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Abstract

Serious reportable or notifiable diseases are discussed in the context of the International Health Regulations 2005 and its historical development. The relevance of these Regulations and the local legislative reporting requirements to forensic practitioners is outlined and an example of the local reporting requirements in Victoria, Australia is provided.

Introduction

What is a serious communicable disease? What is a reportable disease? Do you have obligations should you diagnose or manage one? Are they an issue in forensic medicine? Before discussing these questions, consider first a very brief overview of the history of surveillance and reporting of communicable diseases, meaning those diseases that are spread from either one person or animal to another person.

History

Communicable diseases have been part of humans throughout our time on earth. Although we may not have created the actual pathogens, we have either unwittingly or deliberately permitted the environment that has both brought forth the pathogen and in some situations improved the environment to enable them to flourish (Kiple, 1999). Unwittingly, through our development and the establishment of trade routes, and especially now with rapid travel so readily available to large numbers of people, we have enabled pathogens to spread around the world as the recent Ebola outbreak has shown. But we have also deliberately spread communicable diseases and the history of this goes back hundreds of years. Although biological warfare may not be entirely ethical, it is a reality that has a long history. Infected cadavers and animal carcasses were an early means of biological warfare. The siege of Kaffa in 1345–1346 was an excellent although more recent example of this (Murray, 2004). Kaffa (now known as Feodosiya) was then a bustling sea port on the Crimean Peninsula. The Mongols, whose attacking troops, became infected with the plague (Yersinia pestis), threw the infected cadavers over the city wall resulting in an epidemic in the city, presumably aided and abetted by the rats and their fleas, and the eventual surrender of the besieged city. It is thought that some of those who escaped Kaffa by sea were responsible for the Black Death that spread to Constantinople (Istanbul) and then through Europe.

The occurrence of the Black Death in Europe in 1348 saw the emergence of a basic form of health surveillance with the appointment of three guardians by the Venetian Republic. The role of these guardians was to detect and exclude ships carrying infected people on board from entering the port (Declich and Carter, 1994; Evans and Kaslow, 1999). Health surveillance, similar to current concepts, consisting of the general principles of data collection, analysis, and dissemination for action did not come into existence until later in the development of civilization. During the seventeenth century, the parish clerks in London made regular reports of deaths from the plague to the Parish Clerks’ Company who compiled and analyzed the data for weekly dissemination and action (Declich and Carter, 1994). It was not, however, until the early nineteenth century that the more modern principles of health surveillance were created. The father of this was William Farr, Superintendent of the Statistical Department of the General Registry of London, who wrote a series of letters on the causes of death in England. Although this brief description may suggest it, not all surveillance achievements occurred in England. Many occurred at various times over the past centuries in Europe (both east and west) and later in the United States.

Prior to 1950, surveillance referred to the observation of persons exposed to infectious diseases. In 1949, the concept of surveillance as the monitoring of disease occurrence in populations as expounded by Langmuir (1963) was implemented by the newly created Communicable Diseases Center (now the Centers for Disease Control and Prevention (CDC)) to monitor malaria and later residual smallpox cases in the United States. This new concept of surveillance, when applied to a disease meant

the continued watchfulness over the distribution and trends of incidence through the systematic collection, consolidation and evaluation of morbidity and mortality reports and other relevant data. Intrinsically in the concept is the regular dissemination of the basic data and interpretations to all who have contributed and to all others who need to know. (Langmuir, 1963)
In 1963, Karel Raška, an eminent Czechoslovakian physician and epidemiologist, became Director of the World Health Organisation (WHO) Division of Communicable Disease. His definition of disease surveillance is “the epidemiological study of a disease as a dynamic process involving the ecology of the infectious agent, the host, the reservoirs, and the vectors, as well as the complex mechanisms concerned in the spread of infection and the extent to which this spread occurs,” was accepted by WHO in 1968 (Raška, 1966).

The WHO itself was established in 1948 and with this came the organization’s authority to direct and coordinate international health activities under the arm of the World Health Authority (WHA). In 1951, under Article 21 of the WHO Constitution, member states of the WHA agreed to the consolidation of the various conventions and regulations in force at the time into a single standard for notification of and responses to potentially infectious travelers or goods (Declich and Carter, 1994). This was called the International Sanitary Regulations and these related principally to preventing the spread of smallpox, relapsing fever, typhus, cholera, plague, and yellow fever whilst protecting trade and travel. The Regulations were updated in 1969 and renamed the International Health Regulations (IHR 1969). With the successful eradication of smallpox, the Regulations were revised in 1981 to remove smallpox. By this time, the only priority diseases remaining of the original six were cholera, plague, and yellow fever, diseases that were no longer a serious threat to developed countries. Although the Regulations remained, the political will to implement them dissipated in the developed countries encouraging indifference from the developing countries (Fischer et al., 2011).

Over the last 40 years there has been a change in the type of infection confronting the world with the re-emergence of dengue fever (a flavivirus), the appearance of human immunodeficiency virus (HIV) (a lentivirus) in the early 1980s, and the outbreak of Ebola (a filovirus) in 2014. The outbreak of HIV was initially identified and reported by the CDC in 1981 in a cluster of gay males in Los Angeles who developed the opportunistic Pneumocystis carinii pneumonia and died (CDC, 2001). The report prompted additional reports from other American cities. Similar patterns of opportunistic diseases and unusual tumors were found in African heterosexuals of both sexes. The conditions were enteropathic illnesses (‘slim disease’; esophageal candidiasis; cryptococcal meningitis) and an unusual tumor (Kaposi’s sarcoma) (Quinn, 2001). Evidence now shows that HIV was an escalating epidemic in central Africa and that the development of this epidemic had gone unnoticed officially until the infection spread internationally (Fischer et al., 2011). In 1983, WHO held its first meeting regarding the infection and initiated global surveillance. With the emergence of new and the reemerging of past infectious diseases, the WHA adopted two resolutions requiring the revision of the IHR to achieve “maximum protection against the international spread of disease with minimal interference with traffic and trade” (WHA Resolution 48.7) and to develop strategies for the containment of these infections as well for their detection (WHA Resolution 48.13) (Fidler, 2003). The WHO Division of Emerging and Other Communicable Diseases was established to coordinate these programs (Fischer et al., 2011).

IHR 1969 had lost its relevance by the 1990s as it only applied to cholera, plague, and yellow fever. It had other problems, it limited surveillance to information provided by governments, lacked mechanisms for assessing public health risks, did not provide strategies for developing surveillance capabilities, and had limited capacity to ensure compliance by WHO member states (Baker and Fidler, 2006). A review of IHR was commenced and the outcome assisted by the emergence of the severe acute respiratory syndrome (SARS – avian influenza virus, H5N1) epidemic in China in 2002. This epidemic of atypical pneumonia began in Guangdong Province but the Chinese did not disclose the infection to the international community until after a physician, who had been treating infected patients in Guangdong Province, developed symptoms himself and spread the infection to others whilst in Hong Kong. The infection spread to many countries causing approximately 8000 cases, 800 deaths, and significant financial costs (Fischer et al., 2011).

**International Health Regulations 2005**

On 23 May 2005, the WHA adopted the new International Health Regulations (IHR 2005) as an international treaty. These came into force in most member countries on 15 June 2007 with full compliance by 2012. They aim to “prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade” (WHO, 2005). IHR 2005 is significantly different to IHR 1969. It expands the scope of the Regulations’ application, places new requirements on member countries to prepare for health crises, adds new responsibilities and authority on WHO to coordinate international public health responses, mandates more demanding surveillance and response obligations, and applies human rights principles to public health interventions. From the perspective of this chapter, and perhaps one of the most important changes in the new Regulations, is the implementation of a surveillance system that far surpasses that required under IHR 1969 (for reviews and further information see Fidler, 2005; Baker and Fidler, 2006; Fischer et al., 2011; WHO web site http://www.who.int/ihr/about/en/).
Surveillance Requirements and Reporting

Under IHR 2005, all signatories (‘state party’) agree to be bound by the regulations and must report to WHO “all events which may cause a public health emergency of international concern” (Article 6) within a period of 24 h of assessment. The regulations define a ‘public health emergency of international concern’ (PHEIC) as an extraordinary public health event which is determined, under specific procedures:

a. “to constitute a public health risk to other States through the international spread of disease; and
b. to potentially require a coordinated international response.” (Article 1)

Article 1 also defines disease as an “illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans”. To assist in determining what constitutes a PHEIC, IHR 2005 contains a decision instrument (Annex 2) based on the following criteria:

a. seriousness of the public health impact of the event;
b. unusual or unexpected nature of the event;
c. potential for the event to spread internationally; and/or
d. the risk that restrictions to travel or trade may result because of the event.

Annex 1 outlines the core capacity requirements for surveillance and response. This includes the utilization of individual State national structures and resources through local community, intermediate public health, and national level to meet the core capacity in relation to ‘surveillance, reporting, notification, verification, response and collaboration activities.’

The regulations contain a list of diseases for which a single case that is unusual or unexpected, and may constitute a PHEIC, must be immediately reported to WHO. This list is small and consists of:

- smallpox,
- poliomyelitis due to wild-type poliovirus,
- HIV caused by a new subtype, and
- SARS.

There is a second list of diseases where a single case requires an assessment using the algorithm provided in Annex 2 to determine its public health impact. The list consists of:

- cholera,
- pneumonic plague,
- yellow fever,
- viral hemorrhagic fevers (Ebola, Lassa, and Marburg),
- West Nile fever; and
- other diseases that are of national or regional concern, for example, dengue fever, Rift valley fever, and meningococcal disease.

The remaining reportable events that may constitute a PHEIC include ‘those of unknown causes or sources and those involving other events or diseases than those listed’ above that may lead to an assessment using the algorithm.

Baker and Fidler (2006) point out in their assessment of the new regulations that the expansion in the range of public health events under surveillance and the use of the algorithm in determining what is reportable to WHO is probably the single most important surveillance event as it greatly enhances effective surveillance of emerging infectious diseases.

Serious Reportable Communicable Diseases and Forensic Medicine

Let us now return to the original questions. What is a serious communicable disease? What is a reportable disease? Do you have obligations should you diagnose or manage one? Are they of issue in forensic medicine?

The General Medical Council (United Kingdom) defined serious communicable disease as those diseases “which may be transmitted from human to human and which may result in death or serious illness. It particularly concerns, but is not limited to, infections such as human immunodeficiency virus (HIV), tuberculosis and hepatitis B and C” (GMC, 1997). The document containing this definition has been withdrawn but the term is probably in keeping with the more commonly used terms of ‘notifiable’ or ‘reportable’ disease where there is a requirement under law to report a particular disease to government authorities. There are many definitions of ‘notifiable’ or ‘reportable’ diseases but the definition used by the CDC (CDC, 2014) appears most satisfactory: “a notifiable disease is one for which regular, frequent, and timely information regarding individual cases is considered necessary for the prevention and control of the disease.” The surveillance and reporting of these diseases is in keeping with the requirements of IHR 2005 that most countries/states are signatories to and were obligated to implement by 2012. For many countries, surveillance and reporting (but not necessarily to WHO) was already in place and operative nationally or locally before IHR 2005 was adopted. The United Kingdom, for instance, implemented notification of infectious diseases toward the end of the nineteenth century. Australia, on the other hand, only implemented a national reporting system in 1917. With the implementation of IHR 2005, all ‘party states’ will have some form of legislation in place that enables them to fully comply with the International Regulations. Examples include the Public Health and Wellbeing Act 2008 in Victoria, Australia, and the Public Health (Control of Disease) Act 1984 and the Health Protection (Notification) Regulations 2010 in the United Kingdom. They will also have a list of reportable diseases and on most
lists the majority, if not all, diseases are infectious diseases and would be classified as potentially serious infections. These lists are usually available on the Internet and web sites for some countries are given in Table 1. Depending upon the constitution and make up of countries, there may be a national regulatory body with state or local government agencies reporting to it. Australia, a federation of sovereign states, is one such example. Each sovereign state maintains its own health department but reports to a national body (Table 1).

The final two questions relate to obligations for health professionals (medical diagnostic laboratories are included) who diagnose a reportable disease and that includes forensic practitioners, both clinicians and pathologists. Legislation in each jurisdiction will mandate the reporting of certain infectious disease cases to government agencies. Those mandated at the local level are usually medical practitioners or pathology laboratories. Does this affect forensic practitioners? The answer is obviously ‘yes.’ Forensic practitioners may be in a position where they will diagnose someone with a reportable disease and they are required under their local legislation to report the case to the designated authorities within a certain time period. There may be additional obligations on the clinical forensic practitioner to also either trace or assist in the tracing of contacts of the diagnosed case and to treat both the case and that person’s contacts. The precise requirements will depend upon local jurisdictional legislation and regulations.

### Confidentiality Issues

In many but not all jurisdictions, privacy or confidentiality legislation has been implemented to safeguard personal information including health information. The release of health information including what infectious disease someone is suffering from could constitute a breach of the local privacy jurisdiction. In relation to the reporting of mandated diseases, either the privacy legislation or the legislation mandating the reporting of the disease will allow for medical practitioners and laboratories to report the case to government authorities without penalty to the reporter. Although confidential medical care is generally recognized in law, the reporting of potentially serious communicable diseases is in the public interest as disclosure protects both the individual and society from the risks of serious harm.

### A Local Example – Victoria, Australia

Australia is not a country per se but a federation of territories and sovereign states. Each state and territory has a parliament which legislates for that state or territory. Although the Commonwealth of Australia legislates for some aspects of national government, each state and territory has separate health and health-related departments and associated legislation pertaining to health. Australia implemented reporting of certain diseases in 1917. The Communicable Diseases Network Australia (CDNA) was established in 1989 to provide “national public health co-ordination on communicable disease surveillance, prevention and control, and offers strategic advice to governments and other key bodies on public health actions to minimise the impact of communicable diseases in Australia and the region.” (Department Health, Australia, 2014a) In order to do this, CDNA established the current National Notifiable Diseases Surveillance System (NNDSS) (Department Health, Australia, 2014b) in 1990 which coordinates the national surveillance of certain communicable diseases. Notifications are made to the respective States or Territory health authority by medical practitioners under the provisions of the State or Territory public health acts. The Victoria Department of Health established a National Communicable Disease Surveillance System (NCDSS) to coordinate the notification of certain infectious diseases which includes forensic practitioners, both clinicians and pathologists. The NCDSS was established under the provisions of the Victorian Public Health Act 1989 and is managed by the Victoria Department of Health and Human Services who has the responsibility for notifiable disease surveillance, prevention and control. The NCDSS is responsible for the following:

- Collecting and analyzing data on notified cases of certain infectious diseases
- Monitoring trends in disease occurrence
- Informing the general public about diseases
- Providing information to health professionals and other relevant agencies
- Reporting data to the Commonwealth of Australia

The NCDSS is supported by a variety of health professionals including forensic practitioners, both clinicians and pathologists. The Victorian Public Health Act 1989 makes it mandatory for all health professionals to report certain infectious diseases, including those that are notifiable. The NCDSS is responsible for ensuring that all reports are accurately recorded and that the information is made available to other relevant agencies. The NCDSS also provides support to health professionals who are reporting infectious diseases, including forensic practitioners, by providing them with guidance and training on how to report infectious diseases.

### Table 1: Listings of notifiable/reportable diseases in some countries/states

| Country/state         | Web site                                                                 |
|-----------------------|---------------------------------------------------------------------------|
| Australia             | http://www.health.gov.au/Internet/main/publishing.nsf/Content/cda-pubs-cdi-2000-cdi2408-cdi2408g.htm |
| Australian States     |                                                                             |
| Queensland            | http://www.health.qld.gov.au/publichealthact/notifiable/                   |
| New South Wales       | http://www.health.nsw.gov.au/infectious/pages/notification.aspx            |
| Northern Territory    | http://www.health.nt.gov.au/Centre_for_Disease_Control/Notifiable_Diseases/index.aspx |
| Victoria              | http://ideas.health.vic.gov.au/notifying.asp                               |
| South Australia       | http://www.health.nsw.gov.au/infectious/pages/notification.aspx            |
| Western Australia     | http://www.public.health.wa.gov.au/3/2843/notifiable_comm.prm             |
| Tasmania              | http://www.dhhs.tas.gov.au/_data/assets/pdf_file/0007/165362/Guidelines_for_Notification_of_Notifiable_Diseases_Human_Pathogenic_Organisms_and_Co.png |
| Canada                | http://dsol-smrd.phac-aspc.gc.ca/dsol-smrd/ndis/list-eng.php               |
| Hong Kong             | https://cen.chp.gov.hk/disease.jsp                                         |
| India                 | http://health.puducherry.gov.in/details_of_notifiable_diseases.htm         |
| New Zealand           | http://www.health.govt.nz/our-work/diseases-and-conditions/notifiable-diseases |
| United Kingdom        | https://www.gov.uk/notifiable-diseases-and-causative-organisms-how-to-report |
| United States – CDC   | http://www.cdc.gov/mmwr/mmwr_nd/                                          |
|                      |                                                                           |

Table 1 lists the majority, if not all, diseases are infectious diseases and would be classified as potentially serious infections. These lists are usually available on the Internet and web sites for some countries are given in Table 1.
health legislation and the information is then collated and analyzed by the NNDSS. With the adoption of IHR 2005, the Commonwealth entered into an agreement (National Health Security Agreement) with the States and Territories in conjunction with the National Health Security Act 2007 to implement the requirements of IHR 2005.

In Victoria, one of the Australian States, the Public Health and Wellbeing Act 2008 requires that prescribed diseases are notified to the Victorian Department of Health by, significantly, both persons in charge of pathology laboratories and medical practitioners making the diagnosis (Department of Health, Victoria, 2009). The dual notification system is to provide a safety net for reporting. The notifiable conditions are divided into four groups, Groups A–D (Table 2), on the basis of the method of notification and the information required. The groups are as follows:

- **Group A** – Conditions that require immediate notification to the Department of Health by telephone upon initial diagnosis (presumptive or confirmed) with written notification to follow within 5 days.
- **Group B** – Conditions that require written notification only within 5 days of diagnosis (presumptive or confirmed).
- **Group C** – Conditions are sexually transmissible diseases and should be notified to the Department in

| Group A                                      | Group B                                      | Group C                                      | Group D                                      |
|----------------------------------------------|----------------------------------------------|----------------------------------------------|----------------------------------------------|
| Anthrax                                      | Barmah Forest virus infection                 | Chlamydia trachomatis infection              | Acquired Immunodeficiency Syndrome (AIDS)    |
| Botulism                                     | Arbovirus infections – other arbovirus infections | Donovanosan                                   | Human immunodeficiency virus infection       |
| Cholera                                      | Blood lead greater than 10 µg/dl              | Gonococcal infection                         |                                             |
| Chikungunya virus infection                  | Brucellosis                                   | Syphilis (less than 2 years duration)        |                                             |
| Diphtheria                                   | Campylobacter infection                       | Syphilis (2 years or more duration or unspecified) |                                             |
| Food-borne and water-borne illness (two or more related cases) | Creutzfeldt–Jakob disease (CJD)               | Congenital syphilis                          |                                             |
| Haemolytic Uremic Syndrome (HUS)             | Cryptosporidiosis                             |                                             |                                             |
| Japanese encephalitis                        | Dengue virus infection                        |                                             |                                             |
| Legionellosis                                | Hepatitis B (newly acquired)                  |                                             |                                             |
| Measles                                      | Hepatitis B (unspecifed)                      |                                             |                                             |
| Murray Valley encephalitis virus infection   | Hepatitis C (newly acquired)                  |                                             |                                             |
| Haemophilus influenza, type B (meningitis, epiglottitis, other invasive infections) | Hepatitis C (unspecifed)                      |                                             |                                             |
| Hepatitis A                                 | Hepatitis D                                  |                                             |                                             |
| Meningococcal infection (invasive)           | Hepatitis E                                  |                                             |                                             |
| Paratyphoid                                  | Hepatitis viral (not further specified)       |                                             |                                             |
| Poliomyelitis                                | Herpes zoster                                 |                                             |                                             |
| Plague                                       | Influenza (laboratory confirmed)              |                                             |                                             |
| Rabies                                       | Kunjin virus infection                        |                                             |                                             |
| Severe Acute Respiratory Syndrome (SARS)    | Leprosy                                      |                                             |                                             |
| Smallpox                                     | Leptospirosis                                 |                                             |                                             |
| Tularemia                                    | Listeriosis                                   |                                             |                                             |
| Typhoid                                      | Lyssavirus – Australian Bat lyssavirus        |                                             |                                             |
| Viral hemorrhagic fevers                     | Lyssavirus – other (specify)                  |                                             |                                             |
| Yellow fever                                 | Malaria                                      |                                             |                                             |
|                                              | Mumps                                         |                                             |                                             |
|                                              | Mycobacterium ulcerans                        |                                             |                                             |
|                                              | Pneumococcal infection (invasive)             |                                             |                                             |
|                                              | Psittacosis (ornithosis)                      |                                             |                                             |
|                                              | Pertussis                                     |                                             |                                             |
|                                              | Q Fever                                       |                                             |                                             |
|                                              | Ross River virus infection                     |                                             |                                             |
|                                              | Rubella                                       |                                             |                                             |
|                                              | Congenital Rubella                            |                                             |                                             |
|                                              | Salmonellosis                                 |                                             |                                             |
|                                              | Shiga toxin and Verotoxin producing           |                                             |                                             |
|                                              | *Escherichia coli* (STEC/VTEC)                |                                             |                                             |
|                                              | Shigellosis                                   |                                             |                                             |
|                                              | Tetanus                                       |                                             |                                             |
|                                              | Tuberculosis                                  |                                             |                                             |
|                                              | variant Creutzfeldt–Jakob disease (vCJD)       |                                             |                                             |
|                                              | Varicella                                     |                                             |                                             |

Table 2 Notifiable conditions by group in Victoria in 2014, Australia

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writing within 5 days of diagnosis. To preclude the identification of the patient, only the first two letters of the given and family name of the patient are required.

- Group D – Conditions include HIV infection and acquired immunodeficiency syndrome (AIDS) and written notification to the department is required within 5 days of confirmation of diagnosis. A separate form is used for this purpose due to the need to have national uniformity in collection of data.

Written notification, which is not onerous, is undertaken using forms available either in hard copy or electronically. There are two forms, a standard form for disease Groups A–C and an enhanced form for Group D diseases. The information required on the standard form includes the patient’s name, their address, date of birth, their occupation, the disease, brief clinical information as to risk factors and mode of transmission, and the reporter’s details. Additional information is required for sexually transmitted infections relating to the reason for testing, contact type, and partner follow-up. Medical practitioners and laboratories are protected under both national and state privacy legislation for the provision of this confidential clinical information to government agencies as mandated in the reporting legislation.

See also: Autopsy; Infectious and Serious Communicable Diseases. Consent: Confidentiality and Disclosure. Sudden Natural Death: Infectious Diseases

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