Royal College of Nursing

RCN Travel Health Forum

Summer 2009

Travel Health

www.rcn.org.uk/travelhealth

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Don't miss out! Do we have your email address?

Further information

Send contributions for the next newsletter to Sandra Grieve
Email: awcg1@btinternet.com

GlaxoSmithKline Travel Health

The RCN Travel Health Forum is grateful to GlaxoSmithKline Travel Health for a donation which allows the production and publication of this newsletter. GlaxoSmithKline have no editorial input.

TRAVELLERS' TALES

Thanks to HILARY SIMONS* for sharing her journey with us.

TROPMEDEX Kenya 2009: highlights of a medical tour

1–13 February 2009

I waited a long time for this trip. Originally scheduled for January 2008, fate dictated that it was not to be in that year.

Due to the election process, civil unrest raged in Kenya during December 2007 into January 2008. Opposition supporters accused the ruling party of rigging the vote. Tensions between opposing tribal factions ran high, creating a dangerous and volatile situation. Much of the ensuing violence occurred in Rift Valley cities including Eldoret, Kisumu, Naivasha and Nakuru. Over a thousand Kenyan civilians died in the violence and thousands more were displaced from their homes, particularly in Western Kenya.

Mediation, facilitated by international politicians and the United Nations, resulted in a power share between the two parties and a somewhat uneasy "peace" was restored. During this time, most travellers to Kenya, including myself, heeded the advice of their governments and did not travel.[1]

Like others I had hoped for peace for the Kenyan people and waited for an opportune time to visit. Thus my safari began in late January 2009. The word "safari" is usually associated with the "big five"; this safari was to be somewhat different! Safari is the Kiswahili word for "journey" and my journey was to take me a world away from the long lenses and five star comforts with which I was more familiar.

The itinerary would avoid the tourist route and take me to places where "mzungu" or "wazungu" (white people) were few – apart from a few leathery expats, too long in the sun, and pale young things, just arrived to undertake good work, medical electives or similar. This journey would give me an all too brief taste of the people's Kenya, where access to facilities like education and health care that we take for granted is difficult and life is often tough.

Off the tourist track

TROPMEDEX Kenya 2009[2] offered an exciting itinerary, including visits to a variety of health care facilities (Kenya's health care is delivered on a multi-tier system) and

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Letter from the Chair: SANDRA GRIEVE

Changes are afoot and this will be the last newsletter you receive through your letterbox before the Travel Health Forum is merged with four other forums to form one Public Health Forum (PHF). From October 2009 all RCN newsletters will be emailed to members.

Changes are being made to the Congress voting system as well so if you want your vote to count it must be aligned to the forum which is your first choice (currently you can be a member of up to three forums for free, with a fee of £15 for any extra ones). You can check your status on the RCN website at: www.rcn.org.uk/myrcn

The last few years have been busy as we have been striving to keep the specialty of travel health in the main frame and we will continue to do this through the newly formed PHF. Together with the other merging forum chairs, I am moving across to the PHF committee to see the transition through and implemented in October. Elections will take place in 2010 so keep an eye on the RCN website for updates.

I would like to say a big thank you to my fellow THF committee members, to our previous Chair Jane Chiodini for her continued support, and to you the members for your loyalty. We and the specialty have come a long way since the Travel Health Forum was established from the special interest group in 1993 and we hope to continue to fulfil a role within the RCN for the benefit of travel health nurses.

Letter from the Editor

Once again I am extremely grateful to contributors to this edition. Travel health advisers continue to travel to exciting places. Hilary Simons' account of her time in Kenya starts on page one and Joyce Skeet celebrated a big birthday in China and shares her experience on page nine.

The conference trail is also still being actively trod by travel health nurses and as I write we are about to head to Budapest for CISTM11, along with two forum members we have funded to attend. UK conferences are also important and two are reported on in this issue – our successful Malaria Day, a joint venture with BTHA, is on page 18, part of our special Focus on Malaria feature, and the Tick Alert Conference is covered on page six. Wendy Fox has personal experience of tick-borne disease and helps us understand more about the threats within the UK and abroad on the following page.

As always, Newsround and Bulletin Board have snippets of information I hope you will find useful and don't miss the opportunity to apply for a funded place at our forum annual conference or NECTM in Hamburg – notices on the back page.

Thank you to our generous sponsor GlaxoSmithKline Travel Health for their continued support for this publication over the last 10 years.

Sandra Grieve

2009 Travel Health Nursing Award winners announced

Congratulations to Lynda Bramham, Senior Nurse Adviser, and Shirley Bannatyne, Nurse Adviser/Clinic Manager, from the MASTA Medical Team in Leeds who have won the first-ever *Nursing Standard* Travel Health Nursing Award.

Karen Olorenshaw and Yvonne Stephenson, practice nurses at Shipston Medical Centre, Warwickshire PCT, were commended in a keenly fought competition.

Sponsored by GlaxoSmithKline Travel Health, this prestigious award was launched late last year to recognise nurses who make clinical judgments and decisions that deliver innovation in travel health.

Travel health is one of 13 categories in the *Nursing Standard* Awards. Judging took place on 26–27 May at RCN headquarters and winners will be presented with their awards on 9 November during a gala ceremony at the Dorchester, London. At the end of the evening, one of the category winners will receive the ultimate accolade of *Nursing Standard* Nurse of the Year 2009.

Maura Buchanan, RCN President, praised the dedication, determination and commitment of all the finalists in improving the care and treatment of their patients.

GLAXOSMITHKLINE Travel Health

Important news on the Forum Transition project

RCN forums are groups of RCN members working in a similar nursing specialty or with like interests.

RCN forums:

- provide networking opportunities
- help members enhance their practice knowledge and skills
- provide an expert resource
- support RCN Council
- shape, drive and develop nursing practice
- identify and support nurse leaders in their field
- influence current and future health and social policy in the UK and beyond.

In 2008 RCN Council decided that RCN forums should be streamlined to create 41 stronger, more fit for purpose forums. They will have a revised governance structure and will be supported with new online systems to help them meet the challenges of the 21st century.

Your forum will be merging with a number of others to become the Public Health Forum. You will still be able to access news and information about your specialism through the online communities but in future, all communications will be coming from the Public Health Forum. You can find out more about the changes on the forum website at: **www.rcn.org.uk/forums** , where you can download the full list of the new forums.

Thousands of RCN members throughout the UK already work together in forums to develop and improve nursing care in a range of settings and they remain an essential part of RCN membership. By joining an RCN forum you will be kept up to date by email with the latest developments in your key field of interest. There are also online communities in different specialisms and interests – see: **www.rcn.org.uk/communities** for further information.

Don't forget to update your details at: **www.rcn.org.uk/myrcn** and give us your email address to ensure you continue to receive information and updates from your new forum.

BULLETIN BOARD

Safer medicine supply chain?

In a move to clamp down on counterfeit medicines, new reforms for the sale of prescription medicines were announced from Brussels in December. This means sales across Europe could be tracked through the supply chain thus improving patient safety. The European Commission wants drugs bar-coded so that those who dispense medicines can trace their origin, and ensure quality and authenticity.

In the proposed legislation the EC wants to allow companies to provide product information directly to patients – previously banned in the European Union. The proposals still lack detail and have to go before the European Parliament and the Council of Ministers before they can become law. Nevertheless the Commission hopes they will improve innovation, safety and access to medicines.

A guide on safe food for travellers

WHO's global message – *Prevention of foodborne disease: Five keys to safer food* – is at: **www.who.int/foodsafety/consumer/5keys/en**

Patients to get counterfeit warning with each prescription

New guidance to raise public awareness of fake medicine and its dangers has been launched by the Royal Pharmaceutical Society of Great Britain (RPSGB) and the Medicines and Healthcare products Regulatory Agency (MHRA). Pharmacies will receive the guidance, developed in conjunction with patient groups to ensure it is clear and easy to read, and asked to distribute the new double-sided postcard-size leaflet in prescription bags.

The leaflet offers advice about counterfeit medicines, how to minimise purchasing fakes and what to do if they suspect they have been sold or supplied counterfeits. One side of the postcard explains the safest way to purchase medicines and the other addresses "the dangers of faking it".

HCC bows out with *State of Healthcare*

The Healthcare Commission's final report to Parliament on the state of health care in England and Wales is at: **www.cqc.org.uk/publications.cfm?widCall1=customDocManager.search_do_2&tcl_id=2&top_parent=4513&tax_child=4514&tax_grand_child=4568&search_string=**

In April, the new Care Quality Commission (CQC) replaced the HCC, Commission for Social Care Inspection and the Mental Health Act Commission, joining up the regulation of health and adult social care in England. Healthcare Inspectorate Wales continues to lead on the inspection of health care services there. **www.cqc.org.uk**

Look for Green Book updates online ...

The web version of the Green Book (*Immunisation against infectious disease*) is regularly updated. Patches can be downloaded, printed, cut and pasted into the printed versions so that you always have a fully up-to-date copy. **www.dh.gov.uk/en/Publichealth/Healthprotection/Immunisation/Greenbook/DH_4097254**

... or have them delivered straight to your screen

Simply subscribe to the RSS feed and you will be advised of updates to the Green Book. More information on the Green Book landing page (above) or go directly to: **www.dh.gov.uk/en/Rss/Rss?Feed=DH_091397**

e-Vaccine update

To receive a copy of Vaccine update emailed directly to you each month, contact: **vaccine.supply@dh.gsi.gov.uk**

BULLETIN BOARD

Rabies

The case of the woman from Northern Ireland who contracted rabies following her work as a volunteer in South Africa is a timely reminder to people going off to travel or work – especially closely with animals – in countries where the rabies virus is present. Rabies in UK travellers is fortunately rare, but pre-exposure vaccination should be considered for all those at potential risk. **www.nathnac.org/pro/clinical_updates/rabies_140109.htm**

Increased vector borne disease 'down under'

Australia has experienced extreme weather conditions this year as a result of which there has been increased mosquito activity. The Australian Department of Health issued warnings for residents or travellers visiting the northern part of Western Australia to take insect bite precautions to avoid the risk of mosquito-borne viruses.

The potentially fatal Murray Valley Encephalitis (MVE) was found in several locations and wet season activity of other mosquito-borne viruses was being monitored. In Queensland the number of cases of dengue fever in Cairns was recorded as the city's worst outbreak ever.

Source: ProMED-Mail 2009#126 and ProMED-Mail 2009#102

Dress sense

Clothing impregnated with permethrin and active for up to 70 washings is available for travellers at: **www.insectshield.com/CMSContent/About-About.aspx**

Time running out on Euro health cards

British holidaymakers were urged to check their European Health Insurance Cards (EHIC) as millions are due to expire – indeed, between September 2008 and the end of March 2009 some 3.3m cards expired. Although nearly three in five people claim to have an EHIC, a poll for the Department of Health showed that 68 per cent of them do not know when it expires.

The EHIC offers free or reduced cost health care yet the survey suggested that people who fall ill overseas don't seek help for fear of the costs. The card provides access to health care on the same terms as the country's own citizens in all 25 European Union countries, plus Iceland, Norway, Switzerland and Liechtenstein.

Cards can be ordered or renewed online at: **https://www.ehic.org.uk/Internet/home.do** and will be delivered within seven days.

Who should advise health tourists?

The House of Lords European Union sub-committee on social policy and consumer affairs responded to the EC proposals on cross-border health care by saying that patients travelling abroad for health care should be provided with information financed by each member state. Frontline staff should not be burdened with having to provide this information.

Global financial crisis threatens health in developing countries

The WHO Director-General has issued a statement on the health impact of the global financial and economic crisis at: **www.who.int/mediacentre/news/statements/2008/s12/en/index.html** . Dr Margaret Chan calls for governments and political leaders in affluent countries to continue (and increase) their financial support for health and social services to low- and middle-income countries.

Dr Chan emphasises that investment in health will protect poor and vulnerable people, promote economic recovery and social stability, and help generate efficient health systems. She cited previous economic downturns in the 1980s in which the lack of investment in sub-Saharan African health systems meant these countries were tragically unprepared for the HIV/AIDS pandemic in the decade that followed.

WHO on WER

Recent reports from the World Health Organization's Weekly Epidemiological Record (WER) include:

- *Yellow fever in Africa and South America 2007* (27 March 2009) 13(84), pp.97–108
- *Dengue in Africa: emergence of DENV-3*, Côte d'Ivoire, 2008 (13 March 2009) 11/12 (84), pp.85–96.

Both are at: **www.who.int/wer**

CDC on STDs

Centers for Disease Control and Prevention's *Sexually transmitted disease surveillance 2007*, national overview has now been published at: **www.cdc.gov/std/stats07/toc.htm**

Warning from the jungle

In January it was confirmed that two dead monkeys in Trinidad had died of yellow fever and a vaccination campaign was implemented to ensure population protection. Visitors to Trinidad were advised to have a valid vaccination against yellow fever to ensure they have the same protection as the local population. **www.nathnac.org/pro/clinical_updates/yf_250209.htm**

Emergency treatment of anaphylaxis

The Royal College of Physicians has issued new guidelines highlighting the important use of adrenaline in treating adults having an anaphylactic reaction. They recommend greater follow up and investigation of patients who have suffered anaphylaxis reactions to help learn more about the causes and the reason for rising numbers of incidents.

Emergency treatment of anaphylaxis in adults: concise guidance was published

on 2 April 2009 in *Clinical Medicine*, 9 (2) **www.rcplondon.ac.uk/Pages/index.aspx**

Stamping out lymphatic filariasis

Since an eradication programme was launched 10 years ago, lymphatic filariasis has been eliminated in 16 countries. A private-public partnership involving national governments, WHO and two multinational drug companies led a campaign to treat 570 million people in 48 countries. *BMJ* 2008; 337:a2944.

Cold blooded neglect

According to a new study at least 421,000 people each year are bitten and poisoned by snakes and at least 200,000 die. The authors think this is a neglected risk – figures may be an underestimate and true numbers much higher. *PLoS Med* (2008) 5:e218 doi:10.1371/journal.pmed.0050218 and *BMJ* 2008; 337 1136.

Reducing measles deaths

The Measles Initiative reports that deaths from measles worldwide fell by 74 per cent between 2000 and 2007. In the same period eastern Mediterranean countries including Afghanistan, Somalia, Sudan and Pakistan have cut measles deaths by 90 per cent, achieving the United Nations goal three years early. **www.measlesinitiative.org**

But measles cases up in UK

The HPA figures showed 1,370 confirmed cases of measles in England and Wales last year (January-December 2008) compared to 990 in 2007. Almost half (48 per cent) were from the London region. **www.hpa.org.uk/hpr/archives/2009/news0809.htm#msls0109**

New meningitis B hope

Researchers hope that a new vaccine against meningitis B could be available by 2011. Tests are in the final stages at the University of Oxford following work on the sequencing of the entire genome of the deadly bacterium. The genetic structure of meningococcus B was published in 2000, enabling further work to be done on possible targets for a vaccine. Meningitis B causes most cases and most deaths in the UK and was responsible for 80 per cent of confirmed infections in 2008.

Personal air space

Information on which airlines provide oxygen or allow personal compressors on board is available from the British Lung Foundation at: **www.lunguk.org**

It's good to talk ...

Ryanair became the first airline operating from the UK to allow mobile phones to be used on board. The service is only available on limited flights and serviced by one provider, but others are expected to sign up. However, with calls reported to cost up to £3 per minute passengers are not rushing to use the facility.

... and Twitter

It seems to have appeared from nowhere, but many travellers are catching on to the new way of communicating through Twitter. Online travel agents are using the tool as a way to target customers and direct them to the best bargains and even to resolve complaints quickly. WHO and CDC used it to update people on A(H1N1) influenza (swine flu). It also conjures up a whole new language like "re-tweeting" your message and getting a recommendation through "crowdsourcing". What next?

Hepatitis C: Get tested, get treated

Some 20 years after the virus was first identified a new campaign to raise awareness of hepatitis C has been launched at: **www.nhs.uk/hepatitisc** . It is estimated that 100,000 people in England have undiagnosed chronic hepatitis C infection and nurses are being asked to determine whether patients could be at risk by alerting them to the transmission routes for the virus. Also see:

- Hepatitis C Trust: **www.hepctrust.org.uk**
- British Liver Trust: **www.britishlivertrust.org.uk**

Vaccine supply, storage and distribution

Information is now available in the toolkit at: **www.immunisation.nhs.uk/Local_coordinators_toolkit/Vaccine_supply_distribution_and_storage/Vaccine_supply**

Japanese encephalitis vaccine

IXIARO is the new vaccine against the Japanese encephalitis virus from Novartis. Detailed information on this medicine is available on the European Medicines Agency (EMEA) website at: **www.emea.europa.eu**

Ticks DVD

A short film aiming to raise awareness of ticks among walkers explains bite prevention, tick removal, Lyme disease and tick-borne encephalitis in detail. You can preview the film at: **www.thebmc.co.uk/Feature.aspx?id=2961** . The author is happy to distribute it free to any organisation wishing to host it on their site. Contact the Editor for information.

For parents of child travellers

A useful and informative website aimed at parents of child travellers has been compiled by Dr Karl Neuman, a paediatrician, who invites them to visit **www.KidsTravelDoc.com** to "keep your family safe and healthy for travel and outdoor activities". The site advises how to minimise illness and mishaps, and what to do if they do occur. New subjects are added weekly and existing ones are updated constantly.

Expert warns health officials to tackle tick disease

Tick Alert Conference • 24 April 2009

A leading scientist says a potentially fatal tick disease is being diagnosed in the UK and he is urging health authorities to do more to prevent the risk of cases escalating.

The warning, by Professor Michael Kunze, came as thousands of holidaymakers prepared to visit popular destinations across Europe this summer where tick borne encephalitis (TBE) is now endemic in 27 countries.

Professor Kunze, Chair of the International Scientific Working Group (ISWG) on TBE, a group of experts based in Austria which is investigating the disease, says cases have been confirmed in UK travellers, but health officials are ignoring the threat: "TBE is preventable, not treatable in the same manner as other tick diseases, and more must be done to persuade UK travellers of the need for vaccination."

According to the ISWG, there are on average 10,000 cases of TBE needing hospital treatment across Europe every year. It is fatal in two out of a hundred cases.

Professor Kunze made his comments in a speech at Tick Alert 2009, a conference for representatives from primary care, the NHS, travel health and occupational health advisers held at the Royal College of Physicians.

He added: "Doctors are not routinely thinking to test for tick disease, let alone TBE in patients suffering with meningitis and other symptoms typical of these illnesses. There will be more and more people returning from holidays in Europe and visiting their surgery, and doctors are not prepared for a rise in cases."

Lyme disease

His view was echoed by Wendy Fox, Chair of Borreliosis and Associated Diseases Awareness UK (BADA-UK), a charity promoting understanding and prevention of Lyme disease, which is prevalent in the UK.

Speaking at the conference (see following story) she said: "Many GPs with little or no experience of Lyme disease can miss the possible early signs of infection and treatment may not be forthcoming or be delayed. GPs who work in heavily endemic areas will often treat on the basis of suspicious symptoms and will not always exclude Lyme disease based on a negative test result."

Early symptoms of both Lyme disease and TBE are flu-like, but can progress to a second phase involving meningitis, neck stiffness, severe headaches, delirium and paralysis with long-term health problems.

The Tick Alert Campaign, which organised the conference, is distributing leaflets in GP surgeries and outdoor retailers. Information about tick disease and maps showing risk areas in the UK and Europe are included.

Visit their website at: www.tickalert.org or email: info@tickalert.org

Before embarking on a trip, travellers obviously should take health protection into account. Many opt for vaccination against diseases, generally associated with travel abroad, but few realise there is an increasing threat within the British Isles, and one that is not vaccine preventable.

Tick-borne disease is increasing in the UK and Ireland. Ticks are the most common arthropod vector of disease and a hard tick (*Ixodes* species) usually causes infection in the UK. Ticks are most abundant in forested, heathland and moorland areas, but also in suburban parklands. Owing to several factors, including land management and climate changes, parasite numbers have increased and so has their distribution.

Borreliosis (also referred to as Lyme borreliosis or Lyme disease) is most prevalent tick-borne disease. Cases reported via a voluntary surveillance system have trebled in England and Wales since 2001. In Scotland (where the disease is notifiable) they have increased by a factor of eight.

Underestimated

The Health Protection Agency admits that data for reported cases are incomplete because information doesn't include cases diagnosed and treated on the basis of clinical features, without laboratory tests. They estimate an additional 1,000–2,000 cases each year, with an annual total of approximately 3,000.

Cases in England and Wales are most frequently reported in Exmoor, the New Forest, the South Downs, parts of Wiltshire and Berkshire, Thetford Forest, the Lake District and the North York Moors. However, they have been reported from most counties and the HPA states that any area harbouring ticks may have the potential for borreliosis transmission.

Dr Darrel Ho-Yen, head of the national Lyme Disease Testing Service in Scotland, believes that the known number of proven cases should be multiplied by 10 "*to take account of wrongly-diagnosed cases, tests giving false results, sufferers who weren't tested, people who are infected but not showing symptoms, failures to notify and infected individuals who don't consult a doctor*".

Diagnostic problems

Borreliosis is caused by a spirochaetal bacterium of the Borrelia genus. Lyme disease is generally associated with Old Lyme, Connecticut, in the United States, acquiring its name after a cluster of cases of *Borrelia burgdorferi* infection was identified in 1974. Since then, other strains of

Thanks for this article go to WENDY FOX, Chair of Borreliosis and Associated Diseases Awareness UK (BADA-UK), a charity promoting understanding and prevention of Lyme disease.

LYME DISEASE: A clear and present danger

Borrelia which can have different clinical presentations have been discovered in Europe.

Identifying an infection presents a problem for health care practitioners. There is only one sign specific to Borreliosis – an expanding rash (Erythema Migrans), generally occurring three-to-30 days after a tick bite. This rash doesn't always occur and can vary in presentation (sometimes misdiagnosed as ringworm, cellulitis or allergic reaction). Of cases reported to the HPA in 2007, only one third had documented Erythema Migrans.

Early symptoms are non-specific and flu-like (tiredness, headaches, arthralgia and myalgia). In the following weeks or months more serious symptoms may appear in untreated patients, affecting the nervous system, joints and the heart or other tissues. Neuroborreliosis (infection of the nervous system) can cause facial palsy, viral-like meningitis, pain, weakness or altered sensation of limbs or trunk.

Lyme arthritis, usually affecting the knee, is more common with disease acquired in North America or some parts of Europe.

Too tiny to detect

Another diagnostic problem occurs when patients don't recall a tick bite. Of the cases reported to the HPA in 2007, only 43 per cent reported a bite. Because of anaesthetic and anti-inflammatory properties in their saliva, ticks can bite and feed without discovery.

Nymphal ticks (the second stage in a tick's life-cycle) are the most common cause of infection as they resemble a poppy seed and are seldom seen. Ticks prefer attaching to inaccessible places, like skin folds, armpits, groin, or under hair on the scalp. Body hair will often hide small ticks.

Testing difficulties

A two-tier system is employed in the UK. First, antibody screening tests are performed, followed by immunoblotting (western blotting) of reactive or equivocal samples. Such tests have limitations. Because an antibody response takes several weeks to develop, antibodies may be undetectable in the few weeks after infection. A second sample may then show sero-conversion. Sometimes those with more established infection can be seronegative.

Conversely, people may have antibodies to *Borrelia* bacteria without having a current infection (regular occupational or recreational exposure to tick bites) and other conditions (for example, glandular fever, syphilis, rheumatoid arthritis) can result in false positive reactions.

A cocktail of infection

Ticks in the UK can carry multiple infections including anaplasmosis, Q-fever, babesiosis and bartonellosis. Clinicians should be aware of the possibility of co-infections, which may cause cases of borreliosis to present atypically and influence treatment choice.

The threat to travellers abroad

Tick-borne diseases are a worldwide concern, with many diseases specific to certain areas. Lyme borreliosis is the most prevalent, being endemic to North America and Eurasia. Tick-borne relapsing fever is also caused by a species of Borrelia bacteria and found primarily in Africa, Spain, Saudi Arabia, Asia and certain areas in the western USA and Canada.

Other risks to travellers include:

- **tick-borne encephalitis virus (TBE)** – endemic in temperate regions of Europe and Asia
- **tularemia** (bacterial) – reported from all European countries except Great Britain, Iceland and Portugal. Endemic to the south east, south central and western USA
- **Colorado tick fever** (virus) – endemic to the western USA
- **Crimean-Congo hemorrhagic fever** (virus) – endemic in Asia, eastern Europe and the Middle East, but especially common in east and west Africa
- **Anaplasmosis** (rickettsial) – endemic in the USA and Europe, but recently identified in China
- **Rocky Mountain spotted fever** (rickettsial) – diagnosed throughout the Americas. Some synonyms in other countries include "tick typhus", "tobia fever" in Columbia, "São Paulo fever" or "febre maculosa" in Brazil and "fiebre manchada" in Mexico.
- **Babesiosis** (protozoal) – endemic in many regions of Europe and the USA
- **Tick paralysis** (toxins) – cases occur in the USA and Canada, Australia and Africa. Cases in Eurasia are sporadic.

Disease prevention

Apart from vaccination (where applicable) the best defence is tick awareness. Using repellents and dressing to deter ticks getting under clothing is good policy. Regular body checks will identify ticks before or soon after they attach, minimising the risk of disease transmission which increases the longer the tick remains attached.

Correct removal of ticks is vitally important and should be performed using a tick-removal tool or fine-tipped tweezers, easily carried (with antiseptic wipes) in pockets or rucksacks. Freezing, burning or smothering a tick with any substances is likely to result in regurgitation of infective fluids. Detailed instructions on tick-removal techniques are available at: www.bada-uk.org ("Defence" section).

When evaluating a patient it is important for health care practitioners to be aware of places people have visited or intend visiting.

newsround

Swine flu goes global

You would have to have been on Planet Zog to miss the ongoing reports on A(H1N1) influenza (swine flu) which emerged in Mexico in April. On 11 June, with official reports showing nearly 30,000 cases and 141 deaths across over 70 countries, the World Health Organization (WHO) declared a phase six pandemic and called for a co-ordinated response to contain the disease. Two days later a 38-year-old woman who gave birth prematurely at a hospital in Scotland after testing positive for the A(H1N1) virus, became the first person to die outside the Americas.

As we go to press, WHO continues to recommend no restrictions on travel and no border closures. Daily updates are on several websites:

- **www.cdc.gov/flu/swine/general_info.htm**
- **www.nathnac.org/pro/clinical_updates/swineflucases.htm**
- **www.who.int/csr/don/en**
- **www.hps.scot.nhs.uk/resp/swineinfluenza.aspx**

But avian flu is still out there ...

In June the Ministry of Health and Population of Egypt reported a new human case of infection with A/H5N1 avian influenza, confirmed in a four-year-old girl who had a history of close contact with dead or sick poultry. She was in a stable condition after being treated with oseltamivir.

Of 78 confirmed cases in Egypt, 27 have been fatal. **www.who.int/csr/disease/avian_influenza/en**

And then there's always seasonal flu

The 2009/2010 seasonal flu campaign was announced on 3 April, before the current swine flu situation had developed. In the CMO letter there are no changes to the clinical at-risk or age groups for the main seasonal flu campaign. PCTs are encouraged to promote flu vaccines among poultry workers and health care workers.

Printed copies of the CMO flu letter are not being supplied to GP surgeries this year **so do remind practices to order their flu vaccine now**. The seasonal flu vaccination plan should continue as usual until further advice is given.

Vaccine Update 158 April 2009 is at: **www.immunisation.nhs.uk/Professional_information/CMO_letters**

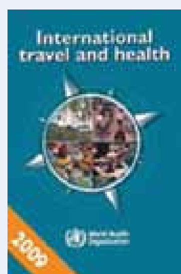
New information on PGDs in general practice

The Medicines and Healthcare products Regulatory Agency (MHRA) has produced new guidance on the use of patient group directions in general practice, specifically PGDs used to authorise the administration of non-NHS vaccines such as those for which the practice charges (for example, yellow fever) and for the supply of malaria chemoprophylaxis.

The MHRA has confirmed that PGDs cannot be used to deliver these private services and the practitioner should ensure that patient specific directions (PSDs) are in place before a non-NHS vaccine is administered.

This guidance, which applies to all four home countries, is at: www.portal.nelm.nhs.uk . Further guidance about the use of PGDs in the private sector is available from the MHRA at: **www.mhra.gov.uk**

International travel and health



WHO's latest *International Travel and Health* has been posted on their website: **www.who.int/ith/chapters/en/index.html** . The 2009 edition includes a chapter on psychological health, detailed maps of major infectious diseases and updated vaccine recommendations and schedules. The book can also be purchased in hard copy.

Rights on immunisation

Everyone in England has "the right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation (JCVI) recommend that you should receive under an NHS provided national immunisation programme". This right is set out in the first NHS Constitution which establishes the principles and values of the NHS in England and is underpinned by law (regulations and directions) that came into force on 1 April 2009. The regulations will require the Secretary of State to fund and implement any cost-effective recommendation made by JCVI.

RCN scaling up the global nursing workforce to combat TB

The increasing number of people contracting tuberculosis and multidrug-resistant (MDR) TB each year places overwhelming pressure on stretched and ill-equipped nursing workforces in developing countries. The RCN's alliance, the International Council of Nurses, announced increased and enhanced support for nurses to combat TB through a four-year training and education programme in partnership with pharmaceutical company Eli Lilly. **www.icn.ch/PR20_08.htm**

HIV-related TB deaths higher than estimates

A new report by WHO shows that the total number of new TB cases worldwide remained stable in 2007 and the percentage of the world's population becoming ill with TB has continued the slow decline first observed in 2004. However, the 2009 global TB control report also reveals that one out of four TB deaths is HIV-related, twice as many as previously recognised. The report at: **www.who.int**

JOYCE SKEET went east and discovered a world apart.

A trip of a lifetime to China

Last October we flew to China to celebrate my husband's 60th birthday and, on arrival in Shanghai, got onto the Maglev train to speed into the city at 460 kph hour to start our trip.

Shanghai is a modern city with shiny high skyscrapers alongside some very old buildings and gardens which have survived all the changes. One of these, the Yuyuan Garden with the Huxing Teahouse, was built in 1559 and is a classical garden complete with beautiful pavilions, ponds and bridges.

The Bund, alongside the river, is a must at night time with all the buildings and boats lit up. Hangzhou and Suzhou are considered the canal towns and the centre of the silk spinning industry. You can see it all – from the silk worms munching their way through piles of mulberry leaves to the cocoons being spun into spools before being dyed and then woven into the most exquisite cloth.

The Humble Administrators Garden is amazing with lots of pavilions, streams and ponds full of lotus flowers and fish, and represents a garden from the Ming dynasty.

The Huqingyutang Ancient Pharmacy, established in 1874 by a Qing merchant, is still open and sells traditional Chinese herbs and medicines for every ailment imaginable. Glass jars and boxes contain the most astounding selection of bits and pieces of plants, insects, snakes and animals. I was very glad I was in good health and was able to decline the services of the pharmacist!

Xian and the Yangtze

No one can prepare you for the size of the pits the Terracotta Armies are housed in – one is the size of a large aircraft hanger and people on the other side of the building look like ants! The detailed features of the warriors and their horses are breathtaking, and the artefacts are in such good condition.

Xian city is modern, but has managed to keep the old Bell Tower, Drum Tower and the Big Wild Goose Pagoda from the Sui Dynasty (581–618) which is the best preserved Buddhist temple complex in China and is visited by many.

A flight down to Wuhan and a coach journey to Yichang to join our ship for a cruise on the Yangtze River was also very interesting. I wanted to visit the Three Gorges before they were finally flooded forever and I'm so glad we did.

The dam itself is massive and the gorges are spectacular, but thousands of local Chinese families have been re-housed in huge new cities as their villages are now metres under the river. This, we were told, is progress and I did wonder how these people manage to eek out a

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TRAVELLERS' TALES

living, having lost their farms. They have now been retrained to work in the many factories in the cities.

Dragons?

Years ago local people buried their dead in hanging tombs high up in the cliffs of the gorges and they can still be seen today. The mists swirl around the mountains and into the valleys surrounding the gorges and it's not hard to imagine local people believing dragons lived here!

Staying in the UNESCO World Heritage site of Pingyao, built in the Ming and Qing Dynasty, was such a privilege.

The houses in the walled town are all built in timber with little courtyards at the back. Houses are all linked and a maze of narrow streets which twist and turn through the town to bring it all together. We stayed in a local guesthouse and our traditional cabin bed had curtains across the front!

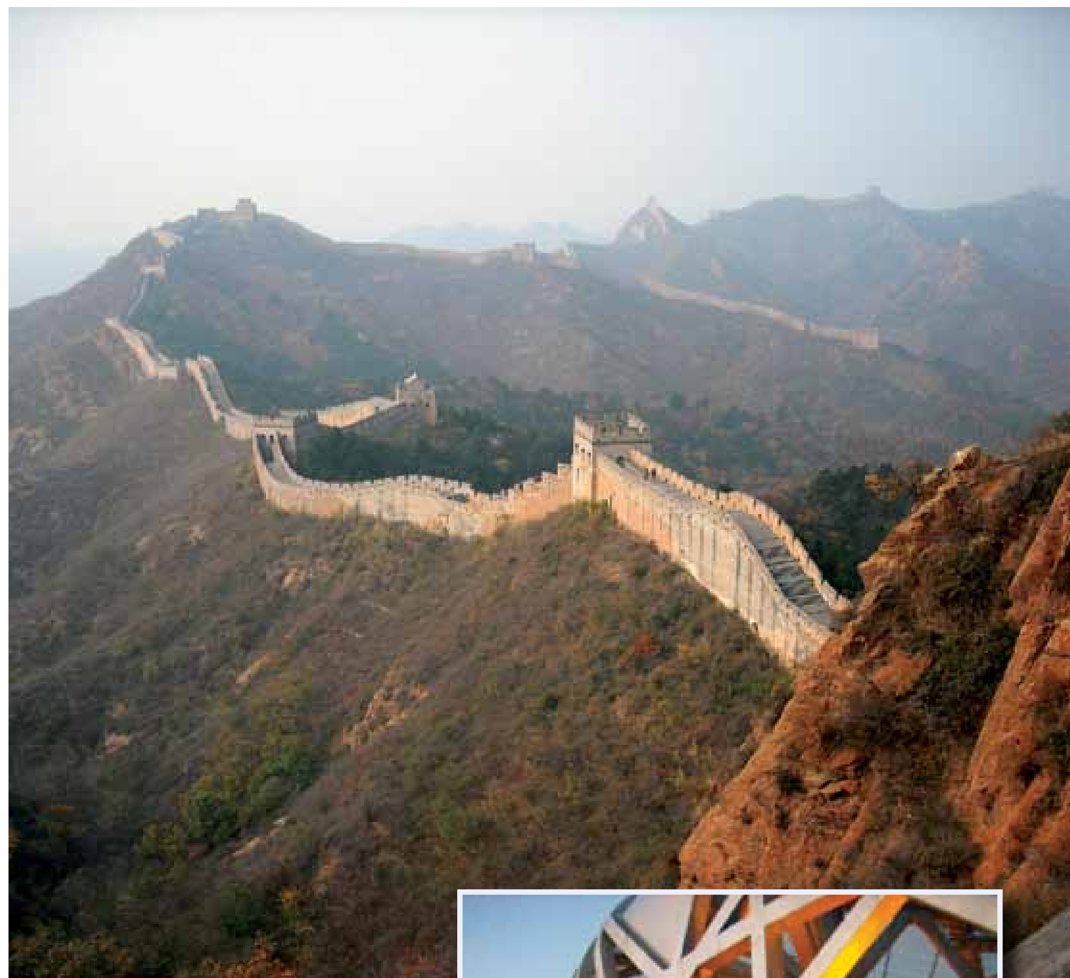
Driving on to Datong to visit the spectacular Hanging Temple, built 1,400 years ago, we travelled through mountainous country and in the distance saw remnants of the Great Wall.

Its temple clings to the rock half way up a sheer cliff with bamboo poles and is uniquely dedicated to the three main religions – Buddhism, Taoism and Confucianism. Climbing up the narrow stairs and passageways glued to our guide was scary, but nothing compared to looking down into the ravine over low knee-high guard rails. Health and Safety would have closed it down in the UK!

Hanging out with the locals

A six-hour train journey from Datong with the locals was quite an experience and I won't comment on the loos! Families take over a group of seats and produce all kinds of food and drink for the journey. We were certainly considered the entertainment as everyone stopped for a look when they passed by.

Our last stay before Beijing was in Chende which was the Emperors' Mountain Resort and the Temples of Punning and Putuozongsheng are spectacular (the latter is modelled on



the Potala palace of Lassa in Tibet). The gold on the roofs of the temples and the paintings in the buildings with dragons, trees, plants, fish and people are beautiful and colourful.

We left Chende early and were rewarded with being all on our own on the Great Wall. We walked for a few hours and enjoyed the solitude – something in short supply in China – before being joined by others trekking along the wall. It was here I met a man from Ireland! The wall is truly amazing as it snakes away into the distance up and down over hills and mountains as far as the eye can see.

Winding up

We had eaten all sorts of food as we toured around. Some was questionable as to what exactly it was since at times we had great difficulty in translating some of the menus, even with pictures! But I'm happy to report that neither of us was ill or needed the Cipro or Imodium I carried throughout the trip.

In Beijing we said goodbye to our guide and driver, and stayed with some friends which was a very nice conclusion to our trip. We visited Tiananmen Square, the Summer Palace and Gardens, the Temple of Heaven and some local markets where my friend Jacqui was having a dress made for a ball. I had a great time there, bartering with the stall holders for some gifts to bring home.

We finished our trip with a visit to the Birds Nest Stadium and Water Cube. Standing in the centre of the stadium looking around at all the costumes displayed from the opening and closing Olympic ceremonies was magical.

China is an amazing place and we have been left with many happy memories of the wonderful trip.

Joyce Skeet RGN, MSc (Travel Medicine), MFTM (RCPSG) is a member of the Travel Health Forum Committee.

TROPMEDEX Kenya 2009

vector prevention and control projects throughout Western and Coastal Kenya. These visits were to be interspersed with lectures on diseases endemic in Kenya, travel medicine issues and the chance to gain practical laboratory experience in the tropics. The tour also promised an opportunity to experience Kenyan culture and to see parts of this great country, not usually visited by tourists.

My travel companions came from all over the world, from various disciplines of medicine and nursing, and included seven doctors (including a microbiologist) and three nurses (myself, a practice nurse from the UK and a public health nurse from Canada).

Our tour leader and mentor was TROPMEDEX Director Dr Kay Schaefer, a consultant in tropical medicine and traveller's health in Germany and in leading medical institutions in East Africa. Dr Schaefer has lived and worked in Africa for over 20 years, speaks Kiswahili and has an enduring respect, passion and understanding of Kenya and her people. He proved an excellent mentor and guide.

On the road

As we left the bustle of Nairobi and took to the open road, the perils of travel by vehicle in a developing country were immediately apparent! Some major roads were well maintained with good surfaces, but this was not the case in more remote areas. Here, roads were rough and pitted with potholes.

It was evident that some Kenyan drivers habitually drive on the wrong side of the road. Not so our expert driver, who dodged the potholes and/or occasional oncoming petrol tankers and people-heavy matatus (mini-buses used as share taxis) with consummate skill. We held onto our seats and to the fact that

VCT promoting awareness and testing at Presbyterian Church of East Africa, Kikuyu Hospital

he had done the run from Uganda to Mombasa, Kenya with heavy freight for years and knew our route well.

On our trip, safety was never compromised, particularly regarding transport. Nevertheless, it is a fact that most deaths and injuries attributed to road traffic accidents each year occur in low- to middle-income countries.[3,4]

‘Safari is the Kiswahili word for “journey” and my journey was to take me a world away from the long lenses and five star comforts with which I was more familiar.’

For this reason, independent driving by inexperienced tourists in Kenya is definitely not advisable. Seeking out a reputable driver and vehicle is a far safer option.

On the day of our departure from Nairobi, the big news in Kenya was that of an overturned petrol tanker on a major highway near Nakuru. Hundreds were killed as the fuel exploded. The scale of the disaster was such that the story was still in the news two weeks later.

AIDS – the real disaster

Shortly after learning about this disaster, a Kenyan nurse said to me "HIV and AIDS

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Dr Elizabeth Meyerhoff and a brave little patient

is Africa and Kenya's disaster" and indeed it is, though Kenya seems to be meeting the challenge of this devastating disease and the number of infections appear to be stabilizing.[5] Early diagnosis and treatment provides the best chance for long-term health and testing is encouraged.

Billboards advertising Voluntary Counselling and Testing Centres (VCTs) are common in towns and larger villages. Often staffed by volunteer counsellors, VCTs were available at most health care facilities we visited. Nevertheless, more VCTs and more intensive outreach programmes are required to promote awareness and facilitate testing, particularly in less accessible rural and remote areas.

Anti retroviral drugs (ARVs) are currently provided free of charge by the Kenyan Government (triple therapy with the generic ARVs, stavudine, nivarapine and lemvirudine). In some areas, those with a positive test are entitled to supplementary feeding with maize for themselves and their family, provided by overseas and religious organisations. This is particularly valuable at a time when the past two harvests have failed, leaving people hungry and under-nourished.

Love and hope

In the Rift Valley village of Kampi ya Samaki, a hot remote place with limited medical facilities, we were privileged to be invited to talk to two young HIV infected individuals, who provided us with an insight into how a positive diagnosis of HIV impacts personally, on their family and the community.

With the support of a local American woman, a long term resident of Kenya, these mentally positive, brave and inspirational young people had formed the "Love and Hope Club" with the aim of reducing the stigma of the disease in their community and providing education, support and financial security (by selling eggs) for each other and other members of their group.

In this stunningly beautiful place, close to the shore of Lake Baringo, you could be forgiven for thinking you were in paradise, but all is not as it seems and life here can be harsh. As with elsewhere in Kenya, many parents and extended family have been lost to HIV/AIDS and young children are left to raise their younger siblings.

Improvisation and wound management

In Kampi ya Samaki, Dr Elizabeth Meyerhoff, an American social anthropologist with no formal medical training, runs a clinic where she and a trained nurse provide treatments for the local community.

Many of their patients are very young burn or scald victims, their injuries sustained as a result of falling into fires or coming into contact with boiling water or, often, boiling porridge. Through trial and error and dogged determination, Elizabeth has developed a wound management technique for burns, using tetracycline, petroleum jelly and silver paper (first from cigarette packets and most recently survival blankets).

In an environment where infection is a problem and wounds are slow to heal,

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TROPMEDEX Kenya 2009

Infant clinic at Marigat (picture by Catherine Boak)

> *... of the ubiquitous suggestion box on the wall outside the building, one of the visitors muttered: "we could suggest more doctors, more nurses, more money and a bunch of cleaners for a start!"*

she has achieved incredible results, but remains well aware of her limitations. Cases she cannot deal with face a 40 km journey to a local district hospital, which is often logistically and financially out of the question.

The clinic relies on charitable donations of equipment and money. In addition to running the busy clinic, Elizabeth and her husband are committed to the health and wellbeing of the Kenyan people and direct the operations of the Charitable Trust, Rehabilitation of Arid Environments (RAE), from their home in Lake Baringo district.[6]

Good people driven by a desire to care

Marigat is a small rural town in Baringo, Rift Valley Province, with nothing much to distinguish it from all the other small rural towns in Kenya. Busy women walk along the dusty streets, carrying huge loads on their heads supported by neck muscles of iron. Men languish in the shade, doing nothing much. Scabby dogs take their chance and lie in the middle of the road in full sun.

Kenya, it seems, is full of good people driven by a desire to provide the best care possible in difficult conditions with limited resources (not only money, but water, electricity, sanitation and so on). At Marigat Sub-District Hospital, we met such a person. Here a young Maasai woman, proud of her heritage and of her position as a Clinical Officer, was an inspiration.

She told me Maasai women did not often get the chance to be educated to the level she had achieved and she exuded passion for her work and her country. Clinical officers have a Diploma in Clinical Medicine and Surgery, complete an internship for one year after basic training and may go on to do a postgraduate diploma in anaesthesia, paediatrics or other specialities.

After this, many work in health care facilities, such as the hospital in Marigat, undertaking comprehensive medical responsibilities. This is normal for Kenya, where qualified doctors are in short supply. The depth of this young woman's medical knowledge was impressive as she presented each case during ward rounds.

The ubiquitous malaria

Malaria, malaria, malaria – unsurprisingly the most vulnerable made up the majority of inpatients (babies aged between six and 18 months, pregnant women and AIDS patients). The infective parasite, where identified, was exclusively *Plasmodium falciparum* and treatment was, in this setting, intravenous (IV) quinine and supportive care.

Accurate diagnosis, effective treatment and follow up are critical for the satisfactory management of malaria (and other diseases). In the facility we visited in Marigat, laboratory facilities were available, but most people were admitted during the night and diagnosis and treatment was usually initiated without the benefit of laboratory blood analysis.

Here in Africa, taking a medical history and performing a thorough physical clinical examination form the cornerstone to accurate diagnosis; the physician often has limited or no access to advanced medical technology.

In Marigat, we were told that those we saw with a diagnosis of malaria who were receiving IV quinine were responding. Most were making a good recovery, but some were, despite treatment, clearly still very sick.

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Dr Kay Schaefer lectures on haemorrhagic fevers

One man had been brought many kilometres and was suffering from cerebral malaria. His convulsions and agitation were proving problematic to treat. Alone and unsupervised he fell crashing to the floor from his bed during our visit. There were just not enough nurses to allow the special individual care that might have been lavished in a European hospital.

Another optical illusion

Climbing out of the great Rift Valley into the lush and fertile highlands of Rift Valley Province, we were struck by how well nourished the people appeared compared to those who were struggling in the heat and drought of the valley below. Again, all was not as it seemed.

We journeyed onward toward the town of Eldoret, at an altitude of 2,100 metres. Perhaps most famous for being the home of Kip Keino and other long distance athletes, we were reminded that it was on the outskirts of this normally peaceful, agricultural town in early 2008, that men, women and children, seeking refuge in a church, perished when their sanctuary was burnt to the ground in one of the most violent events in the aftermath of the 2007 elections.

Reaching the faith-based mission hospital in Kakemega, we were greeted with characteristic politeness and enthusiasm. Our visit was an opportunity for multidisciplinary learning, and nurses and doctors joined us for a lecture given by "Dr. Kay" on haemorrhagic fevers (Marburg, Ebola, Yellow Fever and Rift Valley fever).

Asante sana ... karibu

During the ward round that followed, we were introduced, in a darkened room, to a woman looking much older than her 32 years and clearly weak, subdued and with visual disturbance. She had been "lucky".

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TROPMEDEX Kenya 2009

Crude, but effective laboratory testing of her cerebrospinal fluid (CSF) had enabled a quick identification of cryptococci and a diagnosis of cryptococcal meningitis and cytomegalovirus (CMV) retinitis had been made. Slow infusion of the antifungal drug, Amphotericin B was commenced, the glass bottle infusion and giving set protected by black masking tape to protect the light sensitive drug within.

She had, presumably, yet to come to terms with her newly diagnosed HIV positive status and the cocktail of drugs that would be required to sustain her over the coming years and sat submissively, seemingly oblivious to her predicament, while we discussed her in a foreign tongue. On leaving, I took her hand and thanked her, "*asante sana*" – "*karibu*" (you are welcome) she replied, smiling shyly, but not seeing.

Mosquitoes danced lazily in the still air, waiting for their opportunity to feed. At night all the beds here were covered by bright blue mosquito nets, which during the day hung messily from a high hook in the ceiling over each bay.

The price of care

Despite fairly basic equipment, at least by western standards, one got the impression that this hospital was providing a good standard of care. However, the wards were empty, partly because this was dry season (with little malaria, though malaria is omnipresent in Kenya, whatever the season), and partly because the Government hospitals had reduced their charges so patients chose to go there rather than pay the relatively higher costs of the mission hospital.

At a later visit to a large, Government hospital on the coast (40 km south of Mombasa), the state of the Kenyan health system became evident. To my eyes, wards were in a depressing condition. There were often no sheets on the beds, no soap, and equipment was tired and dated. There seemed a general air of dereliction in a surprisingly young building which, on opening, must have been a showpiece hospital.

Despite working in seemingly difficult conditions, the doctors, clinical officers

Hilary at the AMREF hangar, Wilson Airport, Nairobi

and nurses appeared caring and enthusiastic, and up to speed clinically. Diseases peculiar to the tropics filled every bed here: filiariasis, malaria with profound anaemia, spinal tuberculosis with paralysis and HIV/AIDS. All were presented to the visiting medics with utmost professionalism and with consent from the patient.

Nevertheless, of the ubiquitous suggestion box on the wall outside the building (we saw many on our journey!) one of the visitors muttered "*we could suggest more doctors, more nurses, more money and a bunch of cleaners for a start!*"

Travellers' health

It should be said that Kenya does, however, have some excellent health care facilities. On the coast and in major cities, as a tourist needing medical help, these are the establishments to which you are likely to be referred (gastroenteritis, heart attack and accidents are commonplace). Usually run and funded privately, such clinics and hospitals provide high standards of care and often state of the art facilities (dialysis and ICU), and staff with specialist skills.

Services are offered presuming the patient has the required financial resources to meet the bill, though sometimes exceptions are made. The importance of travel insurance and pre-travel investigation into available medical facilities became crystal clear!

Another valuable service for tourists and Kenyan people alike is the superb African Medical Research Foundation (AMREF).[7] AMREF has an excellent laboratory undertaking research and providing a teaching and diagnosis facility, but is perhaps best known for their long range air rescue and repatriation service. Staffed by expert doctors and nurses, trained in trauma, ICU and anaesthesia, each aircraft and ambulance is kitted out with an impressive range of medical equipment.

In addition the Flying Doctor Outreach service provides expert medical and surgical help to isolated government and mission hospitals in remote Kenya. Funding is by membership (very cheap for tourist travellers) and unused membership supports charity evacuations for the poor.

Beauty and the beast

Returning to the leafy suburbs of Nairobi, I sat in the guest house garden and watched, fascinated, as a beautiful black and white striped *Aedes aegypti* fed persistently on me, despite the DEET I had meticulously and liberally applied. I reflected on my journey in Kenya, knowing that, even in such a short time I had experienced something special and life changing, and I vowed to return.

Thanks to Dr Kay Schaefer, MD PhD MSc DTM&H, and to Dr Elizabeth Meyerhoff, PhD, and to my colleagues Professor David Hill at NaTHNaC and Dr David Lalloo at LSTM.

Further information: www.tropmedex.com

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6. The Rehabilitation of Arid Environments Charitable Trust at: **www.raetrust.org**
7. AMREF Flying Doctors Service at: **www.amref.org**

Further reading:

Linking sexual and reproductive health and HIV/AIDS, Gateways to integration: a case study from Kenya, prepared and published by WHO, UNFPA, UNAIDS, IPPF at: **http://data.unaids.org/pub/Report/2008/20080923_linkages_kenya_en.pdf**

FOCUS ON MALARIA

Here and on the next four pages we take an in-depth look at the current state of play worldwide, including a comprehensive summary of an RCN/BTHA conference on good practice for travel health advisers.

Conference summary by JANE POWELL, GlaxoSmithKline (GSK) Travel Health. The conference and exhibition were wholly sponsored by GSK and Jane attended in her role as Brand Manager.

Malaria: The facts for determining good practice

RCN Travel Health Forum and the British Travel Health Association Joint Conference and Exhibition • Monday, 8 December 2008

- **Malaria in travellers: Continuing public education is key to prevention**
- **VFRs are key targets in the fight against malaria**
- **Fifth malaria variation emerging in European travellers**
- **ABCD: Still at the heart of malaria education**

In early December the RCN Travel Health Forum (THF) and the British Travel Health Association (BTHA) held a joint conference dedicated to the prevention of malaria. It may have been a cold winter morning in London, but the delegates were undaunted in their quest to learn more about this tropical disease and, with 140 attendees and experts in the field sharing their knowledge, the house was full.

Opening address

Following the THF Chair Sandra Grieve's opening remarks, Dr Peter Carter OBE, Chief Executive & General Secretary of the RCN, welcomed delegates to the study day and spoke about the current period of changes and challenges the THF was experiencing. This was mainly due to the merger with four other RCN forums uniting to form a Public Health Forum and the ever-changing global threat of infectious diseases, exemplified by the recent cholera outbreak in Zimbabwe. Dr Carter highlighted that there was a clear need for educational initiatives and further study days to support nurses during this challenging period.

Information and resources on malaria

The first speaker of the day was Jane Chiodini, Travel Health Specialist Nurse, who had succumbed to a winter virus and had effectively lost her voice. She

NEWSNEWSNEWS

Malaria imported to Europe from the Gambia

The WHO Weekly Epidemiological Record on 30 November 2008 reported:

"In recent weeks, several European countries have reported unusually high numbers of cases of *P. falciparum* infection in holiday travellers to the Gambia (West Africa) who had not taken adequate protective measures against malaria.

"This includes Finland, where in November 2008 a total of 12 tourists were diagnosed with falciparum malaria after travelling with inadequate chemoprophylaxis (three patients) or zero prophylaxis (nine patients). In Denmark, eight cases including one death were reported among tourists who had not taken antimalarial chemoprophylaxis.

"Since September 2008, the Netherlands has reported eight imported cases, including one fatal case in a tourist who had taken inadequate chemoprophylaxis. The United Kingdom has reported that at least 12 of the 17 travellers who fell ill with malaria after visiting the Gambia had not taken any chemoprophylaxis."

This was situation was unusual in that many travellers were infected within a short period. A common feature was last minute travel and discounted offers, and most tourists had not sought information about malaria risk, the need for prophylaxis or vaccinations.

West Africa has the highest risk of malaria anywhere in the world, and malaria prophylaxis is recommended for all visitors. **Keep this in mind for travellers going to the Gambia during the same period in 2009.**

VFR travellers to Nigeria and Ghana still bear burden of malaria

Figures released by the Health Protection Agency show that UK travellers visiting friends and family abroad, particularly in Nigeria and Ghana, continue to be the group most likely to acquire malaria. In 2008, of 1,370 cases reported in the UK, 71 per cent of those where the region of travel was known had visited West Africa. Countries with the highest number of cases were Nigeria (492) and Ghana (148).

While there has been a fall of 178 in total cases compared to 2007 (1,548 cases), the total from Nigeria was unchanged at 492 for both years and there was only a modest fall in cases from Ghana (185 in 2007). Among those who were travellers from the UK (rather than normally resident in an endemic area) where reason for travel was known, 552 of 716 (77 per

proceeded stoically and came prepared, presenting her slides with speech bubbles against the background music of The Tremeloes hit *Silence is Golden*. However, what her presentation lacked in volume, it certainly made up for in content. She provided attendees with a valuable overview of the resources available nationally and internationally on malaria prevention, including:

- Health Protection Agency (HPA) Malaria Reference Laboratory, guidelines and regular updates on malaria epidemiology reporting, for example, recent increased incidence of malaria in the Gambia
- The World Health Organization (WHO) website and its new Malaria Report (available at www.who.int/malaria)

Other websites such as:

- Centers for Disease Control and Prevention (Atlanta)
- Health Protection Scotland's Travax for health professionals and Fit-for-Travel for the general public
- The National Travel Health Network and Centre (NaTHNaC)
- Malaria Hotspots

Educational materials:

- The third edition of the Wellcome Trust's CD available from: www.malaria.wellcome.ac.uk
- A new malaria educational resource called *Malaria matters: best practice in malaria prevention*. It is an RCN-accredited training initiative developed by Jane Chiodini, and produced and funded by GSK. It includes a number of features such as animations, case studies and best practice consultation video clips. For more information or for a copy, call the Virgo HEALTH press office on 020 8939 2479.

Jane Chiodini also underlined the importance of referring to these and similar resources regularly in order to stay abreast of travel health developments, such as the newly emerging malaria strain in humans called *Plasmodium knowlesi*.

Knowledge, attitudes and practices of African visiting friends and relatives (VFRs)

Penny Neave, Health Protection Specialist and Health Strategist at the HPA, explored the challenges associated with offering travel health advice to VFRs – a notoriously difficult sector of the population to reach and treat who:

- are mostly based in London, in areas such as Southwark
- may not present for malaria advice believing they already have immunity
- typically do not adhere to the "ABCD" of protection
- may not stick to their antimalarials for a number of reasons, including a belief that prophylactics challenge their African heritage
- perceive malaria as being less serious than typhoid; malaria is viewed as a flu-like illness and it is also confused with a simple fever
- may not present for treatment as they fear being isolated in hospital
- accounted for approximately two-thirds of imported malaria cases last year (the majority of which came from West Africa, with other cases from countries such as Uganda and Sierra Leone).

Penny explained that reluctance to take antimalarials has led to VFR men being twice as likely to die from malaria infection as women and reiterated the importance of recommending chemoprophylaxis: about half of the fatal cases of imported malaria occur in travellers who had taken no chemoprophylaxis.

Ultimately, it is important to remember when working with Africans or African VFRs that this group is not homogenous. Indeed, wide-ranging cultural preferences and socioeconomic factors will shape behaviour of each traveller.

Grappling with mosquitoes!

In the next session, Dr Nigel Hill, an entomologist from the London School of Hygiene and Tropical Medicine, assessed bite prevention methods available for travellers. He emphasised that they should be evaluated in terms of suitability in different circumstances and efficacy, recommending:

- insecticide sprays (containing DEET)
- coils – cheap and relatively effective
- vaporisers – can be highly effective
- sprays – which interfere with mosquitoes' navigational sensors
- nets – an article in the *BMJ* showed an 80 per cent reduction in malaria in patients using nets.[1]

›

cent) were visiting friends and relatives (VFRs) in their country of origin.

Previous research has shown that VFRs are less likely than other travellers to report using malaria preventative measures and, compared to other groups, are more likely to acquire malaria. The overwhelming majority (79 per cent) of all cases of malaria diagnosed in the UK were due to *Plasmodium falciparum*.

Full report at: **www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1195733773780?p=1191942128262**

New HPA publication on VFRs

Health Protection Agency. (2008) *Foreign travel-associated illness – a focus on those visiting friends and relatives*, London: HPA. Order hard copies free at: **tmhs@hpa.org.uk** or read online at: **www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1231419801008?p=1158945066450**

But congratulations to Zambia!

WHO has announced that malaria deaths reported from health facilities in Zambia have declined by 66 per cent. Along with other supporting data this indicates that Zambia has reached the 2010 Roll Back Malaria target of a more than a 50 per cent reduction in malaria mortality compared to 2000. On World Malaria Day (25 April), Zambia's efforts were promoted as a model for other countries. Rwanda, the United Republic of Tanzania, and Sao Tome and Principe have also achieved major reductions in malaria mortality through accelerated malaria control activities.
www.rollbackmalaria.org

FOCUS ON MALARIA

Dr Hill then briefly discussed the methods that he wouldn't recommend to travellers because they have been shown to be ineffective, including:

- buzzers
- vitamin B1 supplements
- foods such as chilli or garlic.

Malaria in returning travellers

In the final morning session, Dr Nick Beeching, Senior Lecturer and Clinical Lead in Infectious Diseases from the Liverpool School of Tropical Medicine, reviewed the latest trends in imported malaria rates. In particular, he highlighted that, although initially it was thought that incidence would decline from the 1950s onwards, malaria is currently resurgent.

Dr Beeching explained that the biggest problems preventing the successful treatment of malaria cases are delays in presentation and delays in diagnosis and treatment. For instance, he recalled three deaths from malaria in Liverpool that were caused by delays in diagnosis. A history of travel should always be recorded, and doctors and nurses investigating illness in travellers returning from malaria endemic regions should always consider malaria as a possible diagnosis until it can be excluded.

With regards to the treatment of malaria infection, Dr Beeching urged delegates to:

- identify what stage the disease is at: blood stage or liver stage
- remember malaria can still be present one-to-two years after travel
- refer to the algorithm available from www.britishinfectionsociety.org for further information.

One of the most recent and important developments that Dr Beeching discussed was the identification of *Plasmodium knowlesi*, a new form of malaria originally found in monkey hosts, but now recognised to cause disease in humans. It is prevalent in Thailand and Malaysia, and is now emerging in travellers returning from these areas to Europe.

Case scenarios and Q&A session

Following lunch and an opportunity to visit the exhibition where various resources available to the delegates were demonstrated, Dr Nick Beeching chaired a panel discussion and interactive session with Diane Parsons, Senior Nurse at InterHealth, representing the THF and Claire Wong, Travel Health Nurse Specialist from NaTHNaC, representing the BTHA. They considered case studies of travellers visiting four at-risk areas (Goa, Guinea, the Caribbean and South America), which illustrated that:

- The prevalence of malaria can vary within a given geographical area. Therefore travel health professionals need to maintain an up-to-date knowledge of at-risk areas.
- It is important to highlight the additional risks malaria poses to women who are pregnant or breastfeeding. It is also advisable for them to find out about health provisions available at their destination.
- Not all areas of at-risk countries require prophylaxis so it is important to determine exactly where travellers are visiting.
- Different antimalarials are recommended for different areas and an appropriate drug must be selected that will protect the patient for the entire trip – that is, one that will not require them to switch halfway through their travels should they have a multi-destination itinerary.

I'll never get malaria

Tim Beacon, Director of the Outdoor Experience, emphasised the importance of assessing travellers' risk of exposure to malaria during adventure travel and that awareness and preparation were crucial for prevention. He reiterated the importance of:

- communicating effectively with travellers to advise them on malaria prophylaxis, using plain language at all times. He advised that using complicated medical terminology caused the traveller to switch off, resulting in the rest of the advice given in a consultation being forgotten

NEWSNEWSNEWS

Malaria Consortium

The Annual Review of the Malaria Consortium for 2007-2008 is at: **www.malariaconsortium.org/~malaqkmt/userfiles/Annual%20Review%202007-08%20Final%20(2).pdf**

Malaria guidelines

Make sure you have a copy! *Malaria guidelines for travellers from the UK* is available free in hard copy and can be downloaded from: **www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1195733823080?p=1191942128258**

Celebrities join the malaria battle

Sports celebrities David Beckham, Andy Murray and Olympic gold medallist Denise Lewis met with Prime Minister Gordon Brown in April to back the "Malaria No More" UK campaign.

The athletes urged Mr Brown to meet his promise to deliver 20 million malaria nets to Africa by next year. So far almost 10 million nets have been delivered and a further 1.9 million are pending from the UK. David Beckham said: "For less than the cost of a football you can protect a family from dying. I urge the UK public to get behind the Malaria No More UK campaign to save a life and make malaria no more."

Beckham and Murray are members of the Malaria No More UK Leadership Council: **www.malarianomore.org.uk**

All Party Parliamentary Malaria Group

The APPMG has launched its fourth report, *Delivering control to those in need: how to succeed in a time of real hope*. As the title implies, they had gathered evidence from around the world throughout the year and were able to be more optimistic than in the first report, published three years ago.

- following the four key steps for malaria prevention:
  Awareness
  Bite prevention
  Chemoprophylaxis
  Diagnosis.

When he was a young traveller, Tim recalled, vital information regarding malaria prevention was unavailable. This led to many of his friends contracting malaria because they were unaware of the risks. Today, he said, there was no excuse for travellers to be unaware of malaria and how to prevent it, but he still thought there was a need for education.

The role of pharmacists in malaria advice

In the following session, Professor Larry Goodyer, Head of the School of Pharmacy at De Montfort University, described the current provision of travel health advice – especially on malaria – as delivered by community pharmacists. He explored the role pharmacists can play in advising travellers on malaria prevention, including:

- the changing role of pharmacy as a provider of services within the NHS. For example, they currently provide advice on bite prevention and antimalarial prophylaxis, either supplying chloroquine and proguanil or referring to medical and nursing colleagues for prescription only products; however, pharmacists are becoming non-medical prescribers.
- the scope for establishing travel clinics in community pharmacies, led either by pharmacists or nurses.

Malaria: advice for children and young people

The final session of the day saw Dr Delane Shingadia, a consultant in paediatric infectious diseases at London's Great Ormond Street Hospital, discussing the challenges faced in the prevention of malaria in children and young people. In particular, he focused on the following points:

- Most malaria in children occurs in VFRs, who often consume local produce or water and stay in rural areas without equipment for bite prevention.
- VFRs should be targeted by health care professionals to ensure that they receive accurate information and use preventative measures.
- Many parents may wrongly believe they have "natural immunity" and also that this immunity is transferred to their children.
- The importance of prescribing appropriately in children: less than half take prophylaxis and only a third of this is appropriate for the areas to which they are travelling.
- Parents need to be alerted to seek prompt treatment for their children if they are ill on return from a malaria endemic area.

Dr Shingadia went on to acknowledge that the source of pre-travel advice in VFR populations is often not clear, with risk factors associated with this group different to the general population. Often VFRs will travel to at-risk areas while pregnant, with children or while unwell with multiple other illnesses. They also frequently arrange travel at the last minute with little time to seek professional advice – and many simply don't ask for advice at all.

At the close of the meeting Dr John Davies, Chair of the BTHA, and Sandra Grieve underlined that malaria is a preventable disease that should be at the forefront of travel health advice for people visiting endemic regions of the world. The high turnout for the event illustrated the desire for up-to-date knowledge as well as the importance of continuing education and sharing best practice in travel health.

[1] Hill N, Lenglet A et al. (2007) "Plant based insect repellent and insecticide treated bed nets to protect against malaria in areas of early evening biting vectors: double blind randomised placebo controlled clinical trial in the Bolivian Amazon", *BMJ* 2007;335(7628):1023.

Malaria No More gets new Ambassador

Jo Yirrell's son died of malaria three years ago. Harry was building schools in Ghana. He thought the local people needed his malaria pills more than he did and left them behind. Sadly he died of malaria a week after returning home to the UK.

Since then his mother has campaigned to raise awareness of malaria and how to prevent it. As an ambassador for the Malaria No More charity, Jo visited the fishing village where Harry worked to see for herself why he loved Ghana and its people, and to try to work with the locals to beat the disease. In June she met International Development Minister, Mike Foster to discuss the campaign.

Jo tells Harry's story at:
www.malariahotspots.co.uk/beenThere_vid12.asp

Malaria matters: Best practice in malaria prevention advice

This educational CD-ROM is designed to enable users to become fully conversant with malaria prevention. The interactive tool is divided into five modules and includes an animated version of the malaria lifecycle, and "real time" interactive case studies and patient consultations. The CD was written by Jane Chiodini, former THF Chair, and has gained RCN accreditation. It is also endorsed by the British Travel Health Association and supported by a grant from GlaxoSmithKline Travel Health.

New name for APPMG

Malaria will remain the main focus of the group's activities, but there are many other diseases in the developing world that do not have a voice. Thus the APPMG has extended its remit to cover Neglected Tropical Diseases (NTDs).
www.appmg-malaria.org.uk

DATES FOR YOUR DIARY

Out of this world

RCN Travel Health Forum Annual Conference and Exhibition
19 September 2009
Royal College of Physicians, London
Contact: kathryn.clark@rcn.org.uk
(see right, back page and enclosed flyer)

Travel medicine – communicating the message

The Royal College of Physicians and Surgeons of Glasgow
Faculty of Travel Medicine Annual Symposium
6 October 2009
RCPSG Glasgow
Website: www.rcpsg.ac.uk

Aviation Health Conference

International Air Transport Association (IATA)
6–7 October, 2009
London
Website: www.iata.org or www.quaynote.com
Email alison@quaynote.com
Telephone: 020 8348 3704

Occupational health practitioners: facilitating change

RCN Occupational Health Nursing Conference and Exhibition
Southport Theatre and Convention Centre
3-4 November 2009
Website: www.rcn.org.uk/newsevents/event_details/rcn_events/occupational_health_nursing_conference_and_exhibition

BTHA Annual Scientific Meeting

(focus on vector-borne diseases)
British Travel Health Association
28 November 2009
Charing Cross Hotel, London
Telephone: Diane on 0845 003 9197
Email: info@btha.org

MASTA Annual Study Day

4 December 2009
Royal Pharmaceutical Society, London
Email: medical@masta.org

NECTM3

Northern European Conference on Travel Medicine
26–29 May 2010
Conference Centre Hamburg
Website: www.nectm.com
(see back page)

RCN Travel Health Forum Annual Conference and Exhibition

19 September 2009
Royal College of Physicians, Regent's Park, London

Out of this world

Conference programme and booking form now available

As carriers face a declining demand for air travel, fares, especially those to long-haul destinations are cheaper than ever and travellers are taking advantage of this unprecedented situation. Nurses are seeing increasing numbers of travellers visiting their surgery for advice. In order to advise these travellers nurses in travel health medicine need to have current information, evidence and resources available to them.

Our expert speakers will address various issues including the newly updated 'Health Information for Overseas Travel' (The Yellow Book) and the Foreign and Commonwealth Office Campaign 'Know Before You Go'. Legal accountability for nurses advising travellers will be addressed along with changes to the use of Patient Group Directions for travel vaccines. Information on malaria and the importance of identifying illness post-travel will also be addressed.

Further information:

For further details about the conference programme, please contact **Kathryn Clark**, RCN Events, Royal College of Nursing, 20 Cavendish Square, London. W1G 0RN
Tel: **020 7647 3585** Fax: **020 7647 3411**
Email: **travelhealth@rcn.org.uk**
Website: **www.rcn.org.uk/events**

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STOP PRESS

The enclosed Flyer refers on the programme listing to the publication "International Travel and Health – The Yellow Book". In the introduction the publication "Health Information for Overseas Travel (The UK Yellow Book)" is the correct title. Please be aware that Dr Field will address the UK publication.

from the journals

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Royal College of Nursing

15th International Network for Psychiatric Nursing Research (NPNR) Conference 2009

Thursday 24 – Friday 25 September 2009
Oxford University, Oxford

Student day rate only
£30

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- **Measuring outcomes in mental health nursing**
- **Research into practice: Practice development**
- **Service users and carers' research**
- **Research in education**
- **Social inclusion**

For further information contact:
Laura Benfield
+44 (0)20 7647 3591
npnr@rcn.org.uk
www.rcn.org.uk/events

Royal College of Nursing

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Primary Health Care... the complete view of community health nursing

*ABC 2006-2007

NECTM3

Northern European Conference on Travel Medicine

Congress Center Hamburg (CCH), Germany • 26–29 May 2010

Following the success of the Northern European Conference on Travel Medicine (NECTM2) in Helsinki we are pleased to be involved in NECTM3, taking place in Hamburg in 2010. The conference is once again being supported by Finland, Denmark, Norway, Sweden, Germany and Ireland, and the International Society of Travel Medicine – and from the UK by the British Travel Health Association (BTHA), the National Travel Health Network and Centre (NaTHNaC), Health Protection Scotland (HPS) and the RCN Travel Health Forum. As previously the programme will focus on regional travel-related issues.

Also once again we will offer some funding for two member places to enable attendance at this conference. The **closing date for applications is 31 August 2009** and the winners will be drawn at our annual conference on 19 September in good time for early-bird registration. A report for the newsletter is a condition of funding.

I would urge you to make sure you would be available to attend before applying as the offer is not transferrable. To apply, fill out the form at www.rcn.org.uk/travelhealth/1234 and tell us why you would like to attend.

Further information is available at: www.nectm.com

Out of this world

RCN Travel Health Forum Annual Conference and Exhibition

Royal College of Physicians, London

19 September 2009

We are funding two registrations for attendance at this conference. You need to be an RCN Travel Health Forum member to apply and must not have received RCN funding in the last five years. To apply, complete a Funding Form, available on the website at: www.rcn.org.uk/travelhealth/1234 and tell us why you would particularly like to attend.

A report for the newsletter is a condition of funding and we will welcome feedback and reflection on your experience. Help is available to produce this, if you need it. We urge you to make sure you would be available to attend before applying as the offer is not transferrable.

The closing date for applications is **Friday 31 July 2009.**

Don’t miss out!

From October 2009 all RCN forum newsletters are going to be emailed to members rather than posted. The content of your newsletter from the world of public health will be just as good if not better as we will be able to include additional information and link directly to useful resources.

A significant number of you have already opted into the electronic versions of the forum newsletters and we aim to continue to enhance our communications with you.

To receive your electronic newsletter simply go to: **www.rcn.org.uk/myrcn** and check we have a current email address for you.

Don’t forget that you can also check out the latest information and updates by going to your online community at: **www.rcn.org.uk/travelhealth**

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Tel: 0845 772 6100 Website: www.rcn.org.uk

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The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies