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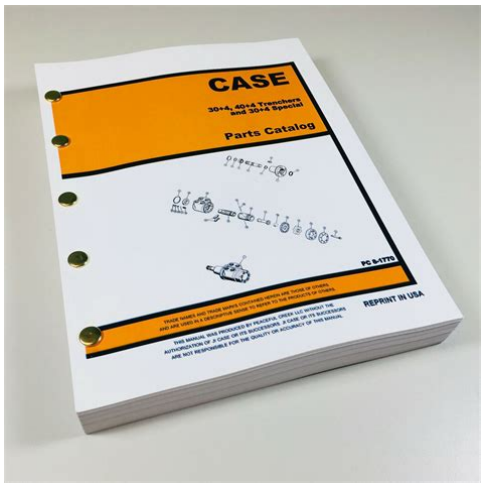

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Unknown source cases represent cases where epidemiologic or virologic link to an imported case was not detected. In 2015, 191 measles cases were reported; 28 15% were importations, and 142 80% of 178 cases among U.S. residents were unvaccinated or had an unknown vaccination status.Thus, current measles epidemiology in the United States is determined by characteristics of the imported cases and their susceptible contacts. The settings of measles transmission have included households, educational institutions e.g., schools, day care, churches, health care facilities, homeless shelters, and other congregate settings. However, recent large outbreaks emphasize the importance of maintaining high levels of measles immunity across the population through routine measles vaccine coverage.Countries in all six WHO regions have adopted measles elimination goals, and four WHO regions endorsed the Global Vaccine Action Plan to eliminate measles by 2015; although these elimination goals were not accomplished.Monovalent measles vaccine is not available in the United States. Any genotype that is found repeatedly in USacquired cases should be thoroughly investigated as a potential endemic genotype, especially if the cases are closely related in time or location. These cases must be carefully assessed epidemiologically to assure that they do not represent a sustained USacquired chain of transmission or an endemic chain of transmission within the United States. For national reporting, however, cases will be classified as either internationally imported or USacquired.Detection of measlesspecific IgM antibody and measles RNA by realtime RTPCR are the most common methods for confirmation of measles infection. Efforts should be made to obtain a serum sample and throat swab or nasopharyngeal swab from suspected cases at first contact.

Urine samples may also contain virus and when feasible to do so, collection of both respiratory and urine samples can increase the likelihood of detecting virus. Staff at the CDC Measles Laboratory are available for consultation and can assist with confirmatory testing as needed for measles. For details on all types of specimens serum, respiratory, urine collection and transport, see the CDC Measles Lab website. To minimize the problem of false positive laboratory results, it is important to restrict case investigation and laboratory tests to patients most likely to have measles i.e., those who meet the clinical case definition, especially if they have risk factors for measles, such as being unvaccinated, recent history of travel abroad, without an alternate explanation for symptoms, for example epilinked to known parvovirus case or those with fever and generalized maculopapular rash with strong suspicion of measles. This is particularly important as the investigation is ending; at that point, laboratory confirmation should be sought for all suspected cases. Occasionally, suspected cases may include vaccinated individuals. For these cases, laboratory confirmation may be challenging. An overview of diagnostic tools is described below. The preferred specimens for virus isolation or RTPCR are throat or nasopharyngeal swabs, but urine may also contain virus. Virus isolation and RNA detection are more likely to be successful when the specimens are collected early ideally within three days of rash onset, but up to ten days post rash may be successful. Isolation of measles virus in cell culture or detection of measles RNA by RTPCR in clinical specimens confirms the diagnosis of measles. In addition, the collection of appropriate specimens from which virus or viral RNA can be obtained or amplified is extremely important for molecular epidemiologic surveillance to identify the genotypes associated with imported cases of measles.

Refer to the CDC Measles Laboratory website for additional information on sample collection, processing and the genetic analysis of measles. At the direction of the state health department, health care providers and state and local health departments may send serum specimens from suspected measles cases to the CDC Measles Laboratory. For detailed information on blood collection and shipping, refer to the CDC Measles Laboratory website. Public health laboratories that use commercial measles assay kits are encouraged to fully characterize and validate the kits in their laboratories using known test panels of positive and negative specimens. Information regarding the performance characteristics of many of the commercially available enzyme immunoassays EIA kits is available by contacting the CDC Measles Laboratory. The reference laboratory at CDC uses an

IgM assay developed at CDC for measles serologic testing of IgM. The assay is a capture IgM format EIA that utilizes a recombinant measles nucleoprotein NP antigen and tends to have high sensitivity and specificity compared to some commercial EIAs. Measles IgG antibodies are generally produced and detectable a few days after the IgM response. IgG levels peak approximately two weeks post rash onset and persist for life. Measles IgM is detectable for at least 30 days after rash onset and frequently longer. Determination of the measles genotype is necessary when measles symptoms occur following an exposure to wild type virus and MMR vaccine had been provided as postexposure prophylaxis. These cases are usually detected during an outbreak or after a known exposure to a confirmed measles case. In rare instances, such cases can occur without a known exposure or other risk factor. If viral testing results are noncontributory, additional serological testing can be performed for highly suspicious cases. See the sections below. As discussed above, false negative results can also occur in a previously vaccinated person.

A brief description for the utility of these assays is given below. More information is available on the CDC Measles webpage. Requests for testing should be directed to the Measles Laboratory at CDC. See Chapter 22, Laboratory Support for the Surveillance of VaccinePreventable Diseases The test for IgG antibody should be conducted with acute and convalescent serum samples at the same time using the same test. IgG avidity assessments would also be informative on such specimens, since low avidity results would rule in a case of measles in this instance See Avidity of IgG below. Refer to the CDC Measles Laboratory website for more information. Specimens for viral isolation should be obtained in addition to serologic testing see " Laboratory Testing " section above; isolation of wild type measles virus would allow confirmation of the case.Unlike the IgG EIA, this test measures measles functional neutralizing antibodies, requires specialized reagents, and is labor and time intensive. Only in rare situations would such testing be deemed necessary. Prior approval should be obtained from the CDC Measles Laboratory. Low avidity IgG confirms a recent measles infection or recent vaccination. Avidity testing can distinguish between primary and secondary vaccine failures. Avidity testing requires specialized reagents and their use is limited to unusual cases prior approval required usually in an outbreak setting when cases with modified or nonclassic presentation of measles are detected. Guidelines have been published for specimen collection and handling for viral and microbiologic agents. Information is also available on using CDC laboratories as support for reference and disease surveillance; this includes Specimens for virus isolation and genotyping should be sent to CDC as directed by the State Health Department. You may contact your local or state health department for reporting requirements in your state.

Measles cases should be reported promptly within 24 hours 3 by the state health department to the CDC or directly to Susan Redd at NCIRD, CDC by telephone 4046398763 or by email. Notifications of confirmed cases using the event code 10140 should then be electronically reported by the state health department to the National Notifiable Diseases Surveillance System NNDSS with the next regularly scheduled electronic transmission. Additional information also may be collected at the direction of the state health department. Efforts should be made to obtain clinical specimens for viral detection see " Laboratory Testing " section above.If unable to contact the QS, call the DGMQ 24hour number at 8666944867 for assistance. Information that should be collected and shared with DGMQ includes dates of travel, departure and arrival locations, and flight or ship carrier and number. In addition, the rapid investigation and reporting of all suspected cases and recording of vaccination history and import status for all cases has become increasingly important. An important indicator of the adequacy of the measles surveillance system is the detection of importations. In the absence of measles endemic transmission, imported cases or cases linked to importations should be detected. A program which reports no imported cases in settings where endemic measles has been eliminated cannot be assumed to have adequate measles surveillance. For more information on surveillance indicators, see Chapter 18, " Surveillance Indicators." Essential components of case investigation include establishing a diagnosis of measles, obtaining immunization histories for

confirmed cases, identifying sources of infection, assessing potential for transmission and identifying contacts without presumptive evidence of immunity, classifying importation status, and obtaining specimens for genotyping. Each imported measles case could result in transmission of measles to susceptible individuals if exposed.

Surveillance and prompt investigation of cases and their susceptible contacts is important because the spread of the disease can be limited with early case identification and public health response including vaccination and quarantine of susceptible contacts without presumptive evidence of immunity. However, because some imported measles cases are not detected in our surveillance system, maintaining a high alertness for measles is needed since not every “sporadic” case occurring in the community can be linked to an importation. Surveillance data are used to characterize persons, groups, or areas in which additional efforts are required to reduce risk of measles disease and outbreaks. If the case was reported within three days of onset of rash, the case may not meet the clinical case definition see “ Case definitions “ and there should be appropriate followup to establish a rash duration of at least three days. However public health action, if needed, should not be delayed. Suspected cases of measles should have laboratory confirmation. Efforts should be made to obtain clinical specimens for viral testing see the section “ Laboratory Testing “. However, health care providers should maintain a high index of suspicion for measles in clinically compatible cases especially among unvaccinated persons and among persons who recently traveled abroad or who have had contact with persons such as travelers or international visitors. In addition, not every sporadic measles case is linked to a known importation, so cases that raise high suspicion of measles, irrespective of associated risk factors, should be investigated for measles unless an alternative diagnosis is likely e.g., known epidemiological link to a parvovirus case. In addition, when evaluating patients with suspected measles who have negative tests for acute measles infection, additional testing for rubella can be considered.

Acceptable proof of vaccination is documented administration of live measles viruscontaining vaccine. Written or electronic records with dates of vaccine administration are the only acceptable evidence of vaccination. Casepatients or their caregivers may have personal copies of immunization records available that include dates of administration; these are acceptable for reporting purposes. Immunization registries are now very useful sources of vaccination histories for children and adolescents. Records at public health departments and health centers should be reviewed, and private physicians should be contacted and asked to review patient records for this information. With careful planning in an outbreak setting, it is possible to contact providers with a list of all casepatients reported to date for whom data are needed, and to call back at a prearranged time, rather than repeatedly contacting providers for records on individual children. The date of vaccination for each dose and the interval between doses should be noted. The vaccination status of persons for whom vaccination status cannot be verified should be classified as unknown. Persons are categorized as unvaccinated if they report that they had no history of being vaccinated; if available, immunization records should be checked to verify lack of vaccine receipt. Casepatients or their caregivers should be asked about contact with other known cases. When no history of contact with a known case can be found, opportunities for exposure to unknown cases should be sought. Such exposures may occur in schools, during air travel, through other contact with recent travelers or foreign visitors, while visiting tourist locations casinos, resorts, theme parks, in health care settings, or in churches.Previously unreported cases may be identified by reviewing emergency room logs, electronic medical records, or laboratory records.

Hospital emergency rooms and physicians serving affected communities are usually recruited to participate in active surveillance. Tracking is easily accomplished by constructing a line listing of cases, allowing ready identification of known and unknown data and ensuring complete case investigation. The line listing is an essential component of every outbreak investigation Table 1 .

Neither susceptibility nor risk of exposure is uniformly distributed throughout the community, and resources available for control may be limited. Therefore, it is essential that data be used to determine the scope of the investigation and the potential for spread and that intervention be based on those determinations using public health judgment to guide investigation and control efforts.Settings at highest risk of transmission based on the epidemiology of the outbreak may be prioritized for public health response. In all these settings, exposures usually result in an identified number of susceptible contacts to follow up on individually. However, efforts to identify the likelihood of exposure in larger settings such as hospitals e.g., patients and health care personnel in ER may be helpful. In particular, one should identify individuals at high risk for severe disease including infants who are not vaccinated, immunocompromised individuals, and pregnant women. However, it is reasonable to delay major control activities, such as checking presumptive evidence of immunity and enforcing student exclusion, pending the return of laboratory results, which should be obtained as quickly as possible within 24 hours. For exposures at such venues as restaurants, stadiums, and malls, communicating with the general public through radio, TV, EpiX, or other media, may be used to reach potentially exposed persons rather than individual contact tracing. Persons can be guided to their physicians or the health department for assessment of immunity status and the need for vaccination.

For assessment of presumptive evidence of immunity of contacts, only doses of vaccine with written documentation of the date of receipt should be accepted as valid. Verbal reports of vaccination without written documentation should not be accepted. When deciding about quarantine, factors to consider include Under special circumstances, such as during outbreaks in schools attended by large numbers of persons who refuse vaccination, restriction of an event or other quarantine measures might be warranted. However, vaccination should be offered at any interval following exposure in order to offer protection from future exposures. For exposed persons without evidence of measles immunity, a rapid IgG antibody test can be used to inform immune status, provided that administration of IG is not delayed. In other settings such as childcare, school, or work, factors such as immune status, intense or prolonged contact, and presence of populations at risk, should be taken into consideration before allowing these individuals to return. These factors may decrease the effectiveness of IG or increase the risk of disease and complications depending on the setting to which they are returning. In educational institutions where there are high rates of vaccine exemptors, the potential risk of spread of the disease is high. Control measures include the following actions Persons receiving their second dose and previously unvaccinated persons receiving their first dose appropriately i.e., before, or within 72 hours of, exposure as part of the outbreak control program may be immediately readmitted to school. However these individuals should be monitored for signs and symptoms of measles. For unvaccinated personnel born before 1957 who lack laboratory evidence of measles immunity or laboratory confirmation of disease, health care facilities should consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval.

For unvaccinated personnel born before 1957 who lack laboratory evidence of measles immunity or laboratory confirmation of disease, health care facilities should recommend 2 doses of MMR vaccine during an outbreak of measles. When a measles case occurs in a health care setting, including outpatient and longterm care facilities, the following measures should be undertaken In clinic settings where a negative air pressure isolation room may not be available, a single room with the door closed and away from susceptible contacts may be used when evaluating persons in whom measles is suspected. Health care facilities should provide MMR vaccine to all personnel without presumptive evidence of measles immunity at no charge. Recently vaccinated HCP i.e., prior to exposure or the outbreak do not require any restriction in their work activities. Those with documentations of one vaccine dose may remain at work and should receive the second dose.Results from serological testing, if performed, can inform on need for the second MMR vaccine dose. This turnover in personnel can cause problems unless activities are organized so that the status of the

investigation is documented at all times. Some practical suggestions for organizing this activity are listed here. Daily briefings are a good way of keeping the whole staff informed of the status of the investigation. The person who receives the initial telephone call should attempt to obtain the information needed to fill in the line listing see Table 1 . It is useful to have one stack of all confirmed cases, one stack of suspected or probable cases awaiting further investigation or lab results, and a separate stack of discarded cases. Subacute sclerosing panencephalitis more cases of this fatal disease are prevented by measles immunization than was previously recognized.Impact of measles in the United States.Measles elimination in the United States.Contagious diseases in the United States from 1888 to the present.

Evolution of measles elimination strategies in the United States.Measles in the United States during the postelimination era.A measles outbreak in an underimmunized Amish community in Ohio.The economic burden of sixteen measles outbreaks on United States public health departments in 2011.Measles eradication in the Americas progress to date.Region of the Americas is declared free of measles external icon.Atlanta, GA CSTE; 2012. Global distribution of measles genotypes and measles molecular epidemiology.Diagnosis of measles with an IgM capture EIA the optimal timing of specimen collection after rash onset.Timing of development of measlesspecific immunoglobulin M and G after primary measles vaccination.A systematic review of humantohuman transmission of measles vaccine virus.Two case studies of modified measles in vaccinated physicians exposed to primary measles cases high risk of infection but low risk of transmission.Laboratory characterization of measles virus infection in previously vaccinated and unvaccinated individuals.Survival of measles virus in air.Measles outbreak in a highly vaccinated population, San Diego, 2008 role of the intentionally undervaccinated.The cost of containing one case of measles the economic impact on the public health infrastructure—Iowa, 2004.Implications of a 2005 measles outbreak in Indiana for sustained elimination of measles in the United States.Early measles vaccination during an outbreak in The Netherlands reduced short and longterm antibody responses in children vaccinated before 12 months of age. J Infect Dis 2019. Measles humoral and cellmediated immunity in children aged 510 years after primary measles immunization administered at 6 or 9 months of age. J Infect Dis 2013;20757482. Health careassociated measles outbreak in the United States after an importation challenges and economic impact. Am I eligible Who are our lawyers.

Our Law Centres Law Manual Resources Overview Law Reform Pipeline Bookshop Legal letters Rights education Specialist Help YouthLaw COVID19 response If you are looking for the latest legal information relating current Coronavirus laws in New Zealand, check out our new section Coronavirus and the Law. Bail is release from court or police custody on the condition that you will appear in court when next required. New Zealand Bill of Rights Act 1990, s 24b Note If you've been charged with a crime, you have the right under the Bill of Rights to be released on bail on reasonable terms and conditions, unless there's a good reason for continuing to hold you. The Bail Act sets out the specific rules around granting or refusing bail, and those rules are explained in this section below. Police bail After you have been arrested for an offence, the police have to decide whether to hold you in police custody while they are waiting for you to be brought before the court or release you. Being granted police bail means the police will release you on conditions, including that you come to court when you are required to. When will the police grant bail. Bail Act 2000, s 21 The power to grant police bail is at the discretion of the police. No person has a right to be granted police bail. The police will consider granting bail in situations where you are charged with an offence, and were arrested without a court warrant. Note Someone who has been arrested and charged with an offence by the police must be brought before a court as soon as reasonably possible.

The police can't grant you bail if you've been charged with certain specified sexual or violent offences or if you have previously been convicted of one of those offences, or an offence with a penalty of three or more years in prison, if the alleged offence happened while you were out on bail

and you have also previously served time in prison, or an offence with a penalty of three or more years in prison, if you have previously been sentenced to prison on 14 or more occasions and have also previously been convicted of offences while on bail or while remanded at large, or drugdealing. The police are unlikely to grant bail if you have been charged with a serious offence, if you have no residential address, or if you have been arrested for breach of bail see below, “What factors will the police consider in deciding whether to grant bail”. Bail Act 2000, s 23 Also, someone arrested for breaching a protection order under the Family Violence Act 2018 must be held in police custody for 24 hours after their arrest see the chapter “Family violence and elder abuse” . During that time, they can’t get police bail. What factors will the police consider in deciding whether to grant bail. If you are granted bail, you have to sign a bail bond, which sets out the conditions of bail. You will then be released from police custody subject to the conditions placed on your bail. You will be kept in police custody. This means you will be taken to the cells or prison by the police and kept there until your next court appearance. When does police bail expire. Police bail expires when you appear in court. If the matter is not going to be resolved at the first appearance, then an application for court bail would need to be considered see below, “Court bail”. What happens if I breach my police bail. Bail Act 2000, ss 24, 26, 39 If you don’t turn up to court at the time and place stated in your police bail notice, this is a criminal offence, separate from the charge that your bail relates to.