

## Contents

- 2 Meet Diane Parsons and Carole Tracey – your new committee members  
Newsround
- 3–17 Bulletin Board – short, sweet and to the point!
- 4 Update: global status of poliomyelitis
- 6 Conference roundup
- Au revoir and bon voyage
  - MASTA Study Day
  - A first for Northern Ireland
- 8 What difference does needle size make in vaccinations for infants?  
Research from Linda Diggle
- 10 First nurses join the RCPSG Faculty of Travel Medicine: a landmark occasion!
- 12 And now for something completely different. Diane Parson in Uganda
- 14–16 Expatriate morbidity. Dipti Patel looks at the health of Brits abroad
- 17 Bush-meat trade: at £300 a kilo, the Ebola comes free
- 18 Hajj 2006: Professor AR Gatrad on health risks
- 20 Resources for travel health advisers
- FAST FACTS: Travel medicine
  - Dates for your diary
  - From the journals.

## Further information

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## Letter from the Chair

### Sandra Grieve takes up the reins

A new era has begun in our forum and a fitting tribute was made at the annual conference to our outgoing Chair, Jane Chiodini. Jane has served on the committee for eight years, six of them as Chair. Given her enormous contribution and enthusiasm she is a hard act to follow, but I will do my best to build on the work she has started.

The good news is that Jane will continue to support us and has agreed to keep on working on the competencies which have been in production for almost a year. A lot of hard work has gone into them and, as they near completion, we hope they will add substance to the already successful guidance document.

In other committee news, thanks also to Annie Bradley who stood down after six years and welcome to new members Diane Parsons and Carole Tracey – we look forward to working with them. A short biography of each is on page two.

The RCN continues to consult on changes to the way professional services are organised. The Professional Development Framework

(PDF) review is ongoing and the views of forums are well represented on the Professional Membership Structure Action Group by six forum chairs. We're staying involved and monitoring the situation, and will update you when more information becomes available. Meanwhile, it's business as usual and no changes are expected until 2008.

Travel medicine also continues to evolve, notably through the formation of the Faculty of Travel Medicine at the Royal College of Physicians and Surgeons of Glasgow. Our outgoing Chair and Carolyn Driver, a committee member, were elected to the Executive Board and Lorna Boyne was appointed Faculty Secretary. Congratulations to all.

Malaria advice is a major part of a pre-travel consultation and the new user friendly malaria guidelines highlighted at our annual conference are expected any minute.

Thank you to everyone for your support. I will aim to build on the strong foundations of the forum.

## ... in this issue

Christmas is almost upon us as our winter edition goes to press. However, there's no winding down for those of us in travel medicine. Our world continues to evolve at a fast pace and the Faculty of Travel Medicine at the Royal College of Physicians and Surgeons of Glasgow is now firmly established. Read more on pages 10 and 11.

Immunisation is a big part of disease prevention in travellers with the national childhood immunisation programme providing a base. The key points of Linda Diggle's research on needle length provides us with an evidence base (see page eight)

and we congratulate Linda on her PhD.

Living life as an expatriate brings its own issues and Dipti Patel has explored some of them, starting on page 14. Professor Gatrad highlights travel issues surrounding the Hajj on page 18 while a report on our excellent annual conference is on page six. Our regular newsround, bulletin board, book reviews and other useful information complete this bumper 20-page edition. My thanks as always go to contributors and sponsors.

Have a good Christmas and travel safely.

**Sandra Grieve**

# Welcome to our new committee members

## MEET DIANE PARSONS ...

Diane says her nursing ambitions actually began at the age of four, but by 11 she made it official when she joined the St John's Ambulance cadets – the rest is history!



It was a pioneering course of integrated nurse training that she entered at Hillingdon Hospital and Chiswick Polytechnic, leading to qualifications as a state registered nurse, district nurse and health visitor. She worked in the community as a health visitor before completing the City and Guilds 730 teaching certificate which enabled her to enter nurse

education as a clinical teacher, specialising in surgery and orthopaedics.

Having gained a Diploma in Adult Education and registered as a nurse tutor, she moved to Great Ormond Street Hospital to teach on their integrated children's and adult nurse training course. She earned a Diploma in Adult Psychodynamic Counselling at Birkbeck College and eventually was invited to help facilitate the certificate course there. For the next seven years, she saw clients in the voluntary sector and supervised practising counsellors.

Her work as a travel health nurse dates back to 1999 when she joined InterHealth, the medical charity. She is currently responsible for managing the Travel Clinic together with a team of four nurses, working alongside doctors who undertake medicals pre-and post-overseas placements as well as for UK staff. Clients come from missions and major agencies, plus ever-increasing numbers of gap year students. The psychological team offers counselling, assessment, de-briefing and work-life balance.

Diane and her husband Mark have a strong Christian faith which motivates and guides them in all they do, including her recent "busman's holiday" during which she worked for a month with a Christian charity in Uganda – read all about it on page 12).

She continues to attend courses and maintains a lively interest in the evolving world of travel medicine.

## AND CAROLE TRACEY

Carole qualified as a registered nurse at Mount Vernon and Harefield Hospital in 1976. After staff nurse jobs in medicine and surgery, she went to Hillingdon Hospital to complete an accident and emergency nursing course and then did midwifery training in Norwich.

A year abroad followed with travel to Newfoundland, United States and Australia where she worked as a night sister in the Prince of Wales Hospital in Sydney.

But it wasn't until 1993, when she started as a practice nurse at the University of East Anglia Medical Centre, that her interest in travel health began.

Carole completed her MSc in Travel Medicine from the University of Glasgow in 2001 and her BSc (Hons) Nurse Practitioner in 2005.

In 2003, part of her personal and professional development involved a sabbatical to Australia, working as a remote area nurse on a traditional Aboriginal community. She considers this a truly privileged learning experience.

In April 2005 she started as a lecturer at the UEA, teaching primary care to student nurses. Keen to maintain her clinical skills she remains involved in travel medicine as the lead nurse at the busy University Travel Clinic. She teaches staff and provides "safe and healthy travel" lectures to students and staff alike.

Carole is a founder member of the British Travel Health Association (BTHA) and a member of the International Society of Travel Medicine (ISTM), regularly attending conferences in the UK and abroad.

Publishing credits include *Professional Nurse* and the "Swimming and Diving" learning unit for the Diploma in Travel Medicine at Glasgow, where she is about to become a personal adviser on the Diploma course.

She is delighted to be a member of the RCN Travel Health Forum and hopes to continue promoting nurse education in travel medicine.



## NEWSROUND

### The new malaria guidelines

As we go to press, these are expected momentarily. Check the news gallery at [www2.rcn.org.uk/pcph/news](http://www2.rcn.org.uk/pcph/news) for the latest.

### Funding!

The Travel Health Forum reminds members that a research grant and/or help with funding attendance

at educational events might be available. Contact the Editor for more information.

### Increased membership

From the President of the International Society of Travel Medicine:

"It gives me great pleasure to let you know ... that our membership has crossed the 2,000 member mark for the first time in the history of the Society. ISTM was founded in 1991 with 287

members. As of today, we have 2,004 members from over 65 countries across the globe. This highlights the growing relevance of our Society and of travel medicine as a much-needed specialty. Considering that most societies are experiencing a decline in membership, this is an accomplishment that we ought to be proud of. Thank you for your continued support ... I look forward to seeing you in Vancouver for "CISTM10". – Prativa Pandey MD

## Tourism's final frontier

Yes, it really happened: the world's first "space tourist" has been there and done that. Anousheh Ansari, 40, an American telecoms entrepreneur, spent 11 days as a paying guest on the International Space Station and arrived back with a Russian cosmonaut and an American astronaut who were completing a six month tour. Mrs Ansari's last entry in her web log spoke of her immense sadness to be leaving the station.

*Where do we go from here in travel health advice? – Ed.*

## Bad passengers

An online survey reveals intoxicated passengers have overtaken crying infants as the most annoying flight companions. Other irritants included "tiresome talkers" and "demanding divas". Frightened flyers attracted more sympathy than anger.

## Capitalising on misery

An audit presented to the US Congress showed that up to 7,000 fraudsters spent federal money intended to clothe and house victims of Hurricane Katrina in New Orleans. The Federal Emergency Management Agency (FEMA) did not check the identity of claimants. One cheat managed to acquire emergency money to fund a sex change operation. Over 1,000 used the names of prisoners to claim money while others used post office boxes or cemetery addresses. In total fraud may have accounted for 16 per cent of the individual assistance paid out. A FEMA spokesman said their highest priority was "to get help quickly to those in desperate need".

## AIDS and the United Nations

A UN meeting in the summer agreed on a declaration of commitment that was stronger than some countries would have liked, but not strong enough for non-governmental and pressure groups. UN Secretary General Kofi Annan called the HIV/AIDS epidemic "the greatest challenge of our generation – the epidemic continues to outpace us". Most countries failed to meet important goals from 2001, he said, including education enabling young people to help themselves

and taking measures to fight the spread of AIDS among women and girls. See [www.un.org/ga/aidsmeeting2006](http://www.un.org/ga/aidsmeeting2006)

## Global crisis on malaria

The UK Coalition Against Malaria, launched in June, was hosted by the All-Party Parliamentary Malaria Group which is calling for "unified action against a global killer". The coalition warned that "the global malaria crisis is desperate and worsening, killing a child somewhere in the world every 30 seconds". See [www.coalitionagainstmalaria.org.uk](http://www.coalitionagainstmalaria.org.uk)

## Cheese, smelly feet and ... malaria?

The biology prize in the annual Ig Nobel Awards at Harvard University went to Dr Knols of the Netherlands and his colleagues in Tanzania, Austria and Italy, following their realisation that Limburger cheese is cultured with *Brevibacterium epidermidis*, a bacterium found on human skin. They discovered that the female mosquito *Anopheles gambiae* craves equally Limburger cheese and smelly feet. This work has practical implications for reducing the spread of malaria in Africa, and the Bill and Melinda Gates Foundation has approved a grant of \$8 million to allow it to continue. More in *BMJ*, 333 (7572) p. 771.

## Chikungunya and dengue in India

Southern and Central India has been affected by an unprecedented epidemic of Chikungunya and a simultaneous outbreak of dengue fever. The failure to control breeding sites for *Aedes aegypti* mosquitoes has led to disease outbreaks, but health officials are investigating other factors which may be contributing to the spread. See [www.nathnac.org](http://www.nathnac.org) for updates.

## Polio in India

Figures from the World Health Organization (WHO) show a four-fold increase in polio cases in India. The outbreak is concentrated in western districts of Uttar Pradesh where, UNICEF says, just five per cent of children are fully immunised.

## New TB threat to Africa

New strains of tuberculosis are spreading through parts of Tanzania, Kenya and Uganda where increasing numbers of cases are proving untreatable. Bad health care provision in poor populations and rising rates of HIV infections allow the infection to mutate in developing countries. In recent months, Kenya has reported 48 cases of multi-drug resistant TB, mainly in Nairobi. Medecins Sans Frontieres says TB and HIV are so closely linked that those with one infection are likely to have the other. Many infected carriers will not seek tests and those who do often fail to complete treatment. If new strains take hold even new and expensive drugs will be useless as those already weakened by HIV succumb to the new TB.

## Stress buster?

Researchers at the University of New Mexico's Health Sciences Center believe they can make patients less fearful by decorating needles with butterflies, flowers and smiley faces. Some children become hysterical at the sight of needles while adults may avoid visiting the doctor altogether. Such decorations likely interfere with an established link between visual recognition of a perceived threat and the subsequent emotional response to that threat, the study suggested. When exposed to the decorated syringes, needle aversion was reduced by 68 percent, and fear and anxiety by 53 per cent. Source: The Associated Press

## Any arachides in this?

You might well ask, if you have anaphylaxis and are travelling in Brazil! For quick translations of foreign words or phrases visit [www.babelfish.altavista.com](http://www.babelfish.altavista.com) and give potentially life-saving advice to travellers with shellfish, nut or other allergies. They can be encouraged to carry a small card containing information in the destination language on foods they must avoid.

## Advice from on high

Holidaymakers in Tuscany, Sicily and Sardinia had a different sort of sun protection this summer in the form of

## From Tropimed news.

## UPDATE: Global status of poliomyelitis

Nigeria, India, Pakistan and Afghanistan are now designated as the only polio-endemic countries in the world. Egypt, previously on this list, has been polio-free for 12 months.

However, the following have experienced imported polio in 2006: Bangladesh, Nepal, Myanmar, DR Congo, Ethiopia, Indonesia, Niger, Somalia, Yemen and, most recently, Namibia (three confirmed plus 31 suspected cases).

Angola, Chad and Sudan have recorded cases during the past year and Cameroon, Eritrea and Mali reported cases in 2005.

Consequences for the traveller: The CDC (Centers for Disease Control and Prevention) now recommends polio vaccination for all travellers to polio-endemic or epidemic regions which include Africa, South Asia, Southeast Asia and the Middle East.

For previously immunised individuals who received a full, four-dose primary series, a single booster sometime as an adult is thought to confer lifetime immunity. For adult travellers who have not received a primary series (at least three doses of vaccine), immunisation with inactivated polio vaccine (IPV) should be completed before travel.

Live polio vaccine (OPV) is no longer manufactured in the US. Standard precautions should also be taken to avoid water- and food-borne infection.

More at [www.cdc.gov/travel](http://www.cdc.gov/travel) under "Outbreaks". Also Travelers' Health Outbreak Notice, 6-7-06 and WHO Disease Outbreak News at [www.who.int](http://www.who.int)

UK information at [www.nathnac.org](http://www.nathnac.org) and [www.travax.nhs.uk](http://www.travax.nhs.uk)

## BULLETIN BOARD

free text messages advising them on how long their sun lotion would allow them to stay in the sun. Medsun is powered by a European Space Agency satellite which scans the Italian coast every 15 minutes and measures the strength of the ultraviolet rays. A physicist thought up the idea after his sister was badly sunburned six years ago. He criticised the advice on sun in the UK, saying that some British people should not go out in the Mediterranean sun at all, but the service did not discourage sunbathing.

### Women only

Officials in Riccione on the Adriatic coast are planning to open a beach solely for women. The area has an increasing number of Muslim tourists and screened areas will allow the women, who must be covered in the presence of men, to remove their headscarves and robes in privacy.

### Taxing times for Italy

By the end of the year, the Italian Parliament is expected to approve charges of up to €5 per person per day to be added to daily accommodation rates. Cities will be allowed to impose the tax on national and international tourists to raise funds for reinvestment in the tourist industry. Italy is already seen as an expensive destination and some feel this tax will bring bad publicity and more damage for Italy's tourist industry. Sardinia already plans to introduce a separate tax on villas and yachts to raise cash for environmental and tourism measures.

### What disabled assistance?

The Department for Transport (DfT) has called for the aviation industry to improve assistance for disabled passengers following a study carried out by their research laboratory. Aviation companies are required to adhere to the Disability Discrimination Act (1995) and encouraged to follow a voluntary code of practice issued in 2003. However, in practice air travel is mainly outside the DDA and the study showed the voluntary code has not been effective. Most airlines and airports await legislation agreed by the European Parliament which comes into effect next year. Under this legislation, assistance to disabled passengers will be a right, not a courtesy.

### Too hot to handle

A study in the *Journal of Sustainable Tourism* is predicting that in the future people will be better off heading north for sunny holidays. Forest fires, jellyfish, water shortages and high temperatures made headline news this summer and could become the norm in the Mediterranean resorts. Dr David Viner, co-author of the report, said average temperatures are predicted to rise by up to six degrees and by 2080 tourists would be heading to the Baltics and southern Scandinavia.

### World's wonders threatened

*The future of world travel* report finds that by 2020 the natural features of some of the remaining "wonders of the world" will be damaged by global warming. The report added that "some tourist areas, particularly those involving long-haul travel from the UK, may require travellers to store up 'air mile credits' based on personal needs and overall energy use. Additionally, social contributions travellers put back into the communities they visit may be considered before visitation rights are granted."

### But where do you hang the dish?

Qatar Airways is to offer passengers live satellite television on flights to Europe and within the Middle East. Aircraft will be equipped with the system by the end of the year.

### No escaping those ring tones

Fred Olsen Cruise Lines is installing mobile and text messaging services on one of their ships. The service is being introduced for winter cruises around the Caribbean, but if successful will be extended to other vessels.

### Holiday – what's that?

Everyone from the Pope to American accountancy firms is warning people of the dangers of overwork. Economic statistics show that the French and other Europeans take more holidays than we do in the UK and they are individually more productive. Some companies in America are so concerned that they are closing down at holiday periods to compel employees to take a break.

## Work v holidays: take two

An Internet company's poll of 1,000 holidaymakers showed that over 42 per cent of men and one in three women packed a laptop and company mobile phone to stay in contact with the office while on holiday. They mentioned fears of being sidelined, losing job security, missing a pay rise or being "talked about" with no chance to respond. Psychologists say that some people may just be addicted to work or feel unable to escape the tyranny of the office. Others may have a feeling of self-importance. The tourist industry has responded by offering wireless Internet connections in remote destinations. Airlines too are now in competition to provide sophisticated in-flight communications systems.

## Brits behaving badly

The Foreign Office (FCO) Know Before You Go campaign has exposed the extent of British bad behaviour abroad. In the year from April 2004 to March 2005, binge drinking was behind much of the trouble and many arrests were down to behaviour caused by excessive alcohol. Of 3,000 Britons surveyed for the report, *British behaviour abroad*, 41 per cent admitted to drinking "much more" on holiday than they would at home. Britons were also the victims of crime abroad with reported rape figures thought to be an underestimate of the true picture. The FCO believes that many problems could be avoided if travellers were better prepared for their trip and more aware of their environment. See [www.fco.gov.uk](http://www.fco.gov.uk)

## That friendly face is a computer

A hotel chain in the USA and Canada is planning to replace the friendly check-in desk with a computer touch screen. Hi-tech counters will enable guests to register, select a room and pay bills as well as print out boarding cards for flights.

## Pole dancers?

In a survey of 18–25 year olds, one in six students on a gap year would consider pole dancing if they ran out of money abroad. Students were prepared to take desperate measures to enable them to continue their travels.

## Age-old problems with insurance cover

A report from *Holiday Which* warns that older holidaymakers are being refused travel insurance or being charged exorbitant rates. Travel insurance for the over-70s has become so expensive or hard to find that many are travelling without sufficient cover. The report also warns that specialist companies offering insurance to the elderly are not necessarily better value. A spokesman for the British Insurance Brokers Association said statistics show that older people are more likely to make a claim, especially for medical reasons, where the costs to insurers can be drastic.

*Pardon me for thinking that was why people took out insurance for travel abroad!*  
– Ed.

## Don't drink and fall

Travellers who are injured or become ill while overseas risk losing their insurance cover if they are found to be under the influence of drugs or alcohol. Insurers are increasingly unwilling to pay where claimants have been drinking and policies make it clear that if someone is under the influence of drink or drugs their policy will be invalidated. Insurers are expecting travellers to take more responsibility for their behaviour abroad, although the interpretation of "inebriated" or "under the influence" varies widely, often leaving people stranded overseas. If insurance is declined and people feel they have been unfairly treated, they can appeal to the Association of British Insurers' financial ombudsman.

## Condom use

Over 29,000 young people, two-thirds of them aged 16–24, took part in an online survey on attitudes to sexual health organised by BBC Radio One, MTV and Durex. Among the 38 per cent who did not always use condoms with new partners, 44 per cent said it was because of partners being on the pill, 17 per cent said they were intoxicated and nine per cent said it would spoil their fun. Almost a third of those surveyed said they lost their virginity before reaching 16 and one in four did not use condoms when they had sex for the first time. Health campaigners say money earmarked for dealing with

sexual problems is being diverted to reduce deficits. The Department of Health plans to launch a campaign aimed at encouraging young people to use condoms.

## It's the difference between a boat and a yacht

Authorities in Tenerife are concerned that images of immigrants arriving on their shores from Africa could damage their tourist industry. Authorities stressed that their main concern was "humanitarian", but police were drafted into tourist areas to ensure that the influx of immigrants did not lead to disturbances. Hundreds of immigrants from African countries have been arriving on various islands by boat. Malta has appealed for help from the European Union after over 1,000 illegal immigrants landed on their shores this year. Many have been reported missing off the island after their vessels, most of which are not sea worthy, sank. The Canary Islands and especially Tenerife has the biggest problem and it is estimated that numbers have doubled to over 11,000 since last year.

## Boom time for Bulgaria

When Bulgaria joins the EU next year it could become the fastest growing destination for British travellers. The travel website Opodo has placed the country at the top of its "up and coming" destinations, followed by Russia and Morocco. A new terminal at Sofia's airport plus new hotels and road links are being constructed in readiness. Some tour operators are already looking to emphasise the country's cultural appeal by introducing city breaks and cultural tours.

## Passport interviews

From next year, first time applicants for British passports will face a Home Office interview. From 2009 all travellers renewing their passports will be interviewed and have their fingerprints taken. The Home Office intercepts around 1,500 fraudulent passport applications each year, many from people with links to organised crime. This is seen as a big step in tightening security and the move will affect around 600,000 people a year. It is anticipated that mobile interview units will

## CONFERENCE ROUNDUP

Once again intrepid travel health enthusiasts battled their way through London's transport problems to attend our annual conference – among them, SANDRA GRIEVE.

## *Au revoir and bon voyage*

CAROLYN DRIVER reports.

### Northern Ireland Conference on Travel Medicine

The first ever conference on travel medicine in Northern Ireland took place at the end of September in a beautiful setting on the shores of Loch Erne in Fermanagh.

Delegates from primary care, public health, occupational health and infectious diseases gathered to hear presentations by experts from all over the UK.

Following an enjoyable conference dinner, delegates at the two-day event were entertained by local hero Neil Elliot who gave an inspirational talk on his recent ascent of Mount Everest. Only a Fermanagh man could make climbing the world's highest peak sound like a stroll in the park!

It was a great event and we hope it will be the first of many. Congratulations to Dr Reggie Cooke for getting the ball rolling



## RCN Travel Health Forum Conference and Exhibition

Royal College of Physicians, London • 30 September 2006

This event has amassed a loyal following and in excess of 200 delegates were not disappointed to find a packed programme and expert speakers awaiting them.

Jane Chiodini introduced the day with a mixture of welcome and farewell as this was her last conference as Forum Chair. She highlighted the important changes in the field of travel medicine, including the updated chapters in "The Green Book", now available online, and a "heads up" on the eagerly awaited new UK malaria guidelines, due for publication at the end of the year.

Invited speakers reflected these changes and their implications for those involved in travel health. Anaphylaxis and acute allergy management is not an easy topic to cover, but it was addressed with a mixture of seriousness and humour. We then flew off to the world of viral hepatitis with a presentation on the epidemiology and risk of travel-related exposure and vaccines available for prevention.

Of course, no vaccine is available to prevent the growth of international travel and its impact on the customs and cultures of the host countries. Our international expert from India suggested a holistic approach between the traveller and the destination,

appreciating the diversity, culture, lifestyle and values of each within the host communities.

The sexual health of female travellers can be a daunting task to address during a pre-travel risk assessment, but everything from risk-taking behaviour, condoms, contraception, assault and help, pre and post travel, was eloquently covered. This led neatly on to safety and security issues for the traveller at home and abroad. Whether the responsibility lies with the traveller or the adviser remains a contentious issue.

Tuberculosis is still a difficult disease to address where travel is concerned, and changes to the UK policy on BCG immunisation, especially in relation to travel, were explained and explored.

The exhibition provided a lively hub for networking and exchange of information with many interesting topics covered.

At the end of the day, the committee and delegates said a fond farewell to Jane and committee member Annie Bradley, thanking them for their input and commitment over their time in office. Thanks also went to the RCN Events Team and the RCP, and to our generous sponsors, Glaxo SmithKline and Sanofi Pasteur MSD. See you next year!

JANE CHIODINI reports from the Medical Advisory Services for Travellers Abroad event.

## MASTA Study Day

RCP London • 10 November 2006

This annual event certainly didn't disappoint its audience in excess of 150 medical and nursing practitioners, predominantly from the occupational sector and MASTA travel clinics around the UK.

The innovative and interesting programme was chaired by Lieutenant Colonel David Ross, Consultant in Public Health Medicine in the Ministry of Defence.

Professor David Hill, Director of the National Travel Health Network and Centre (NaTHNaC), started the day by presenting information on measles, mumps and rubella, concluding that MMR vaccine should be considered for those travelling to endemic areas. He agreed to put his presentation on the NaTHNaC website so look out for this at [www.nathnac.org](http://www.nathnac.org) under "Professional Resources".

Michelle Sellors, a MASTA senior nurse adviser, presented comprehensive and interesting information on dengue fever and Chikungunya – for the latter she had the pronunciation down to a tee, unlike many of us in the audience! Both diseases are transmitted by the daytime biting mosquito *Aedes aegypti* and a clear message was that bite prevention measures should be applied frequently during daylight hours.

Sarah Lang, a former RCN committee member now based in a MASTA travel clinic, gave a succinct yet thorough evaluation of the data available when advising business travellers.

The morning concluded with Sarah Randolph's extremely comprehensive presentation on tick borne encephalitis. She is a master in her field as Professor of Parasite Ecology at Oxford University

and she recommended [www.tbe-info.com](http://www.tbe-info.com) for more information.

Those who considered a five-minute post lunch power nap had no opportunity with the superb but extremely graphic slides presented by Dr Francisco Vega-Lopez, Consultant Dermatologist and Honorary Senior Lecturer at University College London. His presentation on a number of common and rare skin conditions affecting travellers gave a comprehensive overview of risk factors, diagnosis and therapeutic guidelines, delivered with great style and humour.

Dr Albie de Frey, Medical Director, the Travel Doctor Africa, presented a fast moving pictorial overview of the challenges from health, geographical and socio-political viewpoints, and described the medical facilities in different parts of sub-Saharan Africa.

The day ended with the new Director of Clinical Services for MASTA, Dr Dipti Patel, presenting information on the epidemiology and clinical features of hepatitis B, risk and prevention, including the latest guidance from the Department of Health on hepatitis B vaccine and the need for serological testing and boosters.

The Royal College of Physicians as a venue never disappoints and this was an excellent day. Congratulations to all at MASTA for their hard work in delivering a superb event.

PS: If you attended our RCN conference on 30 September you will recall the inconvenience of outside temporary loos. Less than two weeks later the vastly improved facilities were opened – loos that flush without pushing a handle or waving a sensor. I decided they were extremely intelligent and responded to my trouser zip!

be set up around the country to limit travel time. The cost of a passport has risen to £42 for an adult and £25 for a child.

### Plastic passports

A panel of experts for Thomson, Britain's biggest travel company, has predicted credit card-sized passports, commuter belts between Britain and continental Europe and "green" holidays will all be commonplace in 10 years. Paper visas and printed tickets will be replaced by a card containing a micro-chip carrying all our personal travel information. They also predict that more British citizens will choose to live abroad and commute to work in Britain. To meet the growing demand by British travellers, tour operators are expected to label their holidays "green" or "fair trade" if they meet certain criteria.

### Citizen or subject?

Mindful of the ISTM conference in Vancouver next year if you hold a British passport but are a British overseas citizen, a British subject or a British protected person, you must now have a visa for entry to Canada. Airlines heading for the USA have for several years refused to carry holders of British passports with "subject" rather than "citizen". Now Canada is tightening up the rules. It is the passengers' responsibility to ensure that they comply with current visa requirements for the country destination. Airlines are unlikely to be sympathetic as carriers can be fined if they do not ensure that passengers are carrying the correct documents. [www.canada.org.uk/visa-info/visitor/e\\_visit.htm](http://www.canada.org.uk/visa-info/visitor/e_visit.htm)

### Only the truth

The European Commission has announced plans to force airlines to advertise fares which include all charges. No-frills airlines have been criticised for advertising attractive fares which often exclude tax, credit card booking fees and charges for services, insurance and wheelchairs. If approved, changes will come into force in December 2007 and so called "free flights" or "flights for £5" could be outlawed.

### Army to the rescue

The Indian Territorial Army has been drafted in to prevent the poaching of Rajasthan's famous tigers in

Thanks to LINDA DIGGLE, Principal Research Nurse, Oxford Vaccine Group, University of Oxford, for highlighting the key points of her research paper published in the *British Medical Journal* on 4 August.

# Effect of needle size on immunogenicity and reactogenicity of vaccines in infants: randomised controlled trial

It is well known that practitioners vary in their choice of needle size for vaccine administration. While some nurses prefer to use a wide-long (blue hub 23G, 25mm) needle for infant immunisation to ensure the vaccine reaches muscle, others favour the narrower-shorter (orange hub 25G, 16mm) needle. Some authors suggest a wider gauge reduces the incidence of vaccine reactions.<sup>1,2</sup> Uncertainty has arisen over which needle size to use because there has been insufficient data to define best practice.

In response to calls for evidenced based guidance, a previously conducted randomised controlled trial (RCT) showed that wide, long needles significantly reduced the incidence of local reactions at four months of age compared with narrower, shorter needles.<sup>3</sup> This research raised further questions, however:

- Would the wider-longer needle give less local reaction at the two- and three--month immunisations?
- Was the observed reduction in reactogenicity due to the difference of needle gauge or needle length?
- Does needle size affect vaccine immunogenicity.

Clearly, any benefit gained from a reduction in reaction rates with the wider-longer needle would be disregarded if this needle was found to compromise vaccine effectiveness.

## Study methods

A further RCT was undertaken to address these questions and the results have recently been published.<sup>4</sup> In this latest research, 696 infants, recruited through 18 general practices, were randomised to receive their primary vaccinations of diphtheria, tetanus, whole-cell pertussis, *Haemophilus influenzae* type b (DTwP/Hib) and MenC, using one of three needle sizes (Table 1).

A standard WHO IM injection technique was used (Table 2). Parents were not informed of the needle size used for injection and were asked to record local reactions for three days following each vaccination dose.

To address the question of immunogenicity, antibody concentrations were measured following venepuncture (using local anaesthetic cream) at 28–42 days following the third vaccination. If this study again showed a reduction in local reaction rates with the wider-longer needle and if immunogenicity was no worse than that given by the narrower-shorter needle, then this would indicate that use of the wider-longer needle should be recommended as best practice.

## What did the study show?

The incidence of any local reaction was significantly reduced at two, three and four months of age when a wide-long rather than narrow-short needle was used, with relative reductions of between 22 and 54 per cent over the three post-vaccination days. The results indicate that if a wider-longer rather than narrower-shorter needle is used, one child could be prevented from experiencing any local reaction for every six- to-eight infants vaccinated.

Furthermore, the wider-longer needle reduced the severity of local reactions with significantly fewer infants having large local reactions compared to those immunised with the narrower-shorter needle. The study authors believe the difference in reaction rates occurred because the longer needle ensured the vaccine reached infant thigh muscle.

When rates of local reactions were compared between infants vaccinated with needles of the same length but different gauge (wide-long versus narrow-long), few differences were found, suggesting it is needle length – and not gauge – that is responsible for the reduction in local reaction incidence.

The immunogenicity of the vaccines was comparable between wide-longer and narrow-short needles although the data did suggest that immunogenicity for the MenC antigen might be even better following administration with a wider-longer needle.

Since completion of the research, DTwP/Hib vaccine has been

replaced by the less reactogenic DTaP/Hib/IPV (Pediace®l, Sanofi Pasteur MSD) combination. However, as the results imply that local reactogenicity of infant vaccines can be reduced by ensuring delivery into muscle, there is no evidence to indicate that this would be different for other vaccines, nor to other immunisation schedule timings.

All the infants recruited to this study had a birth weight of ≥ 2.5kg and were born at ≥ 37 weeks gestation; the results cannot therefore be extrapolated to low birth weight or pre-term infants. Clinical judgement should continue to guide the selection of needle length for these children.

In summary, the 25mm needle significantly reduced vaccine reactogenicity while achieving comparable immunogenicity; therefore the longer needle should be used for immunisation of term infants. As increasing parental attention is focused on the safety rather than the efficacy of vaccines, a simple intervention such as use of a longer needle that minimises adverse events should be welcomed.

**References**

- 1 Mayon-White, R and Moreton, J (1997) *Immunising children – a practical guide*, Oxford: Radcliffe Medical Press.
- 2 Vaccine Administration Taskforce (2001) *UK guidance on best practice in vaccine administration*, London: Shire Hall Communications.
- 3 Diggle, L and Deeks, J (2000) “Effect of needle length on incidence of local reactions to routine immunisation in infants aged four months: randomised controlled trial”, *British Medical Journal*; 321(7266), pp.931–933.
- 4 Diggle, L; Deeks, J and Pollard, AJ (2006) “Effect of needle size on immunogenicity and reactogenicity of vaccines in infants: randomised controlled trial”, *British Medical Journal*, 333 (7568), pp.571–574.

**Table 1 Needle size groups**

Group 1	Group 2	Group 3
23 gauge 25 mm (wider gauge longer needle)	25 gauge 16 mm (narrower gauge shorter needle)	25 gauge 25 mm (narrower gauge longer needle)

**Table 2 World Health Organization recommended techniques for intramuscular and subcutaneous injection**

Intramuscular	Subcutaneous
Skin at the injection site is stretched flat between thumb and forefinger to optimise insertion of the needle deep into the muscle.	Skin at the injection site is bunched/pinched up to ensure insertion into the fatty tissue just below the skin.
Needle is inserted at a 90( angle to the skin.	Needle is inserted at a 45( angle to the skin
Needle length should be long enough to reach deep into the muscle.	Needle length should be shorter to reduce chance of inadvertent insertion into the muscle.

Ranthambhore National Park. Increasing demands on the tigers’ natural habitat has contributed to declining numbers, but poaching and the illegal trade of tiger skins poses the biggest threat. The tourism industry provides valuable revenue to the area and if the tigers go, so will the economy.

**New ruling**

A landmark ruling in the House of Lords means that British travellers injured abroad can now bring their case to court in the UK. A traveller claiming against a party insured outside Britain is entitled to UK levels of damages, even if the law in the country concerned limits the scope of compensation. The ruling follows the case of a man paralysed from the neck down following a car accident in Australia and four years of legal wrangling through the High Court to the Court of Appeal. Finally the House of Lords ruled that damages assessments should be made in accordance with English law. The ruling applies to courts in England and Wales, but could be persuasive in Scotland and Northern Ireland.

**More complaints**

Even before the turmoil of terror alerts and airport chaos during the summer, complaints against airlines had tripled because they were failing to pay passengers compensation to which they were entitled. The Air Transport Users Council said in its annual report that in the 12 months to 31 March it received 6,094 complaints, compared to 2,204 the previous year. A spokesperson for the Airlines said that they worked hard to ensure that passengers received their entitlement, but company policies were not always applied consistently and the regulations were often confusing for staff and passengers.

**More delays**

Figures released by the Civil Aviation Authority showed that almost half the flights to popular destinations were delayed between April and June. Nice, New York, Mumbai and Athens were worst hit with 40 per cent of flights arriving or leaving late. Luton and Stansted are the airports most prone to delays. Following security scares these numbers are likely to rise.

Earlier this year the Royal College of Physicians and Surgeons of Glasgow (RCPSG) confirmed the establishment of its multidisciplinary Faculty of Travel Medicine and so it was that 19 July 2006 became an historic day in the world of travel medicine. SANDRA GRIEVE reports.

## Nurses admitted to the Faculty of Travel Medicine Celebrating a landmark occasion at the Royal College of Physicians and Surgeons of Glasgow

The sun shone on Glasgow as the first fellows, members and associates were admitted to the RCPSG Faculty of Travel Medicine.

Prior to the ceremony, diplomates were invited to tour the College, founded in 1599, where fellows were on hand to inform guests of the College's history and activities.

The RCPSG enjoys a unique distinction among other colleges in the UK in that physicians, surgeons and dentists make up its membership and fellowship. Now for the first time nurses have been admitted to this illustrious body. Professor Sir Graham Teasdale, RCPSG President, conferred the awards, calling this a new chapter in the College's history.

The ceremony of admission took place at Glasgow University's historic Bute Hall. The university, founded in 1451, is the second oldest in Scotland (after St Andrew's) and the fourth oldest in Britain. The visitors centre, Hunterian Museum and Art Gallery provided an interesting insight into its history, and the collection of medical and scientific material which originated with pioneering obstetrician William Hunter, Honorary Fellow of the College, included treasures from ancient Egypt, Africa and Roman Scotland – apt for those interested in travel medicine.

Appropriately Dr Eric Walker of Health Protection Scotland (HPS) was the first person to receive the award of the Fellowship of the Faculty of Travel Medicine (FFTM RCPS (Glasg)). Dr Walker is well known in the field of travel medicine and has been proactive in education for many years. This award was a fitting tribute to his enormous contribution to the discipline.



The Grieves, the Chiodinis and the Rileys make it a family occasion

On the day, the first nurses to receive the award of Fellowship included two members of the RCN Travel Health Forum Steering Committee, Chair Jane Chiodini and Lorna Boyne. Committee members Sandra Grieve and Alexandra Jordan received the award of Membership of the Faculty (MFTM RCPS (Glasg)).

Among other fellowships awarded on the day, one went to Fiona Genasi, a nurse from HPS. Fiona, Jane and Lorna have been at the forefront of travel health education in the UK for several years now and are well known in the field, both nationally and internationally – and well deserved fellows. Also included were 13 diplomates who were awarded memberships and seven awarded associateships (AFTM RCPS (Glasg)), with other awards made *in absentia*.

In another “first”, awards were made to three married couples. Professor Peter

Chiodini and his wife Jane received fellowships while Dr Steve Riley and his wife Cate, and Dr Alex Grieve and wife Sandra received memberships. There must be few disciplines where this situation arises and it was a unique occasion for the couples.

The day ended with a reception in the Hunter Hall where diplomates were welcomed informally and given a small gift from the College to mark the event.

### Annual General Meeting: October 2006

The first AGM and Educational Meeting of the newly-formed Faculty of Travel Medicine were held in Glasgow this autumn. The Faculty Executive Board and office bearers were elected and welcomed to the RCPSG.

Dr Eric Walker is the newly appointed Dean of the Faculty with Dr Jonathan Cossar, Vice Dean, and Lorna Boyne, Secretary. Lorna is a member of the

Travel Health Forum Steering Committee and her RCN colleagues, Jane Chiodini and Carolyn Driver, were among those elected to the Executive Board.

The educational programme began with an introduction to the College and its role in education and professional development. The Rural Training Adviser (Dental) for the NHS gave a very graphic description of her work in rural India and asked what the Faculty might provide for the consumer.

Professor Robert Steffan, the guest speaker, is well known in travel medicine and gave delegates an insight into the field from a historical and international perspective.

There followed short presentations from practitioners engaged in various areas of travel medicine. They related their vision for the future and discussed how the Faculty might address important issues and provide support.

Congratulations to all those who have been admitted to the Faculty of Travel Medicine – we wish them well in their endeavours.

### Your invitation to join the Faculty of Travel Medicine

The College continues to seek an appropriately qualified and experienced founder membership. Building on the success of the University of Glasgow and the RCPSG Diploma and MSc courses, the Faculty aims to ensure high standards of travel medicine clinical practice through:

- developing its examinations in



Dr Dominic Colbert and Dr Eric Walker

the tradition of the College's high standards

- organising and supporting high quality ongoing continuing professional development
- encouraging the incorporation of the specialty into undergraduate curricula
- relating closely to other involved institutions and specialties, such as general practice, nursing, public health and tropical medicine
- representing the specialty at all levels
- developing constructive relationships with the public and the media.

Nurses with the Diploma in Travel Medicine or other similar qualification are invited and encouraged to apply. See [www.rcpsglasg.ac.uk/news/TravelMedicine](http://www.rcpsglasg.ac.uk/news/TravelMedicine)

Direct your enquiries to James Beaton at [james.beaton@rcpsg.ac.uk](mailto:james.beaton@rcpsg.ac.uk) or telephone 0141 227 3204.



Professor Sir Graeme Teasdale, RCPSG President, with Dr Alex Grieve

## BULLETIN BOARD

### Road safe?

British gap year travellers are at greater risk of being killed in a road crash than catching a tropical disease, warns the Make Roads Safe campaign and the RAC Foundation. Official figures show that two-thirds of all accidental deaths of UK tourists are caused by road crashes. The risk is even higher for young people and male travellers. Around 30,000 students each year formally defer their university place, joining some 200,000 young people between 18 and 25 who have taken time out to travel, volunteer or work abroad. The most popular destination for UK gap year travellers is Australia, which has a good road safety record, but increasing numbers are choosing riskier destinations such as India, Kenya, Thailand, Cambodia and Brazil. The band Dirty Pretty Things backed the campaign after three teenage girls died in a road crash while returning from the band's concert in Ipswich.

### Ski resort virus

The popular ski resort of Val d'Isere, plagued with outbreaks of gastroenteritis in recent years, is taking steps to reassure British tourists that their water system is safe. The council has promised to improve the effectiveness of the water treatment programme and post the results regularly outside the town hall. Restaurants and bars are being asked to adhere to a "hygiene quality charter". The Ski Club of Great Britain welcomed the moves.

### Child immunisation toolkit

Wyeth Vaccines has launched an educational resource to support nurses with the new childhood immunisation programme. This includes information on the new schedule and a step-by-step guide at [www.prevenar.co.uk](http://www.prevenar.co.uk). See a video showing vaccination of four-month old babies with three injections at one time at [www.rcgp.org.uk/extras/videos/immunisation/index.htm](http://www.rcgp.org.uk/extras/videos/immunisation/index.htm)

### Green Book updates

*Immunisation against infectious diseases*, otherwise known as the "Green Book", continues to be updated online so do keep on checking for new information. In August 2006, replacement chapters one-to-35 were posted on the Department of

It's never too late try something new, says DIANE PARSONS.

# And now for something completely

I work with travellers serving in the developing world and I thought it was about time I had some real experience of doing the same myself. So after seven years at InterHealth, I was able to combine a one-off sabbatical leave with a two week holiday and give myself a whole month in which to do something completely different.

Liam, one of the doctors I worked with a few years ago, set up a Christian NGO (non governmental organisation) in Gulu, Northern Uganda, and I decided to offer my skills on the project there. Part of the project is sponsoring education for school-aged children and the organisers also aimed to develop a health initiative. This was to be my responsibility.

Armed with Dr Ted Lankester's book, *Setting up community health programmes*, and following useful discussion with him and Liam, I began to formulate an idea of what could possibly be achieved during my stay.

We were looking at doing some rudimentary health checks on all of the sponsored children, visiting their guardian families and also providing health education talks, particularly to the women's literacy group and church leaders. The project was called Health

Evangelism and fortunately it's captured the interest of a doctor in training in Gulu who has now offered his services for developing the idea further and continuing with the project.

I found the transition into life in Gulu made easy by the friendly and enthusiastic members of the mission. I had a pastor who knew where families lived and accompanied me daily as I moved around to visit people in their homes, schools, hospitals and local clinics. He was my interpreter and teacher, but I did actually manage to learn some Acoli words which meant I could at least greet people every day.

Uganda is a lush country, it was still rainy season and the people were trying to produce crops to provide for their every day needs. They work hard with very little to show for it materially, but they have a fantastically cheerful nature and are always welcoming.

## Getting around safely

On the travel front I learned the importance of sticking to familiar guidelines as far as sensible food choices and drinking bottled water. Hand hygiene was no problem as you are offered the opportunity to wash your hands before and after eating whenever you are entertained.



Transport is another matter. I chose to walk most places and fortunately there was time – no rushing around like in the UK. Other options were riding side-saddle on the back of a moped or bicycle, both equally vulnerable as the roads are just compacted earth with pot holes and contour variations – and no helmets in sight!



Collecting water at an open, unprotected well



Sometimes walking is the safer option

# different

Local women and children at the Gulu government hospital immunisation clinic.



Clearly the biggest health risk is the road traffic accident scenario, especially at night when there are no lights on the roads and definitely none on the bicycles!

For longer journeys it was either the taxi or a 1950s-style coach, fully laden with chickens in boxes on the luggage rack.

It was a great time. I achieved my aims and gained a huge amount from my stay there.

I also learned a lot about the health care provision – or lack of it, depending on supplies available. My advice to travellers now will be hugely enhanced by this experience.



Cooking lunch, Uganda style

Health website. Go to [www.dh.gov.uk/PolicyAndGuidance](http://www.dh.gov.uk/PolicyAndGuidance) and follow the links under “Health and Social Care Topics”.

## Taking medicines on flights

Following restrictions on hand luggage allowed on board aircraft, the Chief Medical Officer issued information on the procedure for taking essential medicines on flights. It's at [www.info.doh.gov.uk/doh/embroadcast.nsf/vwDiscussionAll/2410866367ACC489802571C7004686F7?OpenDocument](http://www.info.doh.gov.uk/doh/embroadcast.nsf/vwDiscussionAll/2410866367ACC489802571C7004686F7?OpenDocument)

## Flying with insulin

Travellers with diabetes can try to get an exemption from the airline/airport authority (using a doctor's letter as proof of insulin need) to take their insulin in hand luggage. If unsuccessful, they should follow Novo Nordisk's advice regarding the storage of insulin and concerns about the risk of it freezing in the hold:

- Attempt to insulate from cold by storing insulin in air tight container such as vacuum flask. If no flask is available, place in bubble wrap or jiffy bag, wrap in towel and put in centre of suitcase/bag.
- Examine the insulin for crystals or cracks in vial. If this occurs, try to get a new supply at holiday destination.
- Insulin can be used if it looks fine physically, but there is no guarantee that its molecular structure has not changed and hence its time action profile. Monitor BMs more frequently and try to get a new supply if there are problems.
- Patients using Novo Nordisk products can telephone 0845 600 5055 for advice and company contact on a customer services number in the country they are visiting.

## Childhood immunisation booklet

Order *A guide to childhood immunisations for babies up to 13 months of age* from DH publications on 08701 555 455 or email [dh@prolog.uk.com](mailto:dh@prolog.uk.com). More at [www.immunisation.nhs.uk](http://www.immunisation.nhs.uk)

## Unwelcome fellow travellers

*Eurosurveillance Weekly* ran an interesting article on 17 August about tick removal. It's at [www.eurosurveillance.org/lew/2006/060817.asp#4](http://www.eurosurveillance.org/lew/2006/060817.asp#4)

Thanks to Dr DIPTI PATEL and the *Journal of Occupational Medicine* for permission to publish this abridged version of the paper which appeared in August.\*

# Expatriate morbidity

Expatriates are an important, but poorly studied subset of international travellers. They are a heterogeneous group, comprising government employees, aid workers, diplomats, military personnel, journalists and business people, and they are frequently accompanied by their families.

A number of studies have investigated the health problems encountered by overseas travellers, but few have looked specifically at expatriate health. To help resolve gaps in current knowledge, a study on an expatriated British government population was undertaken.

The primary aims of the study were to assess the incidence of health events and evaluate factors affecting this incidence.

## Method

The study was a one-year prospective cohort study of morbidity in an expatriate population. The study population comprised 2,020 Foreign and Commonwealth Office (FCO) staff and partners who were overseas for the duration of the study.

The main outcome measure was new illnesses or injuries that required a doctor consultation. Data collection was by postal questionnaire.

Poisson regression was used to estimate the rates of health events and test for association between health events and numerous independent variables including age, sex and marital status.

**Table 1. Risk of doctor-reported health events, infectious disease, trauma and psychological disorders according to employment status, sex, marital status, grade, age, region of posting and previous overseas experience.**

	Doctor reported health events		Infectious disease	
	Number N=422	Adjusted Incidence Rate Ratio (95% Confidence Interval)	Number of cases N=55	Adjusted Incidence rate ratio (95% Confidence interval)
<b>Status</b>				
Partner	120	1	10	1
Employee	322	1.40 (1.06 to 1.85)	<b>45</b>	1.94 (0.81 to 4.65)
<b>Sex</b>				
Female	206	1	25	1
Male	216	0.95 (0.75 to 1.20)	<b>30</b>	0.98 (0.51 to 1.91)
<b>Marital Status</b>				
Accompanied	314	1	36	1
Unaccompanied	108	1.34 (1.03 to 1.74)	<b>19</b>	1.61 (0.79 to 3.29)
<b>Grade</b>				
Junior Grade	272	1	43	1
Senior Grade	150	1.20 (0.96 to 1.50)	<b>15</b>	0.59 (0.27 to 1.30)
<b>Age (years)</b>				
20–29	47	1	9	1
30–39	141	1.13 (0.80 to 1.59)	20	1.18 (0.48 to 2.91)
40–49	120	1.28 (0.87 to 1.88)	15	1.36(0.47 to 3.94)
50+	114	1.17 (0.76 to 1.80)	11	0.92 (0.26 to 3.30)
<b>Continent</b>				
Europe	136	1	9	1
Americas	81	1.17 (0.89 to 1.55)	15	4.13 (1.66 to 10.26)
Africa	92	1.05 (0.85 to 1.44)	17	3.02 (1.20 to 7.63)
Asia + Oceania	113	1.21 (0.94 to 1.55)	<b>14</b>	2.31 (0.90 to 5.90)
<b>Previous Posts</b>				
Nil	89	1	17	1
Postings	33	0.98 (0.93 to 1.04)	38	0.97 (0.81 to 1.16)

## Results

The general characteristics of the study population are illustrated in Figure 1.

The study response rate was 88.5 per cent and the incidence of health events was 20.9 per cent. The hospital admission rate was four per cent and the medical repatriation rate was 2.1 per cent. There were no deaths or premature departures from post.

Incidence of injuries and accidents (4.6 per cent) and infectious disease (2.7 per cent) were the principal causes of morbidity. The incidence of psychological disorders was one per cent.

Some 51 per cent of injuries were due to sports activities and 12 per cent were due to road traffic accidents.

Diarrhoeal illness accounted for 73 per cent of infectious diseases and only four cases of malaria were reported.

In terms of psychological disorders, depression and anxiety disorders predominated.

Figure 1 illustrates the proportional contribution of illness category to total health events.

Figure 2 shows the proportional contribution of illness category to total reported health events.

## Matters for discussion

This study is the first to look at all cause morbidity in expatriates worldwide. Over one year, 20.9 per cent of the study population experienced new health problems. The majority of problems were due to injuries and accidents, and the incidence of psychological disorders was surprisingly low.

Significantly, employees were at increased risk of morbidity when compared to partners, with a higher incidence of health events and psychological disorders. Moreover, unaccompanied employees had higher rates of health events and traumatic injuries when compared to accompanied employees (see Table 1).

While different methodologies make comparison difficult, morbidity in the FCO population was high when compared to short-term travellers. This could reflect the longer duration of exposure to country-related hazards in expatriates or differences in illness behaviour in the two groups.

Trauma		Psychological disorders	
Number of cases N=85	Adjusted Incidence rate ratio (95% Confidence interval)	Number of cases N=20	Adjusted Incidence rate ratio (95% Confidence interval)
27	1	3	1
58	1.01 (0.57 to 1.78)	17	<b>5.87 (1.01 to 34.13)</b>
39	1	13	1
46	<b>1.56 (0.92 to 2.65)</b>	7	<b>0.32 (0.10 to 1.08)</b>
58	1	11	1
27	<b>2.33 (1.27 to 4.29)</b>	9	<b>1.90 (0.61 to 5.92)</b>
59	1	15	1
26	<b>1.32 (0.76 to 2.27)</b>	5	<b>1.53 (0.46 to 5.14)</b>
16	1	2	1
34	0.87 (0.45 to 1.71)	9	1.25 (0.25 to 6.35)
23	0.85 (0.37 to 1.91)	5	1.05 (0.15 to 7.32)
12	<b>0.53 (0.19 to 1.45)</b>	4	<b>0.88 (0.10 to 7.91)</b>
28	1	8	1
11	0.82 (0.39 to 1.71)	3	0.95 (0.24 to 3.84)
21	1.33 (0.73 to 2.44)	5	1.33 (0.40 to 4.44)
25	<b>1.16 (0.64 to 2.10)</b>	4	<b>0.71 (0.17 to 2.85)</b>
26	1	1	1
59	0.90 (0.77 to 1.04)	19	1.09 (0.82 to 1.45)

The incidence of morbidity, however, was lower than that reported in previous expatriate studies. This could be due to differences in study inclusion criteria or differences in environmental and occupational risks. Most expatriate studies have focused on aid workers or military personnel; these groups generally live in rural areas in the developing world.

By contrast, FCO employees generally reside in urban areas and better living/environmental conditions may mean that FCO personnel are less likely to be exposed to many of the hazards encountered by other expatriate groups. The reduced morbidity could also reflect effective selection and preparation of FCO personnel.

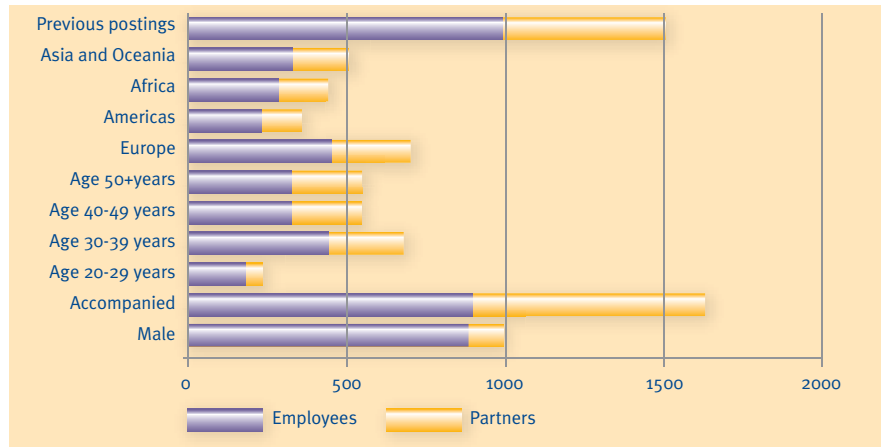
As demonstrated in other studies, trauma accounted for the majority of problems with unaccompanied individuals being at particular risk. However, the incidence of psychological disorders was low and inconsistent with other studies. This could be due to a selection effect or could reflect good support within the FCO. A more likely reason is under-reporting of psychological disorders due to perceived associative stigma.

Employees were at increased risk of morbidity (including psychological disorders) when compared to partners. This correlates with other studies and the healthy worker effect means that differences between employees and partners are likely to be even greater. Possible reasons for this disparity include work-related issues.

As in other publications, women had higher morbidity when compared to men. In the case of female employees, this could be a direct consequence of their position within the FCO (47 per cent of the female employees in this study worked in support grades compared to seven per cent of men).

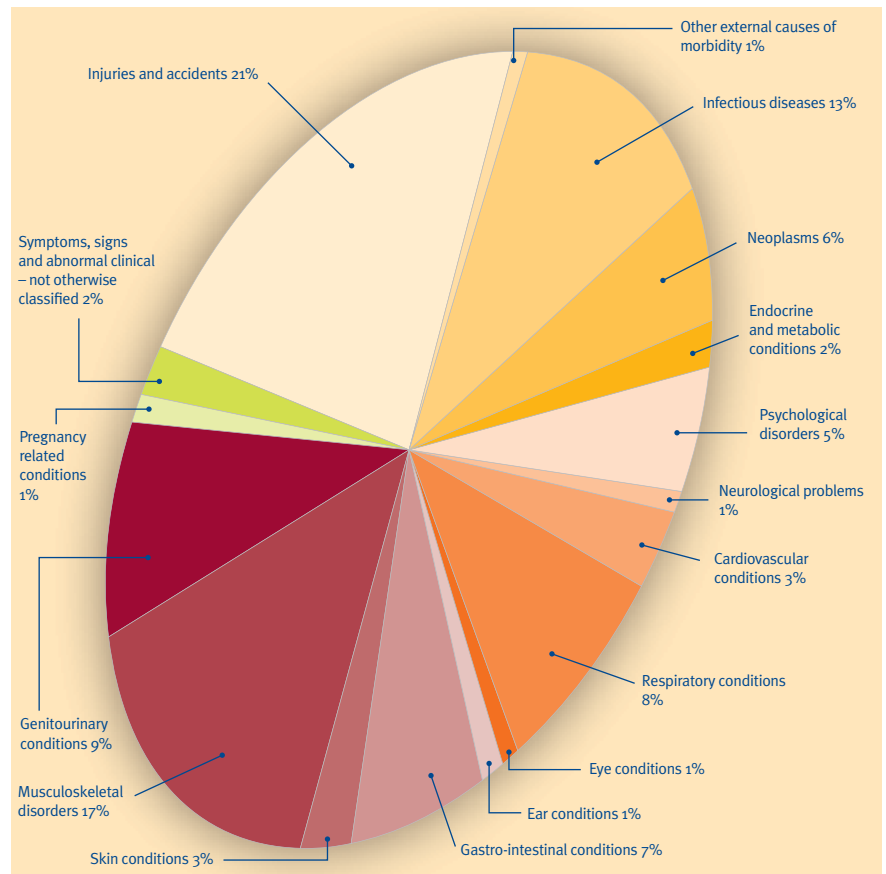
Being unaccompanied at post was also associated with an increased morbidity. The results are consistent with other studies and may reflect increased risk-taking behaviour in unaccompanied employees.

**Figure 1. General characteristics of the study population**



Europe = all European countries  
 Americas = North America, Latin America, West Indies, South Atlantic  
 Africa = Africa, Near East, Middle East  
 Asia and Oceania = Asia, South Pacific, Australasia.

**Figure 2**



This study is well placed to add to current knowledge of expatriate health. The overall findings suggest that the FCO has good arrangements in place for their personnel. However, the higher morbidity risk in employees and unaccompanied individuals warrants further research, particularly to ascertain whether work, isolation, lifestyle and risk-taking behaviour are contributory factors.

\* Patel, D; Easmon, C; Seed, P; Dow, C and Snashall, D (22 May 2006) "Morbidity in expatriates – a prospective cohort study", *Occupational Medicine*, 56 (5), pp.345–352. Available at <http://occmed.oxfordjournals.org/cgi/content/abstract/56/5/345> (Accessed 21 November 2006) (Internet).

**References on request to the Editor.**

# Bush-meat trade: at £300 a kilo, the Ebola come free

Professor Robert Swanepoel, a leading authority on haemorrhagic fevers, has issued a warning about the danger of the boom in supply and imports of wild meat, including body parts of primates such as gorillas and chimpanzees.

Addressing a Conservation International conference in Madagascar on nature and poverty in Africa, he told delegates that the bush-meat trade has increased dramatically as a result of the commercial hunting of up to 71 species. Last year, there were 25,000 seizures of wild meat at UK airports, a 62 per cent increase on 2004.

Conservationists say that the scale of the industry in the rainforests of west and central Africa is driving endangered species, including gorillas and antelope, towards extinction.

Britain is at risk of an outbreak of the lethal Ebola and Marburg viruses because of illegal bush meat from Africa containing the viruses. London and other cities are at particular risk.

Bush meat, often from rare species, is regularly smuggled into Britain in commercial quantities and is on sale in areas of London with African communities at, for example, £60 for a smoked monkey and starting at £300 per kilo for endangered species.

## STOP PRESS

### CISTM 10 Vancouver 20–24 May 2007

The forum is pleased to announce the award of TWO Registrations for this event but you will need to be quick! Early Bird Rate ends on 31 December 2006. This will be on a first come first served basis. Apply to the Editor (contact details on page one).

Further information on:  
[www.istm.org](http://www.istm.org)

## But what does it really cost?

According to the American-based Bush Meat Crisis Task Force, secret markets exist in several European and American cities including Paris and New York. It's an under-the-counter trade conducted away from the gaze of authorities whose resources to stop it are limited.

Foreign nationals say that sourcing bush meat in Britain is not difficult – you just need to know where to go and who to talk to. Trading standards and customs officials in London have seized cane rat, wild pig, water buffalo and a species of antelope found in the Congo Basin.

Professor Swanepoel, who leads South Africa's National Institute for Communicable Diseases, said outbreaks of Ebola and Marburg were becoming more frequent. "There is evidence of a link between bush meat and outbreaks of these diseases, which are extremely dangerous and very, very expensive to treat or contain.

"Air travel means that Ebola could be just as close to anywhere in America or Europe as it is to Kinshasa or Brazzaville."

Health experts say the destructive power of the viruses means that they have the potential to cause widespread loss of life among anyone coming into direct contact with an infected individual, including medical staff treating them.

Professor Swanepoel highlighted a recent case in Johannesburg where a doctor suffering from an illness later identified as Ebola arrived at a hospital in the city: an entire intensive care unit had to be isolated to treat him at a cost of several million dollars. Medical staff are at the frontline, he said, and most susceptible to the virus after the victims.

In a separate incident, a British woman returning from working in Lesotho in May died hours after arriving back in London. She was suffering from a haemorrhagic fever similar to Ebola.

## BULLETIN BOARD

### Permethrin and asthma – the evidence

Following discussion on the ISTM ListServe about exacerbation of asthma possibly induced by permethrin, evidence-based literature was highlighted by the manufacturers: "Since introduction of the aerosol can in 1980 there have been no reports of adverse reaction in either the United States or Canada. Thus, the potential for allergic/asthmatic reaction from wearing permethrin treated clothing seems to be remote at best."

Supporting evidence is found in:

- Safety of pyrethroids for public health use – ref: WHO/CDS/WHOPES/GCDPP/2005.10 and WHO/PCS/RA/2005.1.
- Karpati A et al. (2004) "Pesticide spraying for West Nile virus control and emergency department asthma visits in New York City 2000", *Environmental Health Perspectives*, 112 (11), pp.1183–1187.

### Aid for Africa

The organisation formerly known as Kisiizi Hospital Aid is now called Med-Aid.

It sends redundant medical kit to the developing world and is currently supporting two projects in Uganda and one in Ghana with another due to start in Rwanda. The website [www.medaaid.co.uk](http://www.medaaid.co.uk) is now updated with information on the need for equipment and finance.

### No sex please ...

A new US-funded initiative to prevent unwanted pregnancies in Uganda caters to America's preference for programmes based around abstinence rather than condom use. The colour-coded MoonBeads necklace was designed by a team at Georgetown University in Washington for women who are trying to become pregnant, but it's now helping Ugandan women identify when they are least likely to conceive. The US Agency for International Development has part-funded purchase of the beads for distribution through churches, aid agencies, doctors and pharmacists. Uganda has a soaring birth rate with an average family size of seven children.

With Hajj coming up before the end of the year, we thank Professor AR GATRAD for permission to reproduce this article, first published in the *British Medical Journal*.\*

# Hajj 2006: communicable disease and other health risks with current official guidance for pilgrims

Hajj, the Muslim pilgrimage to Mecca, is the largest annual gathering of its kind in the world. All adult Muslims who are physically and financially able have a religious obligation to make the pilgrimage once in their lifetime. Each year over two million Muslims from around the world gather in Mecca. Around 41,091 pilgrims (Hajjees) from Europe attended the 2005 Hajj season.

The Hajj takes place between the eighth and 13th day of the last month of the Islamic lunar calendar and therefore falls at different dates each year. The next Hajj will take place in late December 2006.

The rites and duties performed during the Hajj take place at different locations in and around Mecca. Many of the rites are physically strenuous:

- *Tawaaf*: circumambulation around the Kaba, the central point towards which Muslims face when performing prayers from anywhere in the world
- *Sa'iee*: rapidly walking between two hillocks (*Safa* and *Marwa*) approximately 500 metres apart
- Staying from dawn to dusk at the Plain of *Arafaat*
- Overnight outdoor camping in *Muzdalifah* where pebbles are collected for the stoning rite
- The symbolic stoning of the devils in Mina.

Each rite must be completed at or within a prescribed time, and doing so in large crowds is physically demanding. It is important for each pilgrim to be fit and healthy to perform all the rites in order to achieve the spiritual goals of the Hajj. Men mark the completion of the rites by shaving their heads, although hair trimming is acceptable. The majority of pilgrims also visit Medina.

Hajj involves the congregation of many people from different parts of the world in unavoidably overcrowded conditions within a confined area for a defined period of time. It presents many public health challenges and health risks are greatly increased, with potential for both local and international consequences. The Saudi authorities take these challenges very seriously and continually review arrangements to improve the pilgrims' environment.

Non-communicable health risks associated with the Hajj are mainly related to heat exhaustion, heat stroke and physical injuries. Practical advice to pilgrims should be offered by

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**“Hajj involves the congregation of many people from different parts of the world in unavoidably overcrowded conditions within a confined area for a defined period of time. It presents many public health challenges ...”**

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health authorities in their home countries and this is now available in some European countries.

The physical exertion, overcrowding and high prevalence of pre-existing health conditions such as diabetes, heart disease, chronic chest conditions, and renal and liver disease favour the spread of communicable diseases, including meningococcal infections, influenza, tuberculosis and gastrointestinal infections. The risks may be minimised by offering pre-travel advice and appropriate immunisations.

The most serious communicable disease risks and preventive measures taken by the Saudi authorities are described here.

## Meningococcal infections

Until the 1987 Hajj, vaccination against meningococcal disease groups A and C was mandatory for pilgrims from sub-Saharan countries. However, an outbreak of *Neisseria meningitidis* serogroup A infection in 1987 highlighted the potential for international spread of infection during pilgrimage, and A and C meningococcal vaccination was made mandatory for all pilgrims applying for visas for Saudi Arabia.

The pilgrimages of 2000 and 2001 were associated with an increased number of *Neisseria meningitidis* serogroup W135 infections in returning UK pilgrims and their close contacts. Many infections associated with this previously uncommon strain were fatal and subsequently reported from several countries in Europe, Africa and the Middle East with a high mortality rate.

Introduction of the quadrivalent ACWY vaccine, together with a high profile awareness campaign by ministries of health worldwide, brought the outbreak quickly to an end. The quadrivalent vaccine is now mandatory before obtaining a visa to enter Saudi Arabia (see links below). All Hajjees

arriving from countries in the African meningitis belt and the Indian subcontinent are given chemoprophylaxis at the port of entry. Continued vigilance and a sustained campaign are essential to prevent further outbreaks of this serious infection.

[www.moh.gov.sa/haj1425/haje.htm](http://www.moh.gov.sa/haj1425/haje.htm)

[www.dh.gov.uk/assetRoot/04/12/22/06/04122206.pdf](http://www.dh.gov.uk/assetRoot/04/12/22/06/04122206.pdf)

## Influenza

Influenza is a highly contagious infection and it is important to increase awareness and uptake of influenza vaccine among pilgrims at risk of serious illness because of their age (over 65 years) or pre-existing medical conditions.

Recent studies have shown a high incidence of influenza infections during the Hajj and so it would seem prudent to regard all Hajj pilgrims at risk, but this is not a national recommendation in any of the European countries. However, the Saudi Ministry of Health recommends that pilgrims are vaccinated against influenza before travel, particularly those at greater risk.

In response to the highly pathogenic avian influenza outbreaks that have recently been occurring, particularly in east Asia, the Saudi Ministry of Health is intensifying influenza surveillance for pilgrims arriving from the most affected countries, including Indonesia, Cambodia, Thailand and Vietnam. Health officials at ports of entry will immediately report any suspected cases for confirmation of diagnosis, proper isolation and administration of oseltamivir.

The Saudi authorities do not permit pilgrims to bring any food into the country and authorities in Indonesia, Cambodia, Thailand and Vietnam have been asked to enforce this regulation at the point of departure so pilgrims do not bring any food containing live or frozen bird meat, in particular.

## Polio

Saudi Arabia was declared polio-free in 1995, but after polio cases were reported in Yemen and Indonesia during 2005, there is now heightened vigilance and determination to keep Saudi Arabia polio-free and to prevent the possibility of spreading the infection between pilgrims during the Hajj.

A new requirement has been introduced: children under 15 years of age travelling to Saudi Arabia from countries where wild poliovirus has been reported must be vaccinated against polio before entry into the country, whether or not they are visiting for the Hajj. Saudi Arabia requires people aged under 15 years travelling from polio-affected countries to be immunised against the disease.

## Cholera and other diarrhoeal/gastrointestinal disease

Outbreaks of diarrhoeal disease and food poisoning used to be frequent during the Hajj due to crowded conditions and the difficulty of maintaining good hygiene. However, with the improvement in sanitation and water delivery to the Hajj sites since the mid-1990s, the situation is now much better.

The last documented outbreak of cholera was in 1989 among Malaysian pilgrims. To avoid future outbreaks, the Saudi

Ministry of Health has intensified surveillance of pilgrims coming from cholera endemic countries, based on the latest WHO reports. All suspected cases will be quarantined at ports of entry and their contacts will be followed up. No pilgrim is allowed to bring food items into the country.

## Blood-borne infections

To reduce the risk of blood-borne infections such as hepatitis B and hepatitis C from the head shaving procedure, the Saudi authorities provide licensed barbers who use a new blade for each pilgrim. Pilgrims should be made aware of this facility and encouraged to use it.

## Most of the likely infections are preventable

Concerted effort is required to ensure that these measures are implemented. Health care professionals, tour operators and individuals have a duty to increase awareness and facilitate uptake of these measures.

In recent years, useful information has been provided from research and surveillance of influenza and other respiratory infections among UK pilgrims, carried out through collaboration with the Health Protection Agency, the NHS and academics, both in the UK and their Saudi counterparts. This collaborative work is expected to continue.

\* Gatrad, A and Sheikh, A (2005) "Clinical review: Hajj, a journey of a lifetime", *BMJ*, 330, pp.133–137.

## References on request to the Editor.

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## STOP PRESS

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## Malaria

A completely new version of the *Guidelines for Malaria Prevention for UK Travellers* from the HPA Advisory Committee on Malaria Prevention are expected to be published on the internet in December 2006 and available in published paper format early in 2007. An update will be available on the RCN Travel Health Forum Website ([www.rcn.org.uk/travelhealth](http://www.rcn.org.uk/travelhealth)) when we receive the information.

[www.hpa.org.uk/infections/topics\\_az/malaria/guidelines.htm](http://www.hpa.org.uk/infections/topics_az/malaria/guidelines.htm)

[www.malaria-reference.co.uk](http://www.malaria-reference.co.uk)

[www.nathnac.org](http://www.nathnac.org)

[www.rcn.org.uk](http://www.rcn.org.uk)

## NaTHNaC

The National Travel Health Network and Centre (NaTHNaC) is currently developing web-based country specific travel health information for health professionals and travellers. These pages are due to be launched in early 2007 and will be available on the NaTHNaC website at [www.nathnac.org](http://www.nathnac.org).

NaTHNaC is also undertaking the revision of *Health Information for Overseas Travel*, (the Yellow Book). The new edition is expected to be published in hard copy and web format towards the end of next year.

# RESOURCES FOR TRAVEL HEALTH ADVISERS

Review by JOYCE SKEET RGN MSc (Travel Medicine)

## FAST FACTS: Travel medicine

Written by two experts in travel medicine, this book has a place on the desk of nurses and doctors working in a travel clinic or general practice.

The colour coded chapters make specific subjects easy to find, such as individuals with special conditions, vaccines, and environmental and climatic factors. Brief descriptions of several infectious diseases are listed. Those transmitted by parasites, animals, ticks, lice, mites and fleas are included with a more detailed section on rabies. Various mosquito-borne diseases have a discrete chapter as does malaria.

Clear maps and tables show affected areas of infectious diseases including transmission and seasonal variations.

The chapter on "returned travellers" with the aetiology of diarrhoea and fever is very useful and lists of the incubation periods aid decision making on which tests are indicated to help with diagnosis.

Advising travellers with pre-existing medical conditions or special needs involves a detailed pre-travel assessment. Some areas of advice

for HIV-positive patients are unclear. One page states that live vaccines are "generally contraindicated" and on the next they are "contraindicated" and other vaccines are "probably safe". For more specific advice on the individual, health professionals would be advised to check specialist resources and seek specialist advice.

In the chapter on vaccines, some of the information has changed since this book was published so you should check current information before immunising and advising travellers.

Overall this book has its place for health professionals with an interest in travel medicine. It is intended for use worldwide, however, so it does not include or refer to resources specifically available to UK health professionals.

**Andrew J Pollard and David R Murdoch (2001) *Fast facts: travel medicine*, Oxford: Health Press. ISBN 1-899541-59-4. 152 pages.**



## DATES FOR YOUR DIARY

### Training in Sexual Health for Nurses

A two day course developed and run by Training in Sexual Health Harrogate District Hospital  
**2007 course dates:** ● 19 and 26 February  
 ● 12–13 April ● 11–12 June  
 More at [www.traininginsexualhealth.co.uk](http://www.traininginsexualhealth.co.uk)

### Practice Nursing

#### Modernising and managing the NHS and clinical practice

26–27 January 2007  
 University of Manchester  
 More at [www.mahealthcarevents.co.uk](http://www.mahealthcarevents.co.uk)

### Preparatory Course for the ISTM Certificate in Travel Health (CTH®) (Co-sponsored by ISTM and NaTHNaC)

9–10 February 2007  
 Crown Plaza Hotel, Liverpool  
 Further information from:  
[www.nathnac.org](http://www.nathnac.org) & [www.istm.org](http://www.istm.org)

### Royal Society of Tropical Medicine and Hygiene

#### Symposium on travel-associated disease

29 March 2007  
 Ondaatje Theatre Royal Geographical Society, London  
 £45 for students and nurses includes lunch.  
 Application form and programme from [mail@rstmh.org](mailto:mail@rstmh.org). More at [www.rstmh.org](http://www.rstmh.org)

### CISTM 10

International Society of Travel Medicine  
 20–24 May 2007  
 Vancouver Conference Centre  
 Contact (856) 423-7222 ext 17  
 More at [www.istm.org](http://www.istm.org)

### Fifth European Congress on Tropical Medicine and International Health

24–28 May 2007  
 Amsterdam  
 More at [www.trop-amsterdam2007.com](http://www.trop-amsterdam2007.com)

### RCN Travel Health Forum

Annual Conference (first announcement)  
 29 September 2007  
 Royal College of Physicians, London  
 Contact [kathryn.clark@rcn.org.uk](mailto:kathryn.clark@rcn.org.uk)

### Mountain and Wilderness Medicine

World Congress  
 3–7 October 2007  
 Aviemore, Scotland  
 More at [www.worldcongress2007.org.uk](http://www.worldcongress2007.org.uk)

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