms and standards on health matters such as:

(a) ensuring food safety;

(b) cleaning, disinfecting, sanitising, sterilising or pasteurising of ambulances, health care provider facilities, beds, incubators, operating theatres, clinics, wards, hospital crèches, hospital kitchens or milk kitchens, laundries, instruments, surgical sundries, health care provider equipment, delivery rooms, neonatal facilities and emergency centres;

(c) management of waste in health care facilities;

(d) information systems on communicable diseases;

(e) specification for the standardisation of therapeutic and diagnostic equipment used for the diagnosis of communicable diseases;

(f) health establishment infection control;

(g) procurement, storage, control and transportation of biological agents;

(h) immunisation programmes and immunisation as emergency measure;

(i) management and control of communicable diseases in crèches, pre-primary, primary, secondary and tertiary educational institutions;

(j) management and control of communicable diseases in correctional service facilities, places of safety and refugee camps, reformatories, schools of industry, homes for older persons and children;

(k) prevention, management and control of communicable diseases in health care facilities;

(l) promotion of adherence to norms and standards for the training of human resources for health;

(m) identification of national health goals and priorities and monitor the progress of their implementation;

(n) co-ordination of health and medical services during national disasters;

(o) participation in inter-sectoral and interdepartmental collaboration;

(p) promotion of health and healthy lifestyles;

(q) promotion of community participation in the planning, provision and evaluation of health services;

(r) conducting and facilitating health systems research in the planning, evaluation and management of health services;

(s) facilitation of the provision of indoor and outdoor environmental prevention and control services;

(t) facilitation and promotion of the provision of health services for the management; and

(u) prevention and control of communicable diseases.

Responsibilities of Provincial Departments

9. The responsibilities of the Provincial Departments of Health with regard to communicable diseases include:

(a) the institution and maintenance of immunisation programmes against common communicable diseases;

(b) the establishment of outbreak response teams that are functional at provincial level and that have local government representatives on its team;

(c) ensuring that a chapter on the surveillance, prevention, occurrence, management and control of infectious diseases is included in their annual reports on the health status of each province;

(d) promoting community participation in the planning, provision and evaluation of health services;

(e) facilitating and promoting the provision of port health services, comprehensive primary health services and community hospital services;

(f) ensuring provision of quality health services and facilities, including occupational health;

(g) providing services for the management, prevention and control of communicable diseases;

(h) providing environmental pollution control services; and

(i) ensuring that provincial health plans are in conformity with national health plans.

Responsibilities of Local Government

10. The responsibilities of the local government are, amongst others:

(a) water quality monitoring;

(b) food control;

(c) waste management;

(d) health surveillance of premises;

(e) surveillance and prevention of communicable diseases, excluding immunisation;

(f) vector control;

(g) environmental pollution control;

(h) disposal of the dead; and

(i) chemical safety,

but excludes port health, malaria control and control of hazardous substances;

(k) taking reasonable steps to ensure that the provision, distribution, storage and marketing of fresh meat, dairy products and all other foodstuffs will take place in such manner as to minimise the development or spread of infectious diseases;

(l) ensuring that municipalities provide health services by ensuring that metropolitan or/and district municipalities provide appropriate municipal health services effectively and equitably in their respective areas;

Responsibilities of Health Establishments

11(1). The head of a health establishment is responsible for the following:

(a) the implementation of the Infection Prevention and Control policy (IPC);

(b) ensuring the availability of dedicated sections or beds for isolation purposes; and

(c) the appointment of at least one or more Infection Control Officers (ICO). Health facilities with less than or equal to two hundred (200) beds must appoint at least one dedicated ICO. Where there are two hundred (200) or more beds in a health care facility, at least one further ICO must be appointed per additional two hundred (200) beds.

(2). the responsibilities of an ICO include:

(a) ensuring implementation of the health establishment's infection prevention and control plans;

(b) assisting with the standardisation of clinical procedures to prevent and control nosocomial outbreaks and/or infections in a health establishment;

(c) facilitating the investigation of nosocomial infections and outbreaks;

(d) advising on and supervising isolation and isolation precautionary procedures;

(e) conducting training and education of all health care provider workers in respect of nosocomial infections as stipulated in applicable legislation and/or policies;

(f) developing and maintaining a standardised surveillance system for communicable diseases and nosocomial infections in the facilities, including timeous reporting;

(g) ensuring the collection of appropriate specimens for microbiological investigations where indicated;

(h) providing data, obtained from facility records, to the head of the health establishment for the purpose of monitoring and surveillance of communicable diseases, including anti-microbial resistance profiles;

(i) maintaining the infection prevention and control equipment inventory and infection control records;

(j) serving on the infection control committee; and facilitating the establishment thereof where not available;

(k) communication and liaison with a microbiologist with expertise in infection control, occupational health expert and environmental health officer with expertise in waste management; and

(l) conducting health establishment risk assessment and make recommendations regarding structural changes to the health establishment, which would enable better infection control.

(3). Health establishments and health care providers are required in terms of these regulations to implement an IPC plan on the prevention and control of nosocomial infections.

CHAPTER 2

NOTIFIABLE COMMUNICABLE DISEASES

Declaration of Notifiable Communicable Diseases

12. The Minister may, after consultation with the National Health Council, declare by Notice in the *Government Gazette* any disease to be a notifiable communicable disease if in his or her opinion, such a disease:

(a) poses a serious threat to an entire or part of a population of a particular province or the Republic;
(b) may require immediate, appropriate and specific action to be taken by the national department, one or more provincial departments and/or one or more municipalities; and
(c) may be regarded as a public health emergency of international concern or a public health risk;

and may determine that –

(i) on application of a province, any disease other than a notifiable communicable disease under (a) and (b), be declared notifiable within a province or district for a period specified in the notice or until the notice is withdrawn;
(ii) certain diseases be notifiable in certain provinces or certain municipalities;
(iii) certain diseases be notifiable by certain categories of health workers; and
(iv) specific diagnostic or laboratory criteria apply to specific diseases for notification.

Notification of Communicable Diseases

13(1). When a health care provider diagnoses the disease referred to in Annexure A in a person or in a specimen obtained from a person, he or she must report the findings thereof to the relevant district and local authority concerned and:

(a) where the disease concerned is acute and life threatening as referred to in Annexure A Table 1, immediate verbal notification based on clinical suspicion, must be done, and this must be followed by notification in writing within 24 hours of laboratory confirmation of the disease;

(b) for diseases listed in Annexure A Table 2, notification must be done in writing within 24 hours of laboratory confirmation of the disease; and for the other communicable diseases referred to in Annexure A Table 3, notification must be done in writing within seven days.

(2) The information referred to in subregulation 13(1) must be furnished by means of the notification Form GW17/5, of Annexure F which, must be submitted to the official responsible for health at the sub-district office and the local municipality concerned.

(3). The sub-district or local municipality in which the disease has occurred must –

(a) take all the necessary measures for the prevention of the spread of the disease; and

(b) inform the other municipality/ies concerned if the person diagnosed with a communicable disease resides in more than one municipality, whether permanent or temporary, the other municipality/ies must be notified so that the necessary measures can be taken to prevent the spread of the disease.

(4) The official responsible for health at the sub-district office and local municipality concerned must on a weekly basis report to the official responsible for health at the district office using notification Form GW17/3, of Annexure D.

(5) The official responsible for health at the district office must report to the official responsible for communicable diseases in the provincial office.

(6) Each head of a provincial department must on a weekly basis furnish the Director-General with data on confirmed/suspected notifiable communicable diseases.

(7) The International Health Regulations National Focal Point through the WHO IHR Contact point must within 24 hours notify the Director-General of the World Health Organisation of any disease or risk that may constitute a public health emergency of international concern that may require a coordinated international response.

Notification of deaths related to Communicable Diseases

14 Notification of deaths related to communicable diseases must be done as follows:

(a) A double notification should be done on any person who contracts a notifiable disease and subsequently dies as a result of such a disease.

(b) The notifications should be done using Form GW17/5 of Annexure F for contracting the disease and Form GW17/4 of Annexure E for the death.

(c) The notification to be submitted to the sub-district and local municipality concerned.

CHAPTER 3

PREVENTION AND CONTROL OF COMMUNICABLE DISEASES BY HEALTH AUTHORITIES AND HEADS OF INSTITUTIONS

Voluntary medical examination, prophylaxis, isolation, quarantine or treatment of persons who are carriers or susceptible contacts

15(1). Any person who reasonably suspects on medical grounds that he or she is a carrier, susceptible contact or person suffering from a disease which is a danger to

public health must subject him/herself for medical examination and isolation, if required, by a health care provider.

(2). The medical examination referred to in sub-section (1) must include, amongst others, the taking of any biological specimens reasonably necessary for the confirmation of a laboratory analysis.

(3). Any health care provider who reasonably suspects on medical scientific grounds that a person is a carrier, susceptible contact or is suffering from a disease which is a danger to the public health, must within 24 hours of having become suspicious inform the relevant health authority of such suspicion.

(4). If a person refuses to undergo voluntary intervention as indicated in subregulation (1), and a healthcare provider concludes on medical scientific grounds that there is a danger that a carrier or susceptible contact may transmit a disease to other people, the head of a health establishment or a health care provider may apply for a court order to compel such a person to go for the necessary medical examination and intervention.

(5) The carrier, susceptible contact or person suffering from the communicable disease must:

(i) at all times comply with and carry out reasonable instructions given to him or her by a health care provider regarding personal and environmental hygiene or other precautionary measures to prevent or restrict the spread of an infection; and

(ii) inform such health care provider of his or her intention to change his or her place of residence or work and furnish such health care provider with the new address.

(6) Upon receipt of the new place of residence or work referred to in subregulation (5)(ii), the health care provider must furnish such new address in writing to the relevant local government in whose area such a carrier or sufferer will be working or residing.

(7) A parent, guardian or person who has legal custody of or control over a child or person who is a carrier or sufferer from a communicable disease must render all

reasonable assistance in the execution of any notice issued in terms of these regulations in respect of such child or person.

Responsibilities of health authorities

16. On receipt of the notice referred to in subregulation (2), a health authority must reasonably satisfy him/herself that the spread of such disease constitutes or will constitute a real danger to public health and in writing inform the owner, occupier or person in control of affected premises that one or more of the following steps are to be taken as they are deemed necessary:

(a) the regulation or restriction of access to any premises within its jurisdiction where the disease may or actually occurs or has occurred or where the occupants of the premises are carriers or susceptible contacts;
(b) the clinical examination of susceptible contacts by a health care provider for the presence of any clinical evidence of a communicable disease;
(c) the obtaining of biological specimens from humans, animals or any inanimate object for laboratory examination for evidence of a communicable disease;
(d) the quarantining of carriers or susceptible contacts;
(e) the cleaning, sanitising, disinfecting, sterilising or decontaminating of any person or object for the reduction or elimination of any pathogens, vectors or reservoirs of infectious agents; and
(f) the employment of any acceptable means to eliminate parasites or infectious agents from the skin of humans or animals harbouring or suspected of harbouring parasites or infectious agents.

17(1). The correspondence from the health authority to the owner, occupier or person in control of the affected premises referred to in Regulation 16 –

(a) must be served on the owner, occupier, controller or any other person in control over such premises; or

(b) if more than one premise is affected, such correspondence must generally be made known through one or more of the following measures as may be deemed necessary:

(i) by notice in the *Government Gazette*;

(ii) by notice in a newspaper in circulation in the area where the order will apply;

(iii) by means of a radio or television announcement;

(iv) by distributing written notices among the public; or

(v) by putting up notices in public or in conspicuous places in the area where the order will apply or by having the order announced orally in the area where it will apply.

(2). A health care provider authorised by the relevant member of a municipal council or a local government may, in order to prevent the spread of a communicable disease referred to in Annexure A or to control or restrict such disease, require that he or she be furnished with the names and addresses of people who are or were at entertainment, recreation, sporting, business, educational or any other public premises or event.

(3). A health care provider who acts in terms of the provisions of Regulation 15(4) must-

(a) immediately after concluding his or her role in such action, give a comprehensive report to the relevant health authority of all action taken;

(b) exercise his or her powers with the necessary circumspection and not cause any unnecessary inconvenience to any person.

Institutions

18(1). The head of an institution such as training or education institutions, care or residential institutions, barracks, prisons -

(a) who is aware or reasonably suspects that any person at the institution of which he or she is head, or who happens to visit such institution -

(i) suffers from a communicable disease listed in Annexure A
(ii) was in contact with a carrier or susceptible contact; or
(iii) is infested with lice or other parasites, must immediately inform the local government in which such institution is situated verbally and in writing; and

Shall quarantine, or isolate and treat such person until informed otherwise by the relevant health authority.

(2). The parent or guardian of a learner in respect of whom to the best knowledge of the parent or guardian a condition referred to in regulation 9(1)(a)(i), (ii) or (iii) applies, must immediately inform the head of an educational institution concerned of such condition and ensure that the said learner does not leave their place of residence until informed otherwise by the relevant health authority.

(3). The parent or guardian of a child of school entry age or younger who attends a care or educational institution as a learner may on admission of the child to the institution be required to submit written proof of all vaccinations against communicable diseases that such child has received, or written proof of having suffered from a vaccine-preventable disease.

(4). The head of a care or education institution attended by learners of school entry age or younger must keep a written record of the immunisations contemplated in Regulation 18(3).

(5). The head of all institutions must make provision to ensure:

(a) the prevention of transmission of communicable diseases, particularly those that are vaccine-preventable; and
(b) the adherence to infection control principles to prevent transmission of infection.

Immunisation as emergency measure

19(1). Where the Director-General reasonably believes on medical and scientific grounds that the health of the entire or part of the population of the Republic including health care providers may be affected by a vaccine-preventable communicable disease (Annexure A), he or she may, subject to a court order and by notice in the *Government Gazette* –

(a) demarcate an area for the compulsory immunisation of all its inhabitants or of a specific group or category of such inhabitants;
(b) designate health establishments and persons that shall carry out such immunisation;
(c) determine a period during which the immunisation shall be done; and
(d) quarantine any person who unreasonably refuses to be immunised under these circumstances, when there is no written exemption because of contradiction on medical grounds.

(2) The health establishment or person referred to in subregulation (1)(b) may authorise any health practitioner or immunise persons in terms of that subregulation as an immunisation officer.

(3) The head of a provincial health department in whose province an area or areas referred to in subregulation (1) fall shall co-ordinate all matters with regard to the immunisations carried out in terms of these regulation.

(4) The health institution or person referred to in subregulation (1)(b) may determine the places, times of compulsory immunisations and the classification of persons at immunisation points, and any other medically significant information that must be recorded.

Defrayment of costs

20. Any costs associated with any actions performed in terms of the Regulations above, shall be defrayed by the State.

CHAPTER 4

Mandatory medical examination, isolation and quarantine

21(1). A health care provider may apply to the High Court for a Court order, if a person who is a carrier or susceptible contact or ill because of a communicable disease as listed in Table 1 of Annexure A or who is diagnosed with MDR or XDR TB and refuses to voluntarily consent:

(a) to a medical examination, including the taking of any biological specimen;
(b) to be admitted at a health establishment; and
(c) mandatory treatment and isolation for Table 1 infected persons and persons with MDR or XDR TB.

subjecting such a person to a mandatory medical examination, admission, treatment and isolation.

(2). A health care provider may apply to a High Court for an order to:

(i) quarantine any person who is a suspected carrier or susceptible contact of a communicable disease such as listed in Table 1 of Annexure A, which may be a threat to public health and which may be contagious before he/she deteriorates (becomes infectious); and
(ii) conduct an autopsy on a corpse of a person, who has presumably died of a communicable disease, in order to ascertain the exact cause of death

only where this is in the interest of public health and on special request by any interested person.

(3). The following conditions have to be fulfilled before mandatory action can be taken, namely:

(i) it must be a confirmed communicable disease that poses a public health risk (Table 1 of Annexure A and MDR and XDR TB);
(ii) other less restrictive measures which may prevent the occurrence or spread of the disease have been tried and have failed;
(iii) an overall evaluation must have been made to the effect that this is clearly the most justifiable course of action in relation to the risk of the disease being transmitted and to stress what the compulsory measure is likely to entail; and
(iv) it is highly probable that other persons will otherwise be infected.

(4). The head physician of the department in which the person is isolated is authorised to annul the decision as soon as the conditions for mandatory action are no longer present, or the person consents to voluntary interventions.

(5). The provisions of subregulation (1) and (2) regarding applications to court, apply *mutatis mutandis* to the relevant members of municipalities concerning public and private individuals and groups, institutions, entertainment, recreational, sporting, business, and any other premises.

(6). An order of the court contemplated in subregulations (1) and (2) shall be valid for a period not exceeding six months where after a new court order must be sought.

(7). Where any order of court is sought by a health care provider in terms of subregulations (1) or (2), the provincial Head of Health must be cited as a co-party to the proceedings.

(8). The seeking of a court order must not delay medical intervention or appropriate action to protect public health.

(9). A person against whom the court order is instituted shall have the right to appeal against such a court order.

CHAPTER 5

PREVENTION OF THE TRANSMISSION OF COMMUNICABLE DISEASE FROM BIOLOGICAL AGENTS AND OTHER VECTORS TO PERSONS

Vehicles of transmission of communicable diseases

22. The relevant local government may appoint an authorised health officer/environmental health officer to conduct environmental health investigations, enter and inspect premises, manage offences in accordance with Chapter 10 of the Act in order to prevent the transmission of a communicable disease to people by or from animals, insects, parasites, contained in goods being transported, conveyances, parcels, premises and any other vehicles of transmission.

Measures to combat vectors and to prevent the transmission of vector-borne diseases

23(1). An owner or occupier of any premises must take reasonable measures to remove, screen or treat any collection of water or any other habitat in which mosquitoes can live or breed, on such premises in such a way as to prevent the survival and breeding of mosquitoes.

(2). An environmental health officer may in writing order the owner or occupier of premises where mosquitoes live or breed to take reasonable measures to prevent the survival and breeding of mosquitoes within a determined period, and if such owner or occupier fails to carry out these measures within the said period the local government concerned may take such measures where practicable for the account of such owner or occupier.

(3). The owner or occupier of any premises must, if so ordered in writing by an environmental health officer, within the period determined in the order:

(i) spray, fumigate, disinfect, or treat the premises or building, structure, goods or article on such premises, with a specific residual insecticide or other agent, in such a way, at such strength of application and with such intervals of application as determined by the order; and

(ii) screen the outer doors, windows and other openings of any building, or structure in which people live, work or meet, with gauze screens with not less than six openings per linear centimetre of the surface, and maintain the gauze screens in good working condition or take any other measures to prevent the entry of mosquitoes.

(4). If an owner or occupier of any premises fails to carry the reasonable measures as ordered in subregulation (3) within the prescribed period , the local government may take such measures as are practicable for the account of such owner or occupier.

(5). The owner or occupier of any premises that have been treated with residual insecticide or other agent as referred to in subregulation (3) or (4), shall ensure that such insecticide or agent is not plastered or painted over, removed or rendered harmless during the effective period of the said insecticide or agent.

(6). Subject to a court order contemplated in these regulations, any person who lives, works or stays in an area where the vector mosquitoes of a mosquito-borne disease occur, or in an area where it is suspected that such a disease occurs must:

(i) if so ordered by an health care provider, subject himself or herself to a medical examination at a time and place determined by such medical officer, in order to establish whether he or she is a carrier of such mosquito-borne disease;

(ii) if so ordered by an health care provider, subject himself or herself to treatment for the prevention or cure of the mosquito-borne disease as prescribed by an health care provider; or

(iii) if he or she has been diagnosed as a carrier or sufferer of a mosquito-borne disease, inform an health care provider of his or her intention to change his or her residence of work, and an health care provider shall furnish such new address to the district health authority of the district in which such a carrier or sufferer is.

Compulsory removal, cleansing, disinfecting and treating of persons and animals infested with fleas, lice or other parasites

24(1). Subject to a court order contemplated in Regulation 21(2), a health care provider who is aware that any person or animal is infested with fleas, lice or other parasites may by written order, order that –

(i) the infested person cleanse, disinfect or treat himself or herself;
(ii) a person with legal custody or control of the infested person cleanse, disinfect or treat such infested person; or
(iii) the owner of an infested animal or the owner or occupier of any premises where an infested animal is found cleanse, disinfect, or treat such animal.

(2). Subject to a court order contemplated in the Regulations 21(1), if such a person, owner or occupier fails to take measures as ordered in Regulation 16(a) to (e), a health care provider may order such person, owner or occupier to bring the infested person or animal to a place and at a time determined in the order so that he or she or it may be cleansed, disinfected or treated there by or under the supervision of a medical officer.

CHAPTER 6

Offences and penalties

25. Any person who fails to comply with the provisions of these Regulations or if liable to notify, fails to notify a condition contemplated in the Annexure A, will be prosecuted

and if found guilty of the offence will be liable to a fine of twenty thousand rands (R20 000.00) or a term of imprisonment not exceeding five (5) years or both such fine and imprisonment.

Repeal

26. The Regulations published under Government Notice No. R 2438 of 30 October 1987, No. 328 of 22 February 1991, No. 716 of 22 April 1994, No. 1307 of 3 October 1997, No. R. 485 of 23 April 1999 are hereby repealed.

DR A. MOTSOALEDI, MP

MINISTER OF HEALTH

ANNEXURE A

Notifiable Communicable Diseases

TABLE 1: Priority Communicable Diseases that need immediate verbal report on clinical suspicion within 24 hours.

Communicable Diseases	ICD10 code
Acute flaccid paralysis	AFP
Anthrax	A22
Cholera	A00
Crimean-Congo Haemorrhagic Fever & other viral haemorrhagic fevers	A98
Food poisoning, food-borne diseases	A02 & A05
Meningococcal infection	A39
Novel influenza subtype	
Plague	A20
Rabies	A82
Smallpox	
Yellow fever	A95
Poliomyelitis (Acute)	A80.1; A80.2
Severe acute respiratory syndrome (SARS)	

TABLE 2: Communicable diseases / conditions reportable within 24 hours of laboratory confirmation

Communicable Diseases	ICD10 code
Measles	B05
MDR TB	
XDR TB	

TABLE 3: Communicable diseases / conditions reportable within seven (7) days

Communicable Diseases	ICD10 code
Brucellosis	A23
Congenital syphilis	A50
Diphtheria	A36
Haemophilus influenzae type B	HIB
Legionellosis	A48
Leprosy	A30
Malaria	B54
Paratyphoid fever	A01
Rheumatic fever	I00
Schistosomiasis (Bilharziasis)	B65
Tetanus	A35
Tetanus neonatorum	A33
Trachoma	A71
Tuberculosis Primary	A15 – A 19
Tuberculosis Pulmonary	
Tuberculosis (other respiratory organs)	
Tuberculosis of meninges	
Tuberculosis of intestine, peritoneum	
Tuberculosis of bones and joints	
Tuberculosis of genito-urinary system	

Tuberculosis of other organs	
Tuberculosis military	
Typhoid fever	A01
Typhus fever (lice-borne)	A75.0
Typhus fever (ratflea-borne)	A75.2
Acute Hepatitis A	B15.9,
Acute Hepatitis B	B16.9,
Acute Hepatitis C	B17.1
Acute Hepatitis E	B17.2
Other specified acute viral hepatitis (Hep non-A non-B (acute) (viral) NEC	B17.8
Unspecified viral hepatitis with hepatic coma	B19
Whooping cough (Pertussis)	A37

TABLE 4: Notifiable Medical conditions

Notifiable Medical condition	**ICD10 code**
Lead poisoning	**T56**
Agricultural chemical poisoning	**T57 & T60**

COMMENTS ON REGULATIONS REGARDING COMMUNICABLE DISEASES

ANNEXURE B

DISEASE	MINIMUM PERIOD OF EXCLUSION WORK/SCHOOL	
	CASE	CONTACTS
CHICKEN POX	5 days after onset of rash (or until all lesions have crusted)	None
DIPHTHERIA	Cases should be isolated with droplet and contact precautions until 2 negative throat and nasal swabs are obtained >24 hours after completion of treatment and taken 24 hours apart.	Throat and nasal swabs should be obtained from those who have had close contact in the previous 7 days. Post-exposure chemo-prophylaxis should also be pro-vided with benzylpenicillin or erythromycin (newer macrolides may also be effective). Those with positive cultures will require treatment and follow up as per symptomatic cases. The aim of chemopro-phylaxis is both to eliminate asymptomatic carriage and to treat incubating disease. Booster immunisation should also be provided to those who have not received a booster in the previous 12 months. Contacts should be monitored for symptoms for at least 7 days. *REF: Bonnet JM, Begg NT. Control of diphtheria: guidance for consultants in communicable disease control. Communicable Disease and Public Health 1999; 2: 242-249.*
GERMAN MEASLES (RUBELLA)	5 days from rash onset	None. Pregnant contacts must urgently consult obstetrician to determine rubella immunity and further testing as required

VIRAL HAEMORRHAGIC FEVERS	Isolation with standard precautions PLUS transmission-based precautions as per VHF protocols.	No exclusion if asymptomatic. Need to differentiate between those requiring 14 days surveillance (CCHF) vs. 21 days (Marburg, Ebola, Lassa fever)
HEPATITIS B AND C	None – advise on mode of transmission	None. Give appropriate PEP as required
HEPATITIS A	7 days from onset of illness	None. Give appropriate PEP
MEASLES	5 days after onset of rash	None
MENINGOCOCCAL DISEASE	Isolation with droplet precautions until 24 hours after an antibiotic has been received that reliably eliminates carriage (penicillin does not achieve this).	No exclusion once appropriate chemoprophylaxis has been given
MUMPS	5 days from onset of symptoms	None
TYPHOID FEVER	After 3 consecutive negative stool or rectal swabs obtained after completion of antibiotic treatment and 24 hours apart	None if asymptomatic but 2 negative stool or rectal swab cultures should be obtained 24 hours apart. If a food handler/health care provider worker/carer of children/elderly – should not return to work until these 2 negative stools are documented
PERTUSSIS (WHOOPING COUGH)	5 days after commencement of appropriate treatment or 21 days after cough onset if no treatment received	None but contacts must receive appropriate PEP and complete immunizations as required

*DOES NOT APPLY TO AN IMMUNOCOMPROMISED PATIENT IN WHOM PERIODS OF INFECTIOUSNESS CAN BE PROLONGED

ANNEXURE C

CASE OUTBREAK LINE LISTING TOOL

ANNEXURE D

DEPARTMENT OF HEALTH

GW17/3 SUMMARY FORM FOR REPORTING CASES ONLY

DAILY AND WEEKLY RETURN OF ALL NOTIFIABLE MEDICAL CONDITIONS LINE LISTING

Instructions

1. **To be completed in duplicate**
2. **N.B! Deaths from infectious diseases should be reported on form GW 17/4**

TO THE DISTRICT DIRECTOR OF HEALTH INFORMATION AND DISEASE SURVEILLANCE SYSTEMS

Name of Local Authority.....

Notifiable medical conditions notified during the week ended Saturday

Patient File Number (privacy??? We have to trace contacts in case of Communicable Disease)	Age	Sex	Address where the patient got sick	Disease	Onset date	Date notified	Any other cases on same premises	Full details of action taken by Local Authority

Date..... Place.....

Signature_____

ANNEXURE E

DEPARTMENT OF HEALTH

GW17/4 SUMMARY FORM FOR REPORTING DEATHS ONLY

WEEKLY RETURN OF ALL NOTIFIABLE MEDICAL CONDITIONS DEATHS FORMS

Instructions

1.To be completed in duplicate

2.This form should be filled in and sent to the District Director of Health services no later than the Monday following the week to which it refer

3.This form must be faxed to the Unit of Vital Registration at STATSSA before it comes to the Department of Health Surveillance and Epidemiology Directorate for notification system capturing

Return of deaths from Notifiable diseases reported to the local Home Affairs office

Name of person (privacy) Patient File No.	Age	Sex	Residential Address	Underlying cause of death	Duration of illness	Date of death	Any other deaths/cases on same premises

Place .....

Signature.....

Town Clerk, Secretary or Magistrate

Home Affairs official

Date.....

ANNEXURE F

DEPARTMENT OF HEALTH

GW17/5

Please print. Where appropriate, mark the correct box with a tick (√). Complete in duplicate. Original to be sent to Local Municipality where patient was diagnosed: copy to remain in book.

DETAILS OF PATIENT

Surname

First Names

_____

Identity No.

Age:

Sex

☐ Male
☐ Female

Race

☐ African ☐ Coloured

Date of birth:

☐ White ☐ Indian/Asian

Residential Address
If resident on a farm, state farmer's name as well as name and number of farm. In other rural areas, give names of chiefs, induna, village, nearest hill, nearest school or clinic

.....
.....
.....

District Municipality.....
Tel.No.....
.....

Name and address of employer, school, creche or other institution where patient spends much of the day

.....
.....
.....

District Municipality.....
Tel.No.....
.....

DETAILS OF MEDICAL CONDITION

Medical Condition

Date of onset: dd/mm/yyyy **Date of death (if applicable):** dd/mm/yyyy
Possible place of infection
Diagnosis was based on **Clinical history and Examination only** ☐
Clinical and other investigations ☐

RESULTS OF INVESTIGATIONS

Investigation- please specify (excluding TB sputum)	*Results*
	Awaiting result ☐
	Awaiting result ☐
	Awaiting result ☐

If TB, give sputum results →
Microscopy Positive ☐ Negative ☐ Awaiting results ☐
Culture Positive ☐ Negative ☐ Awaiting resu ☐

REFERRED TO

Name of hospital or clinic

Patient Registration No. (if applicable) **date of death**
Address
.....Tel No. ( )
Profession **Medical officer**
Nurse
Other (specify)..... **Signature**
.....
Date

Local Municipality: If a copy of this notification is to be sent to another Local Municipality, please confirm whether you will include this in your weekly summaries (GW17/3 or GW17/4) **Yes** **No**

REPLY BY LOCAL MUNICIPALITY

Reply to referring doctor/nurse with brief report of further findings and management

Signature **Date** **Tel No. ( )**

ANNEXURE G

NOTIFICATION PROCESS

LEVEL 1

Health establishment level:

The initial reporting of notifiable medical condition is done on a case-based Form GW 17/5. The Form makes provision for the notification of disease as well as deaths cases. Any person contracting a notifiable disease and then die as a result, should be notified twice as a disease and death case.

LEVEL 2

Once a week all notification forms are collated into a summary Form GW 17/3 and deaths into GW 17/4). All reporting units should submit their disease notifications to reach the district not later than three (3) days after the end of the reporting week (that is by Monday). The weekly notifications are then expected at relevant next higher authority (e.g. district or provincial office).

LEVEL 3

Provincial health offices: Data is captured into the notification system and sent each week via an email to the National Office, where they are collated once or twice a month into the national data set of Notifiable Medical Conditions.