

# Travel Health

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

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## Further information

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## Letter from the Chair: Jane Chiodini

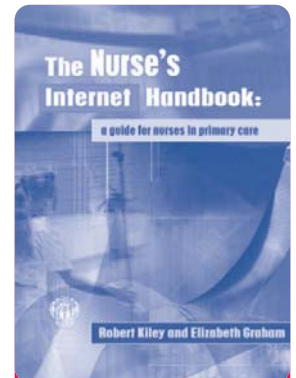
The Travel Health Forum has been exceedingly busy in recent months as this newsletter will reveal. We took the concept of our group to an international level (see page two) and discovered our innovation remains unique and a good model for other countries to follow. We also received particular praise for our newsletter – well done once again, Sandra!

Our joint collaboration for a meeting on malaria (page two) was another first and so successful we've had many requests to organise another one soon! We also advised on a project funded by an educational grant by Sanofi Pasteur MSD, in producing *The Nurse's Internet Handbook* (see inset), a superb publication that shows how invaluable a tool the Internet is for nurses from introductory to advanced level. It guides newcomers through the process of using the Internet and helps confident users explore more complex issues – there's something there for everyone.

The Internet is now our best resource for accessing up-to-date information on health risks for travellers, and in the future national guidelines, which help us make important decisions, may only be published online. That's why we must use this medium more and have protected time at work for doing so.

I've just seen the first draft of our guidelines for nurses working in travel health. This concept has been a long time in the making and I'm

really excited that our booklet will cover an aspect of travel health that is nationally lacking. We've kept the guidelines short but comprehensive and they will help you establish what you need at work to deliver travel health and education to a high standard of care, while exercising best practice. This is the first step on a road to developing competencies, our next plan. Sincere thanks particularly to Lorna Boyne, assisted by Alexandra Jordan, who with support from the Forum Committee have been mainly responsible for the guideline development.



Currently only available to Sanofi Pasteur MSD customers, it will be published in September (ISBN 1-85315-655-8) at £12.95.

## Letter from the Editor

We have a truly international feel to this summer edition.

The Boxing Day tsunami continues to have a huge impact on travel and travellers. Among many health care professionals who went to help in the aftermath, Sally Greenwood tells us of her personal experience on page 13, while Dr Andrew Lee urges caution for the well-intentioned on page 14.

Advice for those planning to attend the Hajj, the most important pilgrimage for Muslims, is of paramount importance in preventing illness and disease. Professors Abdul Rashid Gatrad and Aziz Sheikh share their expertise with us on page five.

A group of practice nurses found a winning formula when they produced a patient leaflet on travel health and, on page 12, Beverley Crapper tells us how they did it.

We've had several exciting conferences recently and for those who were unable to attend, the reports on pages two and three are the next best thing to being there. Meanwhile, we are active participants in next year's international travel health conference in Edinburgh, highlighted on page eight. Newsround, Bulletin Board and other information relevant to the field of travel medicine complete this edition.

Thanks to all contributors, enjoy the summer and travel safely.

It's been a busy season for conferences – thanks to members of the Travel Health Forum Steering Committee for sending in these reports!

## British Travel Health Association (BTHA) 7th Scientific Conference

5 March 2005 – Manchester

We awoke to blizzards in London and reaching Manchester's conference centre looked doubtful, but further north the snow disappeared.

The morning theme was *Health care while overseas*, where Dr Steve Illey's presentation provided an interesting look at the work of an international rescue service and Dr Dave Carroll's humorous and informative talk took us through the pros and cons of telemedicine.

Dr Jane Jones followed with information on the rates of tropical diseases imported into the UK. These are described by the 2004 baseline report available from [www.hpa.org.uk/infections/topics\\_az/travel/pdf/full\\_version.pdf](http://www.hpa.org.uk/infections/topics_az/travel/pdf/full_version.pdf)

Sheila Hall gave a timely reminder of how closely travel health is connected to the wider umbrella of world health. Contributing organisations include:

- World Tourism Organisation [www.world-tourism.org/](http://www.world-tourism.org/)
- Responsible Travel [www.responsibletravel.com/Home.htm](http://www.responsibletravel.com/Home.htm)
- Tourism Concern [www.tourismconcern.org.uk/](http://www.tourismconcern.org.uk/)
- Department for International Development's *Rough guide to a better world* [www.dfid.gov.uk/pubs/files/rough-guide/better-world.pdf](http://www.dfid.gov.uk/pubs/files/rough-guide/better-world.pdf)

The morning session concluded with the presentation of short papers and Fiona Genasi from Health Protection Scotland highlighted the Northern European Conference in Travel Medicine taking place in 2006 (see page eight – Ed).

After lunch, John Williams reminded us of the impact of malaria in endemic areas, followed by Dr Nick Beeching's presentation on infection in challenging

sport, looking at infectious, vector borne and sexually-transmitted diseases, and the risks and special needs of athletes.

Dr Carroll finished the programme with a talk on the pregnant expatriate – first, advice on what to expect and finding prenatal and delivery care overseas, and second, catering for the prenatal care of foreign nationals who don't speak the language or know the system in the host country.

### Take home messages

- Over 50 per cent of injections in the developing world are unsafe.
- Over half of UK-born heterosexuals diagnosed with HIV between 2000–2001 were probably infected abroad – 10 per cent probably in Thailand.
- Mild photosensitivity occurs in approximately three per cent of those who take doxycycline; the risk of severe dermatitis is 1/10,000.
- Between 11 and 46 per cent of travellers comply with malaria prophylaxis. The highest risk time for defaulting is during the post-trip completion of regime.
- Diarrhoea in pregnancy increases risk of ketosis leading to dehydration, which can cause prematurity and spontaneous abortion.
- No vaccine has a known teratogenic effect (that is, causes developmental defects in a foetus).

This was an enjoyable and informative day that provided ample opportunity for discovering new facts from a wide variety of travel health topics, discussing the latest ideas and meeting with colleagues and friends.

**Alexandra Jordan**

## Joint Malaria Meeting

14 April 2005 – RCN London

Dr Pat Schlagenhauf, Research Scientist from the University of Zurich and leading authority on malaria, started the day with a reminder of the problems and trends of imported malaria.

Professor Chris Curtis from the Hospital for Tropical Diseases in London followed with advances in bite prevention. Professor Curtis passed around jars containing mosquitoes (non-infected) and proceeded to demonstrate the effectiveness of insect repellents in preventing bites. This interactive period proved very popular for everyone except the mozzies, who apparently prefer warm, smelly feet to fresh feet. Between two and three in the morning is the worst time for bites.

Dr Barbara Bannister, Chair of the Health Protection Agency Advisory

## 9th Conference of Travel Medic

Over 1,700 delegates gathered in Lisbon on 1 May for the conference, which was preceded by a nurses' welcome meeting co-hosted by our Forum Chair, Jane Chiodini. This was a valuable opportunity for nurses from around the world to share their experiences of working in the field of travel health.

The UK still appears to be unique in having a large organised group of nurses such as the RCN Travel Health Forum.

The opening ceremony heralded a fascinating three-and-a-half days of lectures, symposia and workshops. The relevance of Lisbon as a venue for a travel medicine conference was emphasised during the opening remarks, with a reminder of Portugal's maritime

# RCN and the Royal Society of Tropical Medicine and Hygiene (RSTM&H)

Committee for malaria prevention in travellers from the UK, discussed malaria chemoprophylaxis and the choices available. Advice for travellers with pre-existing conditions like pregnancy, epilepsy and renal or liver impairment was considered, together with the interaction of some malaria drugs in those with heart disease.

Problems related to the group of travellers known as “visiting friends and relatives” (VFRs) were explained by Dr Delane Shingadia, Senior Lecturer in Paediatric Infectious Disease in London. We were encouraged to think of the possibility of malaria in these children following school holidays in January/February and July/August, as parents from this group think they and their children are immune to malaria. Statistics show that 58 per cent took no

prophylaxis, 42 per cent took some, but only 15 per cent took the correct medication for the country visited.

Following lunch Marie Blaze explained her role as Senior Adviser at the HPA Malaria Reference Laboratory in “manning” the phones, and discussed the 10 most frequently asked questions from health professionals.

Jane Chiodini, Chair of the RCN Travel Health Forum Steering Committee, discussed sources of information for malaria management and distributed a very useful resource in the form of a CD-ROM she had compiled and produced.

Professor Peter Chiodini, Director of the Malaria Reference Laboratory, explained the advances and problems of diagnosing malaria in the laboratory and said that although rapid tests are

sometimes used by travellers, evidence shows that only two-thirds could use them properly.

Dr David Laloo, Clinical Director of the Liverpool School of Tropical Medicine, addressed the treatment of malaria in returning travellers, and Dr Sarah Gilbert, Leader in Vaccinology at the Wellcome Trust, completed the programme by summing up the complications involved in producing a workable malaria vaccine. The outlook is hopeful, but there is no prospect of this being achieved for some years.

This was an interesting and informative day, made all the more relevant by the firsthand knowledge and experience of experts in the field.

**Joyce Skeet**

## of the International Society ine (CISTM9)

1–5 May 2005 – Lisbon

history and 16th century explorers. At that time the mortality rate among sailors on a typical voyage from Lisbon to Goa in India was around 50 per cent!

Topics covered during this year’s programme included symposia on influenza, the international health regulations, safety and security, and a special session revealing the experiences of medical personnel working in tsunami-affected areas.

Vaccines, malaria and gastrointestinal diseases were well covered as always, and there were many and varied workshops on specific destinations or disease areas which were particularly well received. Professor David Hill, Director of the UK’s National Travel Health Network and Centre (NaTHNaC), led a very useful

workshop on yellow fever: risk assessment and vaccine safety.

A huge number of posters on display included one describing our forum – congratulations to Sandra Grieve and Jane Chiodini for their hard work in putting this together.

One of the most enjoyable aspects of a large international conference is the opportunity to meet colleagues from around the world and exchange views on the fascinating topics that make up travel medicine. It never ceases to surprise but also reassure me that no matter where in the world you practice, patients present the same challenges and frustrations as they do at home.

The RCN Travel Health Forum has some

### UK nurse reps in ISTM

The UK is well represented within the ISTM’s Practice and Nursing Issues Committee (PNI). Our Forum Chair Jane Chiodini is Co-Chair and RCN Forum Steering Committee members Lorna Boyne and Sandra Grieve are PNI Committee members. Sheila Hall, an RCN Forum member from Scotland, also sits on the PNI Committee.

More on ISTM at [www.istm.org](http://www.istm.org)

one-year ISTM memberships to give away. Membership includes subscription to the excellent *Journal of Travel Medicine* which will carry many of the papers presented at this year’s conference.

**Carolyn Driver**

## NEWS IN BRIEF

**Neglected area**

A BMA report claims that rural health care is being neglected and health policies developed for urban areas do not work in rural ones. Despite the image of “rural idyll”, many poor disadvantaged people live alongside relative affluence. Deprivation and poverty are important acknowledged determinants of health and disease. Lack of public transport in rural and remote areas create severe difficulties for people accessing health care.

**Fake tan**

Sunbeds should never be used by people under 18 or by those who freckle. WHO warns that the high intensity ultraviolet output of the machines is many times higher than the midday sun in most countries. Children exposed to sunburn have an increased risk of melanoma in adulthood. See [www.who.int/mediacentre/factsheets/fs287/en/](http://www.who.int/mediacentre/factsheets/fs287/en/)

**Online fee**

Later this year an online booking fee is to be introduced by British Airways, bringing them into line with other national carriers already charging Britons who book over the Internet. The move was criticised by “no frills” operators, who say they have no plans to introduce similar fees.

**Tidy tourists?**

The Adventure Travel Company is encouraging travellers to leave countries in a clean and tidy state. A “Nile clean-up” trip to Egypt in May featured a three-day felucca trip which stopped at “rubbish hotspots” to collect, sort and dispose of waste with gloves and equipment provided. Similar trips to other countries are planned for the future. See [www.adventurecompany.co.uk](http://www.adventurecompany.co.uk)

**Poor hygiene**

According to the consumer group Holiday TravelWatch, the number of British tourists who become ill during or soon after a package holiday is increasing. In the first quarter of 2005 complaints had risen from the normal 10 a week to over 50, the majority from people who had holidayed in the Caribbean. Some problems were related to poor hygiene. Travellers were advised to research destinations before booking and be vigilant during their stay.

**Food hygiene**

In an effort to reduce the incidence of disease and improve food standards the Egyptian Hotels Association has asked hygiene consultants to inspect over 200 hotels. The EHA, responsible for hotel licenses, wants to prevent a repeat of an outbreak of hepatitis A, which affected German tourists last year.

**Tighter regulations**

The Peruvian government has introduced regulations restricting the number of people on the Inca trail. The 500-person limit includes guides, porters and cooks, which means only 200 tourists would be walking the trail at any one time. Reservations must be made with a registered tour operator, paid in advance, and full passport information provided 30 days prior to departure. International organisations pressed for the changes, designed to lessen the human impact on the trail and ensure conservation for the future.

**Himalayan bus stop**

A new public bus service linking Nepal and Tibet has begun. Officials in Kathmandu said that the three-day journey of 600 miles would operate once a week for nine months of the year. It will cost £37 and provide a cheap alternative to flying which costs around £144 each way between Kathmandu and Lhasa. There has been recent unrest in Nepal. Check updates at [www.fco.gov.uk](http://www.fco.gov.uk)

**Prize-winning conception?**

A Sicilian hotel chain launched a website campaign offering free weekends to couples who conceive during a stay. Couples can return to claim their prize between eight and ten months later – taking the new baby with them. “To conceive a child is the most beautiful thing you can think of” says the promotion on the website. Any takers? Contact [www.chshotels.com](http://www.chshotels.com)

**Sexual health**

In addition to Marie Stopes International ([www.mariestopes.org.uk](http://www.mariestopes.org.uk)), there is an easy-to-follow booklet and website on sex and health at [www.likeitis.org](http://www.likeitis.org)

**New thinking?**

A generation of young Britons are delaying marriage, children and savings in favour of world travel. A third of people between the ages of 25–34 say that seeing the world is their top priority. The research also showed that over 50 per cent put money aside for travel in preference to more traditional expenses like property, cars or weddings.

**Be prepared**

Travellers to the United States whose passports are almost expired are advised to renew them before 20 October or face lengthy queues for visas. The British Government is still struggling to meet a previously extended deadline to produce biometric documents with imbedded face-recognition technology and has requested a further delay. If unsuccessful, those with passports issued after 26 October will need visas for entry to the USA.

**Avian influenza**

American authorities have been given the power to detain or quarantine passengers entering the country suspected of having the H5N1 bird flu virus. President Bush issued a directive giving the Health and Human Services Department the authority as a means of preventing the spread of the infection. WHO says there is no evidence to date to suggest the virus is mutating to allow human-to-human transmission. Updated information is in the “health advice for travellers” section at [www.dh.gov.uk](http://www.dh.gov.uk) Also see:

- a special issue of *Nature* on avian influenza at [www.nature.com/news/2005/050523/full/435399a](http://www.nature.com/news/2005/050523/full/435399a)
- WHO's website at [www.who.int/csr/disease/avian\\_influenza/en/](http://www.who.int/csr/disease/avian_influenza/en/)
- the Centers for Disease Control website at [www.cdc.gov/flu/avian/index.htm](http://www.cdc.gov/flu/avian/index.htm)

**Research Google**

The search engine, Google, has a new research tool. Google Scholar enables you to search for scholarly literature, including abstracts, books, peer-reviewed papers, theses and technical reports from many areas of research. It's at <http://scholar.google.com/>

Thanks to Professors ABDUL RASHID GATRAD and AZIZ SHEIKH for permission to reproduce an abridged version of this article which first appeared in the *BMJ* on 15 January 2005 and to the Islamic Foundation for permission to reproduce the photographs.

# Hajj: the journey of a lifetime

Journeying to Mecca for Hajj (pilgrimage) is no ordinary undertaking. Hajj represents the culmination of years of spiritual preparation and planning. Once completed the pilgrim is given the honorific title *hajji* (pilgrim).

Hajj commemorates the Patriarch Abraham's readiness to sacrifice his son Ishmael in biblical times. Performing Hajj is one of the five pillars of Islam and therefore obligatory for all adult Muslims who are in good health and can afford to undertake the journey. Hajj lasts for five days and as the Islamic calendar is lunar, the precise Gregorian calendar dates vary each year. Muslims travel to Mecca at other times to perform Umrah, a lesser pilgrimage.

Mecca's resident population of about 200,000 swells to over two million during the Hajj season. This rapid increase in numbers poses many challenges, including ensuring adequate food, water and sanitary facilities in Mecca and the neighbouring deserts of Mina and Arafat, which pilgrims must visit as part of the Hajj ritual.

Although the journey is incumbent on a Muslim once in a lifetime, many, particularly those living in the west, will journey more often. Over 20,000 Britons perform the Hajj each year.

Currently the annual figure for Umrah is almost 29,000. In view of the large numbers of people from disparate regions and the hostile climate of the Arabian desert, the chances of disease striking, particularly the elderly and the infirm, are high.

We briefly describe the main rites of the Hajj before focusing on particular health risks associated with it and measures that may be taken to minimise them. Our aim is to offer practical advice to advisers providing care to those planning to attend. In addition to sourced materials we draw on personal experiences, having travelled to Hajj and Umrah, and issued pre-travel medical advice to pilgrims intending to attend.

## The rites of Hajj

Many prospective pilgrims fail to appreciate that Hajj is physically demanding. It is the most complex Islamic ritual



and involves, among other things, walking long distances and camping in desert tents, often with very basic sanitation. Central in these activities is the pilgrim's presence on the desert plain of Arafat from noon until sundown. Here, men dressed in simple garb made up of two pieces of unstitched cloth (Ihram), and women wearing their usual clothing and a headscarf, will spend much of the day standing in humility and prayer, performing a dress rehearsal for the final standing before God on Judgement Day.

Because of the large numbers of people, performing even the simplest rites can take an extraordinary length of time. There is a religious dispensation for those in poor health and many will make use of this after consultation with their doctor.

Some, however, travel against medical advice, often in the hope of dying in the Holy Land. For Muslims living in the west, deciding whether or not to travel on health grounds is often more complex. Most health professionals are unaware of what the Hajj entails or associated health risks and may have difficulty offering an informed opinion.

## HEALTH PROBLEMS AND MINIMISING RISKS

### Sun and heat

Travelling to Mecca in advance of the Hajj is sensible, particularly for those unaccustomed to the oppressive climate of the Arab desert. Pilgrims need to be aware that acclimatisation to very high temperatures can take one-to-two weeks.

Even when Hajj occurs during winter, the average temperature is over 30°C by day and 20°C at night. Heat exhaustion and heatstroke are common and can be fatal. One study reported

more than 1,700 fatalities in a single Hajj season, most heat related. The Saudi authorities, in their role as hosts, undertake valuable health promotion, distributing leaflets and issuing radio and television warnings of the dangers of sun exposure. The number of people who succumb to the heat is evidence that the message needs to be reiterated at every opportunity.

Sunburn with associated risk of malignant tumours is a significant hazard. A high factor sun block will minimise the risks, but sun exposure should be kept to a minimum.

During the Hajj men are prohibited from directly covering their heads (for example, with a hat), thereby increasing the risk of heat exposure. The usefulness of a quality, preferably white, umbrella to deflect the sun cannot be overemphasised. Such simple measures may be life saving if the pilgrim was to lose his or her bearing in the desert, as is easily and not infrequently done. Other precautionary measures are summarised in Box 1.

Heat exhaustion typically occurs in those who undertake strenuous exercise while not acclimatised. Water depletion, or salt and water depletion combined, due to excessive sweating is the underlying cause. Up to five litres of water and up to 20 grams of salt may be lost per day. Most cases are mild with symptoms of weakness, light-headedness and muscle cramps that respond to rest, cooling, fluid and salt replacement. If not adequately treated, heat stroke may occur. Salt tablets can be taken, but may cause vomiting or gastrointestinal upset. We suggest adding a quarter teaspoon of salt (approximately 1g) per pint or two level teaspoons per gallon of drinking water.

Heat stroke is a medical emergency (Box 2) and can occur within 20 minutes of severe exertion. Skin is hot to the touch and there is notable absence of sweating. The very young, the elderly and diabetics are most at risk. The extreme rise in body temperature makes prompt and appropriate treatment imperative. Patients should be moved into the shade, stripped, cooled by spraying the body with cool water and fanning, and, if conscious, given fluid replacement while expert medical attention is urgently sought.

Since the 1980s, cooling units have been installed along the

pilgrim route. Emergency services often suspend patients in a hammock-like bed and spray them liberally with an air/water mixture. The water is warm and cools the body through evaporation, simultaneously preventing further dehydration. These simple devices are significantly quicker in reducing body temperature than the usual method of placing patients in an ice bath, possibly because vasoconstriction and shivering are not induced – responses that ultimately cause the body temperature to rise.

Most pilgrims travel on foot. Quality footwear is important, though frequently overlooked. During the day, the desert sand becomes burning hot, therefore pilgrims should avoid walking

barefoot, seriously risking foot burns. This is particularly important for people with diabetic neuropathy, as extensive damage may quickly occur, often compounded by the problems of poor wound healing and increased risks of infection.

Footwear must be removed before prayers. Those new to Hajj are often unaware of the ease with which people's footwear can become confused and inadvertently taken. While attempting to reclaim their footwear pilgrims may be forced to walk barefoot, with potentially devastating consequences. Pilgrims should be advised to carry footwear in a bag.

## Infectious diseases

An outbreak of group A meningococcal meningitis occurred among British Muslim pilgrims following the 1987 Hajj. There were 18 primary cases among pilgrims and 15 subsequent cases among their direct and indirect contacts. Similarly, outbreaks of W135 meningococcal disease occurred among British

pilgrims in 2000 and 2001. The Saudi authorities now insist that all pilgrims are vaccinated with two doses of the ACWY Vax (3 months apart) with conjugate meningitis vaccination. A medical certificate confirming vaccination is required before visas will be issued.

Vaccination against hepatitis A and malaria prophylaxis, together with advice on measures to minimise risks of exposure, is important. We recommend vaccination against hepatitis B. Tetanus and polio status should be checked and typhoid and diphtheria vaccination considered (pilgrims often visit endemic areas after Hajj).

Following the Hajj many people decide to travel on, particularly to Africa and the Indian subcontinent, so noting

### BOX 1: Minimising the risk of heat exhaustion and heatstroke

- avoid spending long periods in the sun, particularly when it is at its zenith
- travel by night if possible (may also avoid stampedes)
- keep your head covered during the day (use an umbrella)
- consume large volumes of fluid throughout the day
- always keep a canister of fluid with you
- increase dietary salt intake or use salt tablets
- avoid travelling in "open top" buses.

### BOX 2: Symptoms suggesting heat exhaustion and heatstroke

- fatigue, weakness and leg cramps
- headache, nausea and vomiting
- giddiness
- delirium
- syncope and coma.

detailed travel plans is important. Pilgrims need to be reminded of the importance of seeking medical attention for unexpected symptoms, such as fever, diarrhoea, jaundice or a high fever on their return. A persistent cough is also significant because of the reported high incidence of pneumonia (particularly tuberculosis) among pilgrims.

One of the rights of the Hajj is for men to have the head shaved (trimming the hair is also acceptable). Opportunistic “barbers” will shave most in makeshift centres. A razor blade is commonly used and may be used on several scalps before being discarded. The risks of important blood-borne infections such as HIV and hepatitis B and C are obvious, especially since many pilgrims come from regions of the world where such infections are endemic. Pilgrims need to be aware of these dangers and should insist on a new blade.

Physical relationships are prohibited during Hajj, even between husband and wife, and so the risks of acquiring sexually transmitted diseases are minimal.

## Injuries

Injuries, particularly to toes, are relatively common, typically resulting from inadvertently being stamped on when circumambulating the Ka’ba barefoot. More serious injuries, some of which prove to be fatal, occur each year during stampedes in Mina as pilgrims undertake the stoning rite. Pilgrims should be advised to avoid peak times, and the old and infirm advised to consider appointing a proxy for the performance of this rite.

## General advice

Menstruating women are not permitted to perform the Hajj as menstruation is considered a state of ritual impurity. This often causes great concern; understandable remembering the importance of the journey and the time, effort and money

### BOX 3: Travel Pack

- analgesics
- oral rehydration salts
- clove oil for dental pain
- adhesive dressings
- insect repellent
- antiseptic cream
- water sterilisation tablets.

invested. Delaying menstrual bleeding by using the combined oral contraceptive pill or daily progesterone is perfectly acceptable. Many women consult their general practitioners or family planning clinics for this reason before the Hajj season.

Contact lenses are often problematic in arid conditions where sand can be blown into the eyes. Liberal use of ocular

lubricants (such as hypromellose 1% eye drops) can stop lenses adhering to the cornea. Temporarily using spectacles is another option. Several makeshift dispensaries are erected during the Hajj season, but are often difficult to access, largely on account of the human mass. Pilgrims with chronic medical conditions should take enough supplies of their regular medication and carry a written record including generic names. A travel pack containing common remedies is useful (Box 3).

## Diabetes

Diabetes is common among South Asian Muslims. If illness occurs, diabetic control will need careful monitoring and insulin may be required in people with type 2 diabetes. Insulin in Saudi Arabia may be different from the pilgrim’s country of origin so accompanying persons should be aware of the symptoms of hypoglycaemia.

### BOX 4: Hajj travel consultation issues

- fit to perform the Hajj
- heat exhaustion and heatstroke
- foot burns and sunburn
- infectious diseases
- general travel advice
- emergency numbers: ambulance 997; police 999.

## The “Hajj travel consultation”

There are a number of known risks associated with pilgrimage to Mecca which can mar the entire experience. Most problems should, with sensible precautions, be preventable. All potential pilgrims must be protected against meningococcal disease and this

opportunity to review patients can be used to impart other advice (Box 4). Doctors should be vigilant for signs of disease when consulted by Hajjis.



### More information available from:

- [www.dh.gov.uk/traveladvice/hajj.htm](http://www.dh.gov.uk/traveladvice/hajj.htm)
- [www.diabetes.org.uk](http://www.diabetes.org.uk)

Contact the Editor for a list of references.

**FIONA GENASI, Chair of the Organising Committee for the Northern European Conference in Travel Medicine (NECTM), invites you to attend this exciting event.**

# Your chance to attend a key international travel health event!

## Northern European Conference in Travel Medicine

**Edinburgh – 7–10 June 2006**

Here's a wonderful opportunity for nurses to sample a truly international conference, in a programme to suit all levels of travel health practice. It's also your chance to meet and compare notes with colleagues from Europe, the USA and Canada, Australia, South Africa ...!

The RCN Travel Health Forum is actively helping to organise this conference to meet UK nurses' needs, but there will be a definite international flavour attached, with major organising input from the International Society of Travel Medicine, Health Protection Scotland, NaTHNaC, the British Travel



Edinburgh International Conference Centre (EICC), in the heart of Scotland's capital city. There's a wide range of hotels, B&Bs and guesthouses to suit all pockets within easy walking distance, plus unprecedented shopping, restaurants and nightlife. If it's culture you want, there are castles, museums and gardens to explore. And then there are Scotland's unique craft industries – cashmere and tartans, glass and silverware or one of the distilleries that open their doors to curious and thirsty visitors.

### Getting there

Transport links are excellent. Edinburgh Airport, just 12km west of the city centre, has over 25 return flights each day to London, plus regular services to other areas in the UK (0131 333 1000 for flight details). The Great North Eastern Railway line is the fastest intercity railway in Britain, taking just over four hours between Edinburgh and London. ScotRail and Virgin link the city with northern and western Britain (contact National Rail Enquiries on 0345 484 950).

Log onto the conference website at [www.nectm.com](http://www.nectm.com) for programme information and registration details.

Health Association, the Irish Society of Travel Medicine and various Scandinavian travel medicine societies and associations.

The scientific programme features some of the best-known international speakers on travel health issues.

### Still rising

As of February overseas visits by UK residents grew by four per cent to 64.2 million a year ([www.statistics.gov.uk/cgi/nugget.asp?id=352](http://www.statistics.gov.uk/cgi/nugget.asp?id=352))

### Topical and tropical

The Association of British Travel Agents reckons five million trips were made to tropical destinations in 2004 (ABTA Data 2005).

### Malaria Awareness Week ...

... spearheaded by TV personality John Craven, took place 16–22 May, and was marked by an exhibition at London's Natural History Museum. Travellers were reminded of the risk of malaria and advised to attend their travel health advisers in good time before travelling to a malaria-endemic area. A dedicated website gives excellent advice at [www.malariahotspots.co.uk](http://www.malariahotspots.co.uk)

### Keep up to date ...

... by checking the DH website regularly. Chapters for the Green Book are continually being updated and posted on the site – one on rabies in December 2004 was replaced by another dated May 2005. A chapter on consent came out in November 2004. See [www.dh.gov.uk](http://www.dh.gov.uk)

### Mosquito fine

In an attempt to curb cases of dengue fever, Singapore has implemented fines for people who allow mosquitoes to breed in their homes. With the number of cases in 2004 increasing by almost 80 per cent over 2003, public health experts believe the rise is due to mosquitoes breeding in pot plants and other sources of stagnant water in apartment blocks. WHO issued an alert last September following a resurgence of dengue fever in the region.

## New compensation rules

New EU legislation allows passengers whose flights are cancelled to claim compensation in addition to a refund – even if the situation is outwith the airline's control. The measure applies to flights to or from an EU airport or an EU-based airline, and compensation must be paid unless travellers are given two weeks notice or offered a suitable alternative. The IATA, which represents airlines, is to challenge the rule in the European Court of Justice later this year.

## Donations

The Bill and Melinda Gates Foundation has donated \$750m and Norway has committed \$290m to the Global Alliance for Vaccines and Immunisation launched in 2000 ([www.vaccinealliance.org](http://www.vaccinealliance.org)).

## Growing delays

According to figures released in January by the Civil Aviation Authority (CAA), airline punctuality was at its worst level for two years. Of Britain's 10 busiest airports only London City and Birmingham recorded an increase in punctuality on scheduled flights. Heathrow showed one of the biggest declines with travellers facing a fall of 13 per cent – from 74 per cent in 2003 to 61 per cent in 2004.

## Safe travel

The International Air Travellers Association has released research showing that it has never been safer to travel by air. The chance of being killed in an aircraft accident was one in 10 million people flying in 2004, compared with almost three in 2002 and seven in 1996. The Director General of IATA said that it was a victory in a campaign to increase air safety and they are committed to reducing the accident rate further by the end of 2006.

## Or is it?

Weeks after this information was released new figures showed that the first quarter of 2005 was among the worst on record for accidents. A spate of accidents with lesser known carriers has once again raised the question of air safety and the age of aircraft still in service. The Department of Transport and the CAA have suspended permits and grounded aircraft for serious deficiencies and safety breaches.

## Crowded airports

According to figures released by the British Airports Authority, passenger numbers are set to increase this year, leading to crowded airports and lengthy queues. They estimate that with renewed confidence in air travel and continued expansion of new routes, more than 300 million passengers will be travelling in 10 years. Airports are already struggling and many have reached saturation point. In the future the numbers of passengers may have to be limited due to lack of airport capacity.

## Texting?

A free text messaging service alerting travellers about alterations to their flights has become available to EUjet passengers who register their mobile phone numbers. Under EU regulations the airline has to prove it contacted the customer ([www.eujet.com](http://www.eujet.com)).

## Attraction

Researchers have found that those less likely to be bitten by mosquitoes produce natural odours which mask the scent attracting them. They hope that a new insect repellent containing these natural odours may be produced, but acknowledge that other factors also need be considered.

## More at [www.fco.gov.uk](http://www.fco.gov.uk)

### News from the Foreign and Commonwealth Office

#### Prescription medication warning

The FCO has issued a warning to tourists who travel to the United Arab Emirates (UAE) after a woman spent eight weeks in prison, on remand, in a gulf state for having traces of codeine and Temazepam in her urine. The FCO changed advice for travellers following the woman's arrest. Other countries may have medical restrictions that are unbeknown to travellers.

#### British Hajj Delegation

The British Hajj Delegation to Mecca was launched for the sixth year. The Delegation provides consular, medical and pastoral help to British Hajjis. In 2004 the volunteer doctors and counsellors provided assistance to over 3,500 pilgrims. The FCO has doubled its contribution this year. See page five for health information on Hajj.

#### Arabic website

An Arabic website was launched by the FCO in January. The site provides detailed information on a broad range of policy issues, as well as information on the FCO and links to sites on visiting, studying or doing business in the UK. They hope to give Arabic-speaking people worldwide a better understanding of Britain and its diverse society.

# Update on deep vein thrombosis

## Adverts

Following the success of a television advertising campaign last summer, the Scholl flight socks adverts returned to our screens to target winter holidaymakers. The ad shows that although passengers are encouraged and willing to exercise when flying, cramped conditions make it difficult.

## Travel agents

Travel agents are being encouraged to raise awareness of DVT through educating the public about risks and preventative measures. According to John Smith MP, who is Chair of the All Party Parliamentary Group on DVT Awareness: "It is logical for travel agents to provide information about holiday health as they are the face of the travel industry and the point of contact for the public."

## Regulation puts air travellers at greater risk

A gap in a general insurance regulation was condemned for putting air travellers lives at greater risk, after the sale of travel insurance was granted an exemption from the regulations for general insurance. John Smith MP said: "I, along with the families of DVT victims, am very disappointed with this incomprehensive and short-sighted piece of legislation. With WHO-commissioned research expected to establish a causal link between flying and thrombosis, it runs counter to commonsense to exempt travel insurance from regulation."

Unbeknown to most air travellers, travel insurance does not provide cover for death or injury resulting from flight-related DVT. He added: "Not only are air travellers denied insurance against DVT, but they are left without protection against the mis-selling of insurance."

## DVT prevention?

Scientists have questioned a new natural food supplement designed to reduce the risk of DVT during long-haul flights. Zinopin, containing high doses of pine bark and ginger, has become widely available in the UK. Dr John Scurr, a vascular surgeon, recently published preliminary findings on the research and says that the extracts are shown to be effective in reducing the blood's ability to clot. Some scientists are less certain and say further trials are necessary.

## Welcome report

In a published report, the prestigious Health Select Committee has recognised the link between long-haul flying and DVT. John Smith MP said: "Now that an authoritative body has implicitly acknowledged the link, it begs the question of how much longer will airlines deny the link and their responsibility for the well-being of their passengers?"

The report estimated that over 32,000 people in the UK die unnecessarily from blood clots every year (25,000 are hospital acquired), more than Aids, breast cancer and traffic accidents put together. John Smith MP said: "We believe a significant number of these deaths are air-related – according to some research, one in five. By making people aware, making treatment available and having standard guidelines in hospitals throughout the NHS, we can prevent thousands of these unnecessary deaths every year."

Advice for travellers on DVT is at [www.dh.gov.uk/PolicyAndGuidance](http://www.dh.gov.uk/PolicyAndGuidance)

## NEWSROUND

### Tsunami travel health information

The Health Protection Agency advised those travelling to areas affected by the tsunami in the Indian Ocean that considerable damage to the underlying health care, emergency response and housing resources have led to flooding, stagnant water, disruption of sewer lines and poor quality sanitation conditions. Increased risk of intestinal illness, mosquito-transmitted diseases and other diseases such as leptospirosis are likely. Those intending to travel to tsunami-affected countries who changed their itinerary are advised to check that their travel health needs are still appropriate for the new destination.

Mental health experts and voluntary organisations developed guidelines to help health professionals in the early recognition of acute stress and post-traumatic stress disorder (PTSD) in survivors (including emergency staff), the bereaved and their families, and UK residents whose relatives were affected by the incident. More about effective treatments for PTSD is at [www.nice.org.uk](http://www.nice.org.uk)

*See page 13 for related websites and personal perspectives on the tsunami.*

### Holidaymakers can help

The online travel agency, [www.responsibletravel.com](http://www.responsibletravel.com), promotes companies that support local environments and is asking travellers to return to tsunami-stricken areas and spend their money wisely. Holidaymakers can help economic recovery by using locally-owned accommodation, buying local crafts and using local restaurants and guides. Many discounted package holidays became available almost immediately following the tsunami as tour operators tried to encourage travellers back to affected areas. In March an earthquake off Sumatra triggered a tsunami alert and many people were evacuated as a precaution. Despite some structural damage and loss of life, no tsunami followed.

### But tourism's blamed

The United Nations blamed tourism development for worsening the effects of the tsunami. The report from the UN Environment Programme revealed that where mangrove forests or reefs had been destroyed to make way for tourist developments, the tsunami had a more

devastating impact than it would have had previously. Reefs damaged by coral mining and fishing by dynamite were ineffective in protecting the coastline.

## Call for hep B immunisation

The British Medical Association says that hepatitis B virus transmission in the UK is increasing. Doctors called for children to be routinely immunised. Notifications of infection in England and Wales rose from 489 in 1992 to 1,151 in 2003 – a 135 per cent increase.

## Mumps

The Department of Health has alerted GPs to the risks of mumps in children and young adults following 5,000 recorded cases in January alone this year. The outbreak has mainly affected 19–23 year olds, too old to have been offered MMR vaccination as infants, but young children are also affected. More from:

- Gupta, RK; Best, J and MacMahon, E (2005) Mumps and the UK epidemic 2005, clinical review, *BMJ*, 330, pp.1,132–1,135.
- Savage, E; Ramsay, M; White J et al (2005) Mumps outbreaks across England and Wales in 2004: observational study, *BMJ*, 330, pp.1,119–1,120.
- [www.hpa.org.uk/hpa/news/articles](http://www.hpa.org.uk/hpa/news/articles)
- [www.hpa.org.uk/infections/topics\\_az/mumps/menu.htm](http://www.hpa.org.uk/infections/topics_az/mumps/menu.htm)

## Marburg fever

The World Health Organization (WHO) has updates on the outbreak of marburg virus in Angola at [www.who.int](http://www.who.int). Advice for travellers is at [www.who.int/csr/don/archive/disease/marburg\\_virus\\_disease/en/](http://www.who.int/csr/don/archive/disease/marburg_virus_disease/en/)

## Be prepared nationally ...

The Department of Health and Scottish Executive Health Department have prepared a UK Influenza Pandemic Contingency Plan. The Health Secretary, (pre-election) John Reid, announced that over the next two financial years the DH is to procure 14.6 million courses of oseltamivir (Tamiflu), an antiviral drug as part of the UK's preparedness. The Contingency Plan and explanatory documents are at [www.dh.gov.uk](http://www.dh.gov.uk), [www.hpa.org.uk/infections/topics\\_az/influenza/pdfs/HPApandemicplan.pdf](http://www.hpa.org.uk/infections/topics_az/influenza/pdfs/HPApandemicplan.pdf) and [www.scotland.gov.uk](http://www.scotland.gov.uk)

## ... and internationally

WHO has published its Global Influenza Preparedness Plan at [www.who.int/csr/resources/publications/influenza/en/WHO\\_CDS\\_CSR\\_GIP\\_2005\\_5.pdf](http://www.who.int/csr/resources/publications/influenza/en/WHO_CDS_CSR_GIP_2005_5.pdf)

## It's official!

The DH's Heatwave Plan aims to reduce health risks caused by hot weather, informing the public and health and social care professionals of possible dangers. A Heat-Health Watch system will run in England from June to September every year based on Met Office forecasts which will trigger the level of response required – from awareness to emergency. Factsheets are at [www.dh.gov.uk](http://www.dh.gov.uk)

## Changes

Updates have been announced by MASTA (Medical Advisory Service for Travellers Abroad). Refer to the updated Summary of Product Characteristics (SPC).

### Epaxal (hepatitis A vaccine)

The main changes: (section 4.1) Epaxal is now licensed for adults and children from age one; (section 4.2) two new statements added – “Epaxal can be used interchangeably with other inactivated hepatitis A vaccines for the first and second (booster) dose.” The second dose “is preferably given between six–12 months after the first dose, but based on experience in adult travellers” may be given up to four years later.

Information on the Green Cross Japanese encephalitis vaccine has also changed. This is now a three-dose rather than a two-dose regime.

See [www.masta.org](http://www.masta.org)

## Meningitis update

As of May 2005 an outbreak of bacterial meningitis (serogroup A) in Delhi was still spreading (*CDR Weekly*, 15 [19]). For travellers at risk, immunisation with ACW<sub>135</sub>Y should be considered. More about meningitis at [www.dh.gov.uk](http://www.dh.gov.uk) and [www.who.int/en/](http://www.who.int/en/). Updates from [www.fco.gov.uk](http://www.fco.gov.uk) and [www.nathnac.org](http://www.nathnac.org)

## Reminder

*Eye of the needle*, the HPA report on needlestick injury, highlights cases of hepatitis C infection through needlestick injury over the last six years in which nine

health care workers, three of them nurses, have been exposed to the virus. Download the report at [www.hpa.org.uk/infections/topicsaz/bbv/pdf/eyeoftheneedle.pdf](http://www.hpa.org.uk/infections/topicsaz/bbv/pdf/eyeoftheneedle.pdf)

## Supply of Revaxis® vaccine

Sanofi Pasteur MSD is temporarily unable to supply Revaxis® (Td/IPV) for adult and travel use.

In order to prevent disruption to the childhood vaccination programme, the Department of Health (DH) recommends that supplies of Revaxis from Farillon are reserved for the vaccination of teenage school leavers only.

In the interim period the DH recommends Diftavax® (Td) be used for adults and travellers where indicated. Diftavax® is available free of charge from Farillon or directly from Sanofi Pasteur MSD.

Revaxis®, Diftavax® and IPV are all reimbursable from the Prescriptions Pricing Authority (PPA) on an FP10. Sanofi Pasteur MSD are working on securing more Revaxis® supplies. In the meantime customers who have a monthly scheduled agreement with SP-MSD will still receive their doses of Revaxis®.

The monovalent inactivated polio vaccine (IPV), available from Sanofi Pasteur MSD need only be given to those travelling to destinations where Polio is endemic.

The current recommendation for polio vaccination is that all travellers are up to date with their UK immunisation schedule. Updates from [www.nathnac.org](http://www.nathnac.org)

Recommendations for travel to the different WHO regions are provided below.

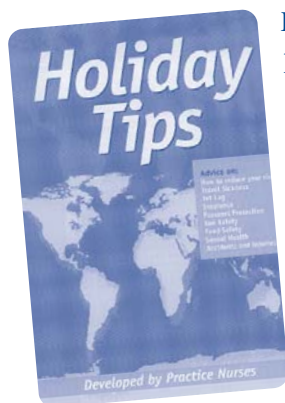
**WHO European Region** (certified polio free June 2002): a polio booster is no longer recommended for travel to countries within this region, unless the traveller has never completed a primary course. In these circumstances the primary course should be completed.

**WHO Western Pacific Region** (certified polio free October 2000): a polio booster is no longer recommended for travel to countries within this region, unless the traveller has never completed a primary course. In these circumstances the primary course should be completed.

**WHO American Region** (certified polio 

BEVERLEY CRAPPER was the leader of an innovative new project which won a prize in the *Practice Nurse 2004* Sharing Good Practice Competition (for which the RCN Travel Health Forum was involved in the judging process). Beverley tells us how it happened.

## Holiday tips is a winner with the judges



Early in 2003 our local primary care trust held a meeting to highlight the availability of the Community Budget Fund to support innovative project ideas. Although contrary to the equality of opportunity being advocated, the PCT

acknowledged that no practice nurses were currently involved in activities.

Thus four other practice nurses – Olwen Swarbrick, Moira Carnazza, Glenda George, Sue Wright and myself began brainstorming ideas for applying to the Community Budget Fund. Providing health education and advice relating to travel health appeared to be an ideal subject, a reflection of the specialist service provided by practice nurses. Government statistics showed over 53 million visits abroad by UK residents (ONS 2000) [see page eight for updated figures – ED] and Cossar and Reid (1992), suggested travellers prefer to get their health information direct from “their own” surgery.

These facts together, clearly demonstrated that travel health is a primary care service and a public health requirement. We believe each traveller

should be in receipt of basic information and advice to ensure their foreign travel is a wonderful experience, not a health disaster.

The team decided to create a travel health resource providing basic advice for travellers in an easy-to-read, non-promotional manner. We recognised that there was already a vast array of materials available – for example, from the DH, Foreign and Commonwealth Office and WHO travel websites. Nevertheless, we felt the key components of the booklet would provide continuity of health education across local PCTs, especially for other health disciplines.

By ensuring fundamental information is available the practice nurse has more time and opportunity during the consultation to design advice specifically to meet individual needs. Health professionals recognise that patients do not retain all the information provided during the session, so we felt that the booklet would re-enforce the advice.

We applied to the Selby and York PCT and were awarded £1,200 for development and production costs. The practice nurses contributed their time and skills voluntarily. The PCT’s Health Promotion Department provided access to a graphic designer, who assisted us in creating the eye-catching product.

We negotiated producing 3,000 booklets with a local printing company. Using the internal mail system, the resource was distributed to all primary care premises at minimal cost, and by summer each practice nurse received a minimum of 30 copies. Booklets were also distributed to local travel agents for comment and feedback.

Currently we are gathering feedback from practice nurses and the general public through evaluation forms and will collate the information over the next few months. When evaluation and audit is complete, we hope to approach the PCT with the aim of reproducing the booklet on their Internet site or funding an updated edition.

Following nomination from the local practice nurse group, we entered the *Practice Nurse* competition, aiming to demonstrate the role of practice nurses and the innovation developing in primary care. We were surprised and overwhelmed to be short-listed and ultimately win the “Good Practice in Travel Health” category.

The project allowed us to “liberate our talents” (DH, 2002) and to improve service provision locally. Meanwhile, using the £1,000 we got as winners of the *Practice Nurse* award, we anticipate discussions for sustaining our interest in travel health.



free in September 1994): a polio booster is no longer recommended for travel to countries within this region, unless the traveller has never completed a primary course. In these circumstances the primary course should be completed.

**WHO African Region:** a booster dose of polio is recommended for those who have not received a dose within the previous 10 years

**WHO South East Asian Region:** a booster dose of polio is recommended for those who have not received a dose within the previous 10 years

**WHO Eastern Mediterranean Region:** a booster dose of polio is recommended for

those who have not received a dose within the previous 10 years.

Further explanation of these changes can be found in the June issue of Vaccine Update, the monthly publication from the NHS Purchasing and Supply Agency: <http://www.pasa.nhs.uk/pharma/vaccines.stm>

### Links

World Health Organization Polio Eradication Initiative  
<http://www.polioeradication.org>

A list of countries currently reporting cases of wild type poliomyelitis can be found at: <http://www.polioeradication.org/casecount.asp>

### Holiday tips: aims of the project

- facilitate travel health information through a non-promotional booklet
- empower the travelling public through education, advice and information to make their own choices
- raise public health issues: travel health impacts on the health of the wider community
- promote the skills and knowledge of practice nursing within a wider health arena.

Contact the Editor for a list of references.

In the first of two articles presenting different perspectives on how to provide aid to those in need following disaster situations, SALLY GREENWOOD, a Specialist Nurse Practitioner with BP, tells about her time in Sri Lanka. This article first appeared in *Practice Nurse* 29 (5) 44–47.

# Tsunami experience: A nurse's view

On 12 January 2005 I set off with an eight-member medical team to north eastern Sri Lanka to give aid to Tsunami victims. The area was politically volatile and in the Tsunami aftermath, evidence was that aid was in short supply. We took medical supplies with us to ensure they were used where needed. Five team members were Tamil speaking natives with local knowledge and contacts, enabling us to be more effective.

When humanitarian teams arrived in Sri Lanka there was no co-ordination of the relief effort, leaving many teams desperately frustrated with no direction – wasting desperately needed resources.

We planned to operate clinics at refugee camps where there had been little or no medical input and to identify people who would benefit from direct sponsorship. We wanted to provide evidence of proper use of donations, but it was difficult to prioritise people, who by western standards, were all in dire need. Someone had requested their donation be used to sponsor a school so we needed to identify a suitable one.

We visited many camps where, not uncommonly, people were living in hot, overcrowded tents. Conditions were inadequate and often appalling. We saw typical human problems and chronic conditions not commonly seen in the west. (Table 1)

Here where there is poverty and a poor primary care infrastructure, people endured illness and disability without complaint. We struggled with the primitive conditions, food, lack of sleep and a perceived moral obligation not to raise expectations. Often we returned dispirited and downhearted.

In one forested area camp, UNICEF had distributed simple open tents. Food was prepared communally. There was no toilet and people used the snake- and mosquito-ridden forest during



darkness (no lamps), exposing themselves to malaria, dengue fever and injury.

## Heading into the wilderness to find an orphanage ...

This was very disconcerting and I was aware that the vehicle we were travelling in was not roadworthy. A flat tyre was a regular occurrence and if mechanical problems developed we were far from help and civilisation. Mobile phones wouldn't work, putting safety at risk.

Time was immaterial in Sri Lanka. A proposed three-hour journey could take all day! We were hampered by impassable roads (no driving standards), army check points and flat tyres, and competed with dogs, cows, people and cycles.

Unfortunately our orphanage visit became impossible with the arrival of the monsoons. Reluctantly we turned back, but our journey was fraught with difficulties. Under the deluge, widespread flooding caused remaining roads to disappear. To everyone's relief we got back in one piece and learned lessons in accepting our limitations. Some areas were inaccessible except by helicopter. I dread to think what people endured in remote areas.

[Sally accompanied a team of Sri Lankan medical team – ED]

**Table 1: Some medical issues encountered**

Malnutrition	Fevers
Diarrhoea	Arthritis
Asthma	Anaemia
Worm infestation	Injuries
Minor illness	Pregnancy



An encounter with the Tamil Tiger organisation was memorable. Despite having little to offer they gave us food and beds, and made their facilities available to us. We slept in a breezeblock shell with a “shower” and “toilet” in the garden. They provided tea in the morning (definitely not Tetley’s!). This surreal experience turned out to be the most comfortable night’s sleep we had there.

Some refugee camps were housed in breezeblock and concrete buildings, usually having a squat toilet and a well with clean water. Everything was dirty and dingy, often without electricity. Children, surrounded by flies, played in the dirt on filthy floors in a food preparation area. There were many sad stories, an emotional time, but we saw strength in the face of adversity.

Driving through villages people would smile and wave, children especially excited and curious. They were often shy or afraid, though those more confident would push forward and welcome us. I couldn’t resist giving them “treats” which they examined and treasured. How humbling and heart wrenching – I was tempted to smuggle them back in my rucksack!

The Sri Lankans showed great dignity, grace and stoicism. It was a privilege to move among such warm, generous people, always smiling though with little to smile about, showing gratitude and never complaining. They have a generous spirit. Many lost everything in the tsunami. Some who previously lived and worked happily by the sea were now so terrified they were unable to look at it. They were grateful for even small interventions.

I have witnessed firsthand the effect a government can have on its people and how they can be held at its mercy. Without government support no sustainable development can be achieved there. I have no idea how to make this happen, but hopefully someone reading this does. I can only highlight the problems.

## Our last day arrived too quickly

We had distributed all our medical supplies to areas where they would be most useful, donating the remainder to Trincomalee Hospital. We bought bags of rice, lentils, sugar and powdered milk for camps we previously assessed as most needy. Distributing food was enjoyable, a real feeling of achievement.

We informed the camp at Sallee that toilets were on the way, then visited an orphanage we intended sponsoring. Children there had fled when tsunami came, but fortunately the waters had receded quickly and they salvaged their belongings. The children sang for us, leaving not a dry eye in the house.

We accomplished a lot during our short time in Sri Lanka. We were able to sponsor individuals, deliver food to camps and arrange a toilet and lamps for the camp that had none. Sadly this is just the tip of the iceberg.

It was a great privilege to be part of and work alongside that medical team. My thanks to BP for their support, for making it possible for me to go to Sri Lanka and for their donation of £1,000 towards medical equipment. A truly unique and remarkable experience.

Dr ANDREW LEE, Specialist Registrar in Public Health, was the Medical Co-ordinator for MEDAIR, an international non-government organisation, in Sri Lanka and previously in Afghanistan. He cautions against individuals rushing to disaster areas.

Following the tsunamis that struck South Asia in December, more than 200,000 people lost their lives. In the aftermath, there was a lot of goodwill and public sympathy raised worldwide for the victims and survivors. Along with the aid workers, military personnel, search-and-rescue teams and the media, many private individuals from around the world travelled out to the disaster sites.

Some of these private individuals were unashamedly voyeurs out to see the scenes of destruction firsthand. Others were well-meaning volunteers seeking to help in their own personal way. Both share the label “disaster tourists”.

Disaster tourism is not a new phenomenon. For centuries, many bystanders on the battlefields would watch armies wage war. At the battle of Solferino, Henri Dunant was one such observer. When the battle ended, he was angered and moved by the plight of the wounded soldiers left to die where they lay. There, he set up a makeshift hospital and cared for many of the dying. This event was the first step that eventually saw him found perhaps the world’s best-known relief agency, the Red Cross. However, Henri Dunant did not go to the battle of Solferino for altruistic reasons. He was just one of several “battlefield tourists”, today’s equivalent of the “disaster-tourist”, there to witness the spectacle.



### Websites for information

[www.dh.gov.uk/PolicyAndGuidance/HealthAdviceForTravellers/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/HealthAdviceForTravellers/fs/en)

[www.who.int/hac/crises/international/asia\\_tsunami/en](http://www.who.int/hac/crises/international/asia_tsunami/en)

[www.bt.cdc.gov/disasters/tsunamis](http://www.bt.cdc.gov/disasters/tsunamis)

<http://fco.gov.uk>

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

[www.nathnac.org/travellers/index.html](http://www.nathnac.org/travellers/index.html)

# Disaster tourists – bane or boon?

In Sri Lanka after the tsunamis, there were similar instances of disaster tourists running makeshift clinics or distributing relief items such as blankets, food and medicines, mostly purchased with their own funds. In one instance in Sri Lanka, there was even a distribution of jam in a refugee camp.

These volunteers tended to work on their own and not through a governmental or relief agency. Their presence was generally short-term, often no longer than two weeks, in situations where local needs are chronic and there are no quick fixes.

However well intended, the unregulated and uncoordinated activities of these volunteers may have adverse consequences. For example, volunteers may lack adequate cultural sensitivity and awareness. Coupled with the problem of language barriers, this can potentially cause serious misunderstandings with the local communities.

Their presence could also place an additional burden on local communities to support and accommodate them. They may contribute to local inflation, leading to higher living costs for locals, as well as higher operating costs for NGOs.

Doctors and nurses from high-income countries in the west are another type of disaster tourists, who go out to disaster areas to treat the victims. Although they may be highly skilled in their home countries, they are often unfamiliar with the tropical disease profiles and working conditions in resource-poor or disaster settings.

One common practice was the use of roving mobile clinics. Though they may feel they are “doing some good”, the mobile clinics undermine local health systems and provide poor

quality care. There is inadequate follow-up of patients, patients often did not know what medications were prescribed and for what purpose, and did not know when, if at all, the roving clinics would return.

## What then should volunteers and other disaster tourists do?

First, they should consider whether their trip is really necessary. Could the money spent on airfares, accommodation and so forth be better used if donated to charities and relief agencies at work in these disaster areas? If they went out, would they place an undue burden on local hosts and communities? What are the potential adverse effects of their efforts? Would their skills be put to better use by working with an NGO, such as Voluntary Service Overseas or Medecins sans frontieres, preferably on a longer-term basis?

If they are still intent on going out, they need to be adequately informed, trained and prepared. They should keep up to date with what is happening locally and check the advice of the Foreign and Commonwealth Office.

Medical and travel insurance is essential and they should ensure that their insurance covers disaster areas. Critically, many travel insurances have clauses that invalidate the cover if the volunteer travels to a disaster area against FCO advice.

While out in the disaster areas, volunteers need to be aware of their limitations and conscious of local sensitivities and culture. Most importantly, the disaster tourist should abide by the overarching principle of *primum non nocere*: first do no harm.

## Dates for your diary

8 September 2005

### Travel on a Thursday

RCN Travel Health Forum Annual Conference

Royal College of Physicians, London  
Contact: victoria.langley@rcn.org.uk

14 September 2005

### Health inequalities: patient and public safety

Health Protection Agency Annual Conference

University of Warwick  
Contact: www.hpaconference.org.uk

20 October 2005

### MASTA Annual Study Day

Royal College of Physicians, London  
Details at medical@masta.org

10–11 November 2005

### Travel medicine and infectious disease

1st International Conference of the *Journal of Travel Medicine*

Royal College of Surgeons of England, London

Contact:  
www.travelmedicine.elsevier.com

7–10 June 2006

### Northern European Conference in Travel Medicine (NECTM)

Edinburgh

Contact: NECTM 2006 Secretariat on 0131 556 9245 or email: NECTM@in-conference.org.uk . Details at www.nectm.com

23–25 June 2006

### Globalisation and health

5th European Conference on Travel Medicine

Venice

Details at www.ectm5.org

SANDRA GRIEVE reports on a day out with the RCN Forum Newsletter team.

## Advanced Editors Workshop aims to make newsletters both informative and fun!

In my fifth year in this role for our forum, I was fortunate to attend the first Advanced Editors Workshop for the RCN Forum Newsletter Editors. Held at RCN headquarters, the event was organised by the Newsletter Co-ordinator, Antonio Pineda, with freelance journalist Lynne Pearce as tutor for the day.

Previous participation at an editor's workshop was a prerequisite and eight editors attended. The RCN Print Production Controller, Louise Pope and Tanya West from the Sponsorship Department, were present to explain their roles. We valued meeting RCN staff involved with newsletters and hearing them acknowledge that our publications are a valuable resource and support.

The day began with an opportunity to mingle. Introductions showed the diversity of nursing backgrounds, a tiny sample of disciplines covered through the 75 RCN forums.

Ours is the largest newsletter produced by the RCN and it was interesting to see how other editors chose to compile and share their information. It became apparent how fortunate we are in the field of travel medicine to have support from our peers.

There was agreement on the desire to make newsletters informative and fun, and to seek ways of improving how information is presented. We exchanged ideas, examined our approach, discussed the use of digital photography and toyed with ways of changing newsletter titles for something pithier or eye catching (any ideas will be considered).

Each editor is a volunteer and dedicated to enhancing their skills. I personally was humbled to hear the level of expertise and everyone's enthusiasm was apparent. We were guinea pigs in this venture – I hope others will follow by attending what is a very worthwhile day.



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