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## Further information

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# Travel Health

## TRAVELLERS' TALES

In July 2006, Dr JON COSSAR Vice Dean, Faculty of Travel Medicine RCPSCG, celebrated his 60th birthday at 5,895m atop Mt Kilimanjaro. One year on and for those who reckoned his 61st would be a bit of a downer, he came up with an equally exhilarating experience at sea level. We just wonder how on earth (or where) he will be celebrating his next birthday!



## Hands-on travel medicine in Peru's Amazonia

Having heard about the work of the Vine Trust, I made contact and after an enquiry was allocated to a team scheduled for the Amazon Hope 2 (AH2) last July.

Not surprisingly, this stimulated a number of anxieties and apprehensions, both professional and personal. The professional concerns included having adequate skills for the task, no longer being in active clinical

work, unusual and unfamiliar illnesses, an uncertain clinical working environment, very limited access to supportive clinical investigation, and restricted and unfamiliar availability of medications.

My personal concerns encompassed the exposure to new, exotic pathogens, hazardous flora, fauna and disease vectors, language inadequacy and uncertainties about what was expected of me as well as limited or no knowledge about the composition, skills and personalities of my team colleagues.

### Not for the faint hearted

Pre-departure guidance notes included information on the Peruvian Health System,



Peru boat people

## Letter from the Chair

Summer is fast approaching and so is the time for the latest newsletter. Such a lot has happened since our winter edition – not least in April, when I attended the European section of the Commonwealth Nurses Federation Conference which included Malta, Cyprus and the UK.

This was a new departure for us as it was not a travel medicine conference – the aim was to widen the network and raise awareness of travel medicine in other countries and other areas of health care. Our poster provoked a lot of interest as did the two plenary sessions – one on the *Competencies* and the other on “developing a nurse-led speciality”.

We aim to capitalise on this approach and share our experiences wherever we can as we are fortunate in the UK to have such a service and access to study days and academic courses for formal education.

By the time you receive this, the NECTM2 conference in Helsinki will be over. We have played a full part in the conference organisation and, by doing so, have kept nurses in the wider arena of travel medicine practice. Our two lucky attendance winners will share their experience in the next edition.

### “Forums are here to stay”

So said Dr Peter Carter very emphatically in his address to Congress. However, the RCN restructuring process is ongoing and following a Forum Chairs’ meeting in April and another later that month at Congress, many issues were clarified – although there is still work to be done.

Meanwhile, there will be no forum elections until the restructuring process is complete so the current committee will remain in place until further notice.

There is still time to apply for free registration for our annual conference – see page 24 for details. It promises to be a good day and we hope to see you there, whether you win one of the three funded places or not. Also, do approach the committee and let us have your suggestions or concerns and we will do our best to address them.

**Sandra Grieve**



That's Sandra (second from left) in forum activist mode at Congress!

## In this edition

I hope that the contributors to the winter newsletter were pleased with their efforts and that it gave others a taste for writing. I am always happy to share your experiences, knowing we can all learn from each other.

Following our report last time on the Mountain and Wilderness Medicine Conference, I've had several queries regarding rabies boosters. Further information on the subject starts on page eight with a roundup of news, followed by a view from Dr David Shlim, whose comments were reported last time, and Sarah Lang's personal experience following a rabies booster that went wrong.

You will see that there have been several conferences and events on offer and the reports on pages four to seven are here to encourage you to attend. Remember that we offer financial help enabling attendance at educational events. Carolyn Driver attended the Asia Pacific Conference in Australia, Joyce Skeet reports on the MASTA conference and, together with Alex Jordan, she attended the first Faculty of Travel Medicine regional meeting in London. Similar events will follow so keep an eye on the websites.

Sadly, as we went to press, we learned of the untimely death of Professor Chris Curtis – a tribute to him appears on page seven.

If you are thinking of setting up a travel clinic, then Sarah Buckley has advice for you, starting on page 16. The travel bug is alive and well and Dr Cossar shares his experience on page 12 while Alex realised her dream with a magical trip to the Galapagos Islands, reported on page 14. My thanks as always to our contributors.

Have a good summer and travel safely.

**Sandra Grieve**

### Did you know you can read this newsletter online?

This and other forum newsletters are available on the RCN website even before they are mailed out to members.

So if you would like to be one of the first to read the next issue log on to **MyRCN** at [www.rcn.org.uk/myrcn](http://www.rcn.org.uk/myrcn), or call RCN Direct on **0845 772 6100**, to register your email address and opt in to our email services. You'll then be sent an email with a link through to the newsletter each time it is published rather than be sent a printed copy.

**Help us reduce our carbon footprint and save some trees!**

## NEWSROUND

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### New resuscitation guidelines

- The RCN, British Medical Association (BMA) and the Resuscitation Council (UK) have issued new guidelines for health professionals on resuscitation procedures following a cardiac or respiratory arrest. See: [www.bma.org/ap.nsf/Content/CPRDecisions07](http://www.bma.org/ap.nsf/Content/CPRDecisions07)
- *Emergency treatment of anaphylactic reactions* emphasises the importance of being transparent about decisions and adds advice on who should be informed. See: [www.nathnac.org/pro/news/anaphylaxis\\_110208.htm](http://www.nathnac.org/pro/news/anaphylaxis_110208.htm)
- The Mental Capacity Act has been included for those patients who lack capacity, who should be involved and what to do in the event of a disagreement between the clinical team and an appointed attorney.

Also see: [www.resus.org.uk](http://www.resus.org.uk) and [www.travax.scot.nhs.uk/registered/index-wn.asp](http://www.travax.scot.nhs.uk/registered/index-wn.asp)

### Universal hepatitis B vaccination

In June 2007 the BMA annual representatives meeting voted in favour of adding the BMA's voice to that of other UK expert groups, calling on the Department of Health (DH) to introduce the hepatitis B vaccine to the UK childhood schedule without delay.

The World Health Organization (WHO) had called for the global introduction of a vaccine prevention programme by 1997. By 2005, 82 per cent of countries in the world had introduced universal hepatitis B immunisation with 55 per cent of the world's children now receiving three doses of the vaccine.

The UK advocates an "at risk" policy due to the low incidence of hepatitis B in the UK compared to other countries. The argument raises the point that in the UK there are 180,000 people chronically infected with the virus and they can transmit infection to the un-immunised population. With increasing travel and migration the risk of transmission is increased. See Pollard, AJ (2007) *BMJ*, 335, p. 950.

### Hep B in national schedule Ireland

The National Immunisation Advisory Committee (NIAC) has notified changes for 2008 for the childhood schedule, including the addition of pneumococcal vaccine and hepatitis B vaccine as part of a six-in-one vaccine. There will be changes to the timing of haemophilus influenzae type B (hib) and meningococcal C vaccine. More at: [www.immunisation.ie/en/Publications/PDFFile\\_14064\\_en.pdf](http://www.immunisation.ie/en/Publications/PDFFile_14064_en.pdf)

### Updates to the Green Book

Updates are available to download as "patches" which can be placed over the existing text. Look out for the latest changes and insert them in your hard copy. They are at: [www.dh.gov.uk/en/PublicHealth/HealthProtection/Immunisation/Greenbook/DH\\_4097254?CONTENT\\_ID=4097254&chk=isTfGX](http://www.dh.gov.uk/en/PublicHealth/HealthProtection/Immunisation/Greenbook/DH_4097254?CONTENT_ID=4097254&chk=isTfGX)

### Re-launch of government sites

The Department of Health and Health Protection Agency websites have been re-launched to make them more user-friendly. See for yourself at: [www.dh.gov.uk/en/Home](http://www.dh.gov.uk/en/Home) and [www.hpa.org.uk/web/home](http://www.hpa.org.uk/web/home)

### PILs online

X-PIL ensures that patient information leaflets (PILs) supplied with medicines are accessible to everyone, including those with sight problems. See X-PIL online at: <http://xpil.medicines.org.uk>

### Information change

Sanofi Pasteur MSD has rewritten and reformatted the PIL for VAQTA® Paediatric with a minor change to the Summary of Product Characteristics (SPC). More at: <http://xpil.medicines.org.uk/ViewPil.aspx?DocID=17390#sectionS0>

### WHO's latest edition

WHO publication *International travel and health* (2008) is available online or to order from: [www.who.int/ith/en](http://www.who.int/ith/en)



### Medical tourism on the rise

The Joint Commission International (JCI) performs accreditation of international medical facilities. It currently accredits almost 200 medical facilities in 22 countries, but this figure is expected to reach 300 by the end of 2008. See: [www.jointcommissioninternational.com/23218/iortiz](http://www.jointcommissioninternational.com/23218/iortiz)

### Bringing problems home

The consumer magazine *Which?* found that one in five of those who travelled abroad for cheap medical treatment ran into problems. Of the 300 people surveyed, eight per cent needed NHS emergency care on return and a quarter did not receive the follow-up care they expected. In 2006 approximately 80,000 people went abroad for surgery.

### Education Skills for Health

A fringe event at Congress launched a series of workshops for the summer of 2008 called: "Step forward into your future – using the KSF". The workshops aim to raise awareness and understanding of the NHS Knowledge and Skills Framework and how to realise its benefits in enabling you to demonstrate your role, service, and value to patient care and your employers. The workshops will demonstrate the tools and resources the RCN and Skills for Health have to support the development of yourself, your teams and the services you deliver.

#### 2008 workshop dates:

- 20 June – RCN Offices, Edinburgh
- 9 July – RCN Offices, Ty Meath, Cardiff
- 4 September – Skills for Health Offices, Brewer's Wharf, Leeds.

## TRAVEL HEALTH ON THE CONFERENCE TRAIL

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ALEX JORDAN and JOYCE SKEET were there and send this report.

# THE FACULTY OF TRAVEL MEDICINE (RCPSG) The Nets and Bolts

4 April 2008

The RCPSG Faculty of Travel Medicine held a regional spring meeting in the Teaching Laboratory of the London School of Hygiene and Tropical Medicine with 40 delegates attending – and what a busy day it turned out to be!

There were 10 delegates allocated to each of four stations and rotated around the experts in the laboratory.

Travelling round in the same group, we started with Professor Chris Curtis, who introduced us to *Culex* and *Anopheles* mosquitoes contained in glass jars and passed them around to identify males and females.

He explained how millions of treated bed nets are being manufactured and given to families, helping to reduce the number of malaria cases in Africa. He demonstrated how effective treated bed nets are by placing some mosquitoes into a small netted area – they were all dead in 10 minutes.

An invitation was extended to interested parties to view the mosquito breeding centre, based in former coal cellars of houses in Gower Street. So seven of us crammed into this tiny cave-like space to see mosquito larvae, pupae and adults in various stages of development. Absolutely fascinating!

### RDT in action

Next was Professor Peter Chiodini who explained how Malaria Rapid Diagnostic Tests (RDTs) work and he got everyone to do a test using the medium, reading the result 20 minutes later.

It's easy to see how difficult this could be if the user had a high temperature and was feeling unwell. These tests could transform malaria diagnosis in the future, but a study done in Cambodia showed that 40 per cent of tests were kept too hot so quality control is essential.

Dr Nigel Hill demonstrated the number of insect repellents on the market and those which worked best, explaining that garlic and vitamin B are useless and shouldn't be considered. He showed various coils that can be burned to eradicate mosquitoes indoors and items of clothing impregnated with insecticide.

Marie Blaze from the Malaria Reference Laboratory discussed the number of imported cases of malaria into the UK over the last 30 years. Numbers haven't really changed, but there has

been an increase in the number of *P. falciparum* cases from travel to Sub-Saharan Africa.

In 2007 there were only 14 cases imported from Central and South America and 11 of these were due to Vivax. Prophylactic drug regimes and guidelines for pregnant and breastfeeding



Professor Chiodini demonstrates how the RDT works.

women were discussed. We were also given a copy of the UK malaria guidelines.

### **When the love bug bites**

After lunch Mark Longman from Camden PCT gave an informative talk including useful tips on sexual health education for travellers. With the growing number of travellers going abroad for medical surgery and sex tourism (and unplanned sex), travellers need to be reminded of the importance of using condoms and femidoms.

These travellers need to be aware of STIs, Hepatitis B and HIV risks. He showed how many anti-retroviral tablets a patient with HIV would take daily.

Sun awareness and dermatology in the traveller was addressed by Professor Vega-Lopez. He explained that sunburn, ageing and skin cancer were the three main problems caused by the sun. Travellers should be encouraged to use sun blocks with a high factor which protects against UVB, but also having 4\* will protect against UVA.

Still, 25 per cent of all travellers will return with a skin problem. He recommended the good old tea bag to be used for treating pyogenic skin infections and insect bites.

### **No traveller should be without ...**

Professor Goodyer demonstrated medical kit contents for the independent traveller and gave details for larger packs used for expeditions.

Our last station was “Water Purification in the Field” where Sqdn Leader Tania Thomas from the Ministry of Defence gave a very useful presentation on the variety of products and devices on the market for purifying water.

She has served in Iraq and Afghanistan so was used to advising troops on the necessity and safety of water purification pre-deployment. We then got to “play” with various products set up in the laboratory and to see how they worked.

The day ended with us being given a pack containing a CDROM which included all the presentations and useful WHO maps on the global distribution of malaria and areas of drug resistance.

There are plans to present this day again in other parts of the UK so if you get a chance to go, it will be a day well spent!



## **A tribute to Professor Chris Curtis**

As we were going to press we received the sad news that Chris Curtis died on 13 May after a brief, sudden illness.

Chris was one of the world's leading medical entomologists. He has made enormous contributions to the science and application of vector control and his pioneering studies have laid the foundation for many of the current approaches to controlling malaria.

Equally importantly, he was a tireless educator who has inspired generations of students all over the world.

The huge volume of messages that have flooded in and the depth of feeling that they express show that there is a remarkably large community of people, scattered over the world, whose work and lives have been given lasting inspiration by Chris's gentleness, integrity, generosity and commitment. Our thoughts are with Jill and his family.

As a tribute, we show him here in full flow at the “Nets & Bolts” conference in April, doing the work he loved. Chris was never too busy to answer nurses' questions and he will certainly be missed on the malaria circuit.

### **Sandra**



**Prof Chris Curtis in full flow on mosquito nets**

## TRAVEL HEALTH ON THE CONFERENCE TRAIL

SANDRA GRIEVE has been spreading the word about travel health within the wider nursing world.

### The Commonwealth Nurses Federation (CNF)

4-5 April • Malta

This event was hosted by the Maltese Nursing and Midwives Union, the Cyprus Nursing and Midwifery Association and the RCN. Attendance represented a new departure for the Travel Health Forum and a means of raising awareness of our discipline in the wider nursing arena.

Programme topics were varied and ranged from treating mouth ulcers in children undergoing chemotherapy to new ways of using technology to teach nursing students.

#### Exciting research from very diverse areas of practice

Working within the armed services is a nursing skill which is very demanding and involves more than a good bedside manner. We felt fortunate that serving personnel were on hand to share their experience.

On a lighter note, we were entertained by traditional Maltese dancing and addressed by the Minister of Health for the island. Malta has a brand new hospital and recently joined the European Union so the island is changing and the population growing.

As always at these meetings, it's the networking and meeting people you'd never come across otherwise that is most beneficial. Sometimes it's good to "specialise", but it's also good to share information with nurses in other specialties and that's what we did.

Cyprus will host the next meeting in 2010.

CAROLYN DRIVER attended the Asia Pacific ISTM Conference in Melbourne on behalf of the forum and sends back this report.

## Travel medicine down under!

I was fortunate to leave the wet British winter behind in February to attend the third Regional Conference of the International Society of Travel Medicine which was co-sponsored by the Asia Pacific Travel Health Society and the Australasian College of Tropical Medicine.

It was held in Melbourne and although the local delegates were complaining about their "poor" summer, it was the sort

of weather we would be thrilled to have anytime.

Around 600 delegates attended, mostly from Australia, New Zealand and SE Asia. The focus was on the host region so it was particularly interesting for those of us from Europe to learn more about the important issues in that part of the world.

Avian influenza and the possibility of a pandemic naturally were discussed, but

JOYCE SKEET reports on a most interesting event from Medical Advisory Services for Travellers Abroad – or MASTA – a leading private travel health provider with a network of travel clinics across the UK.

## MASTA Travel Medicine Study Day

30 November 2007 • Royal College of Physicians, London

This event attracted over 180 delegates and began with Professor Warrell giving an informative talk on the seriously ill returning traveller. He reminded us that not all infectious diseases are "exotic" and recalled seeing a man suffering from a severe case of chicken pox.

Some travellers returning ill can be misdiagnosed and he cited two cases of rabies where both travellers died. In India in 2005 some 16 million reported bites and there were 20,000 deaths from rabies. We should educate travellers and encourage pre-exposure vaccination.

Malaria, dengue and leptospirosis are all seen in returning travellers so taking a detailed travel history is important.

#### A varied programme

An update on Japanese encephalitis from Lieutenant Colonel Ross followed. He asked: "Has anyone here seen a hypersensitive reaction to JE Vac?" – not one hand went up!

Centers for Disease Control and Prevention (CDC) estimate that the seasonal risk is one case per 20,000 travellers per week. As the risk exists in Asian countries, travel advisers should not be dogmatic in refusing the vaccine when requested.

Malaria, including misunderstandings and reasons for stopping prophylaxis, was covered by Nurse Adviser Lynda Bramham (MASTA). In 2006 there were 1,758 cases of malaria in the UK with eight unnecessary deaths, mainly owing

we also learned about the local flora and fauna, particularly those that may bite or sting! It was a wonderful opportunity to hear from people who live and work in the more remote parts of the region such as the Solomon Islands, Fiji and Vanuatu.

### **Nurses to the fore**

There was a very interesting nurse-led session on what happens to tourists who visit Australia. Trauma featured significantly and was usually due to engaging in familiar activities in unfamiliar conditions, with poor planning or naivety playing a major role.

Sadly there was very little nurse participation in the programme although a significant number of nurses were among the delegates. However, Fiona

to failure in taking prophylaxis.

The main reasons for stopping tablets were forgetting, “no mozzies” and not understanding how important prophylaxis was. Educating travellers on the importance of completing the course and reminding them that malaria is the largest killer of humans today may help.

### **Flying the RCN flag**

Sandra Grieve, Chair of RCN Travel Health Forum, presented an update on what’s new in travel medicine. No delegate could say they left not knowing where to get information on malaria, competencies, norovirus on cruise ships, yellow fever vaccination centres, diarrhoeal illness and avian flu – to name but a few!

Sandra provided website addresses and reminded us of the number of travellers who will be heading off to the Olympic Games in China this summer.

Advice for space travellers may be the future for travel health practitioners!

The afternoon covered how to avoid medical legal pitfalls. Professor Seymour from the Medical Protection Society said we must recognise our own limitations and, if asked to help in a mid-air crisis, remember that the crew is trained and must take the lead.

Genasi (from Health Protection Scotland) and I held an informal get together during a session break and described the activities of the RCN Travel Health Forum, particularly the publication of the *Competencies for nurses working in travel medicine*.

The nurses were very interested and we gave them food for thought as, although there are opportunities for education in travel health, there is no cohesive nurse group that can help to drive forward standards in the region.

Our well travelled poster was displayed and the UK was also represented by a stand advertising the Faculty of Travel Medicine of the Royal College of Physicians and Surgeons of Glasgow.

### **Roof of the world**

Dr Paul Richards who was involved in the Xtreme Everest project gave a very graphic talk on travel in Nepal, the health risks and medical facilities.

In Nepal there are around 100 deaths a year from rabies with monkeys held responsible for 45 per cent of the risk exposure. And annually there are about 10,000 cases of malaria, the main transmission period being June – August. However, he showed beautiful slides and I have definitely added Nepal to my list of places to visit!

Last on the programme Shane Winser covered safety and security issues for travellers. He told us about **red24** – the world’s largest security specialists who protect their members if they have a problem while travelling abroad.

**AlertNet** provides news, information and analysis for everyone interested in emergency relief. There are now British Standards for gap year, school and university trips. **BS 8848** aims to give one person overall responsibility for each trip and they will give accountable and defined roles to the others.

This was an excellent study day, packed with interest and great speakers.

## **MALARIA DOSSIER**

### **Supporting a charity**

The Travel Health Forum is supporting the RCN Presidents Project aimed at ICROSS, a small charity working mainly in Kenya and Tanzania. ICROSS has a project that provides malaria nets for HIV+ mothers and children. The project was promoted at RCN Congress and will be highlighted at our forum conference in September. Anything that can help reduce the burden of malaria is worthwhile and we hope you will support us in this endeavour. Have a look at their website: [www.icross.ie](http://www.icross.ie) and sign up to the newsletter to view their work.

### **RCN Congress resolution update**

Last year the forum seconded a resolution entitled “Back WHO on Malaria”. Council’s report on progress can be seen here.

[www.rcn.org.uk/newsevents/congress/2008/2007\\_agenda\\_items/13\\_back\\_who\\_on\\_malaria](http://www.rcn.org.uk/newsevents/congress/2008/2007_agenda_items/13_back_who_on_malaria)

### **Malaria statistics**

*Malaria imported into the UK in 2007: implications for those advising travellers* suggests that although figures are slightly down, “a significant cause of infections is failure to take prophylaxis”. See Health Protection Report (HPR) 2 (17) 25 April for the full report: [www.hpa.org.uk/hpr/archives/2008/hpr1708.pdf](http://www.hpa.org.uk/hpr/archives/2008/hpr1708.pdf)

### **Malaria guidelines**

Have you got your copy yet? Download from: [www.malaria-reference.co.uk](http://www.malaria-reference.co.uk). And keep an eye on the website for updates.

### **World Malaria Day**

World Malaria Day was held in London on 25 April and from now on will be celebrated on this date each year. The forum was represented at the event and further information is available from: [www.malariaconsortium.org/pages/world\\_malaria\\_day\\_2008.html](http://www.malariaconsortium.org/pages/world_malaria_day_2008.html)

### **Malaria Awareness Week**

If you celebrated this in your workplace in May, write in and tell us what you did – ED.

## RABIES ROUNDUP

### Weekly Epidemiological Record (WER) WHO

Rabies Vaccines: WHO position paper. 7 December 2007. No 49/50 82 425-436.

### Information for UK travellers and health professionals is available from:

- TRAVAX: [www.travax.scot.nhs.uk/registered/index-wn.asp](http://www.travax.scot.nhs.uk/registered/index-wn.asp)
- NaTHNaC: [www.nathnac.org/pro/factsheets/rabies.htm](http://www.nathnac.org/pro/factsheets/rabies.htm)
- Immunisation against Infectious Disease (The Green Book) Rabies Chapter 27: [www.dh.gov.uk/en/PublicHealth/HealthProtection/Immunisation/Greenbook/DH\\_4097254?CONTENT\\_ID=4097254&chk=isTfGX](http://www.dh.gov.uk/en/PublicHealth/HealthProtection/Immunisation/Greenbook/DH_4097254?CONTENT_ID=4097254&chk=isTfGX)

### CDC Yellow Book

[www.cdc.gov/travel/yellowBookCh4-Rabies.aspx](http://www.cdc.gov/travel/yellowBookCh4-Rabies.aspx)

A table of risk exposure and booster recommendations from WHO is at: [www.who.int/rabies/human/sympt\\_pre\\_exp/en](http://www.who.int/rabies/human/sympt_pre_exp/en)

### “We don’t do rabies”

During a weekend trip to Bucharest, a traveller was bitten by a stray dog. She had heard horror stories of hospitals in Romania, but decided that a visit was preferable to developing rabies. She received excellent care, but do read about her experience on returning to the UK and her attempts to complete the post-exposure rabies vaccine course. It’s in the New Statesman:

[www.newstatesman.com/200803270028](http://www.newstatesman.com/200803270028)

### Rabies in bat case

A Dutch woman scratched by a bat while she was on holiday in Kenya died of human rabies (Duvenhage virus) in Amsterdam in December 2007. She had received only first aid at the health centre in Kenya as staff were not aware of rabies in bats in the area and no further action was recommended. When symptoms developed upon her return home she received both passive and active post-exposure prophylaxis (PEP) for rabies, followed as her condition deteriorated by the experimental “Wisconsin rabies treatment protocol”, but she subsequently died. This incident shows that in a rabies endemic area PEP has to be applied in case of every, however minor, bite or scratch exposure to a mammalian animal, including bats. *Euro Surveill* 2008;13(2).

Available online:

[www.eurosurveillance.org/edition/v13n02/080110\\_01.asp](http://www.eurosurveillance.org/edition/v13n02/080110_01.asp)

### Canine rabies in France

In February the Pasteur Institute in France confirmed a case of rabies in a dog from an area outside Paris. The dog, thought to have been imported from Morocco, was destroyed. Following a veterinary investigation two other dogs were suspected to have died from rabies. As a result of this incident France lost its rabies free-status.

The HPA advised anyone who has sustained a dog bite while travelling or visiting the affected regions to seek medical attention. The risk to humans from this incident is considered low.

More information from:

- [www.hpa.org.uk/hpa/news/articles/press\\_releases](http://www.hpa.org.uk/hpa/news/articles/press_releases/2008/080303_rabies.htm)

[/2008/080303\\_rabies.htm](http://www.nathnac.org/pro/clinical_updates/rabies_040308.htm)

- [www.nathnac.org/pro/clinical\\_updates/rabies\\_040308.htm](http://www.nathnac.org/pro/clinical_updates/rabies_040308.htm)

The Health Protection Report (25 April 2008) at: [www.hpa.org.uk/hpr/news/default.htm#rab](http://www.hpa.org.uk/hpr/news/default.htm#rab)

### From ISTM Listserve

A review of human rabies vaccines by Debra Briggs in the second edition of *Rabies* (2007) edited by Alan Jackson and William Wunner. ISBN 978-0-12-36966-2.

Professor Henry Wilde’s group has published a practical summary of issues with PEP in Thailand in *Travel Medicine and Infectious Diseases* (2007), 5, pp.189–193. See: [www.who.int/en](http://www.who.int/en)

### Links:

- [www.worldrabiesday.org](http://www.worldrabiesday.org) (click on teaching materials) – AVMA has a useful PDF brochure.
- [www.rabiescontrol.org](http://www.rabiescontrol.org) has a map and information useful for handouts.
- [www.cdc.gov/rabies](http://www.cdc.gov/rabies) has fact sheets, a children’s site and a two-page PDF bat brochure.
- [www.cdc.gov/healthypets/diseases/rabies.htm](http://www.cdc.gov/healthypets/diseases/rabies.htm) has information for public on animals and rabies.

### Advice for GPs on how to deal with patients with dog bite injuries

The Medical Defence Union (MDU) has warned GPs to take particular care when treating patients with dog bite injuries. Figures showed the number of patients attending A&E with such injuries has increased by 40 per cent over the past four years.

MDU medico-legal adviser Dr Michael Devlin said: “If not properly managed, animal bites can have serious repercussions for the patient, including infections, scarring, nerve damage, psychological effects and even death, which is why we are warning GP members to take particular care in assessing trauma caused by animal bites.” See: [www.the-mdu.com](http://www.the-mdu.com)

# WORLD RABIES DAY

## 28 September 2008

SARAH LANG got a rather nasty surprise when she went for what she thought would be a routine rabies booster. She works for the Oxford Vaccine Group so although rare, it could happen to anybody!

## The harrowing tale of a rare rabies reaction

I had never really noticed the sentence at the bottom of the paragraph in text books saying “up to six per cent of persons may develop an allergic reaction compatible with a type three hypersensitivity/immune complex reaction to a booster dose of rabies vaccine”. More importantly, I did not know that this reaction could be delayed.

However, I was shortly to be made aware of all this as I had my very own rabies vaccine reaction.

Prior to starting my world travels in 1997 I received a full IM pre exposure course of rabies vaccine. Then 10 years later, in September 2007, I received a booster vaccine. Then, 12 days following the booster, I began to develop urticaria.

### A mystery

The urticaria began on my palms and buttocks, then my trunk, legs and scalp. Having enjoyed a leisurely lunch in the garden I couldn't think of anything I had consumed or touched that would have set this off.

As it was the weekend, I attended the out-of-hours service and was treated with fexofenadine and piriton. Nonetheless the urticaria continued to intensify with small areas joining to become large patches, intense irritation and arthralgia.

By the second evening I felt like I had head lice my head was so itchy and hot. Some 30 hours after the reaction started I awoke at 4 am and was horrified to find a very puffy face and my lips about four times their normal size. The on-call doctor suggested I put the phone down and call 999.

A very unimpressed paramedic – I was not anaphylactic – transported me to A&E and after two doses of IV piriton, some IV

Some 30 hours after the reaction started I awoke at 4 am and was horrified to find a very puffy face and my lips about four times their normal size. 🐾

hydrocortisone and metoclopramide I was back home.

Even after this the reaction continued to flare with new patches of urticaria appearing on my abdomen, arms and legs. One week of oral prednisolone and two further weeks of antihistamines were required to settle the reaction.

### At last, an explanation

It was only when I saw my GP four days after the reaction began that the link was made with the rabies vaccine and Dr Andrew Pollard, my colleague at the Oxford Vaccine Group (OVG), confirmed that this was a type III hypersensitivity reaction.

**A type three hypersensitivity reaction** is assumed to occur when a person who has high numbers of circulating antibodies is administered an antigen causing the formation of immune complexes in the circulation. Some immune complexes are not removed by the usual process of phagocytosis and may be deposited in the walls of blood vessels which manifest as macular rashes, urticaria and angio-oedema.

The reactions following booster doses of rabies vaccine have been associated with the presence of **betapropiolactone**-altered human albumin in the HDCV and

the development of immunoglobulin E (IgE) antibodies to this allergen.\*

Another OVG colleague, virologist Dr Mary Warrell, explained betapropiolactone's use: “The vaccine virus is inactivated by betapropiolactone which acts as a hapten, rendering other vaccine constituents, notably human serum albumin, immunogenic.” (personal communication)

### It happens ...

From a practical point, there are no determining factors to predict these reactions. Most of the data on these reactions are reported from the US. But practitioners should be aware of the rare chance of occurrence so that if it should occur patients can be well managed.

Until the rabies vaccine was identified as the cause of my reaction, I was very anxious about eating anything potentially allergenic as I had discounted such a long time from administration to reaction.

So if I am ever bitten by an animal in a rabies endemic area, would I have post exposure rabies vaccine? Yes, of course, as my non anaphylactic reaction is not a contraindication to further immunisation.

\* CDC at: [www.cdc.gov/mmwr/PDF/rr/rr4801.pdf](http://www.cdc.gov/mmwr/PDF/rr/rr4801.pdf) – page 15.

### Further reading

Anderson MC, Baer H, Frazier DJ and Quinnan GV (1987) The role of specific IgE and beta-propiolactone in reactions resulting from booster doses of human diploid cell rabies vaccine, *J Allerg Clin Immunol*, 80, pp.861–868.

Dreesen DW, Bernard KW, Parker RA et al. (1986) Immune complex-like disease in 23 persons following a booster dose of rabies human diploid cell vaccine, *Vaccine*, 4, pp.45–49.

Swanson MC, Rosanoff E, Gurwith M et al. (1987) IgE and IgG antibodies to  $\beta$ -propiolactone and human serum albumin associated with urticarial reactions to rabies vaccine, *J Inf Dis*, 155, pp.909–913.

Warrington RJ, Martens CJ, Rubin M et al. (1987) Immunologic studies in subjects with a serum sickness-like illness after immunization with human diploid cell rabies vaccine, *J Allerg Clin Immunol*, 79, pp.605–610.

## RABIES ROUNDUP

### A Q&A on rabies: Dr David Shlim

Responding to information we published within the Mountain and Wilderness Medicine World Congress report in our winter edition, I received enquiries surrounding the need for rabies boosters following a complete three-dose pre-exposure rabies vaccine course.

I wrote to Dr David Shlim, who was quoted in the article, and this is his response:

“This question has no clearly definitive answer as yet. However, it does seem true that after someone initially seroconverts, the immune memory is long lasting and boosts readily.

“The Centers for Disease Control and Prevention (CDC) has published guidelines since at least 1985 that state that routine boosters are not necessary for international travellers (who are likely to only have noticed exposures and seek a booster at that time). If someone is likely to have unnoticed exposures (through working with sick animals, for example, or while spelunking\*), then maintaining a higher circulating antibody is thought to make sense.

“Whenever I had the opportunity, I tested people who had had their initial series seven-to-15 years earlier. In each case they had an acceptable level of antibody, and boosted readily. But these are only a handful of cases. These cases are consistent with what everyone else has found so far. On the positive side, no one who has had pre-exposure rabies immunisation and then been boosted

after a possible rabies exposure has ever developed rabies.

“So, you can go to the CDC website and search the Morbidity and Mortality Weekly Report (MMWR) and find the references under three different issues that focused on rabies. Without looking it up, I think they are in 1985, 1991 and 1999. They all say the same thing, and represent the references that you are looking for.

#### Eliminating doubt

“No one really knows how long this boostable memory lasts, but there are some anecdotal cases of boosting evident after 25-to-30 years. I would think you would probably want to give a single booster every 10 years or so for expatriates and frequent travellers. This is not based on anything other than trying to simplify advice and eliminate doubt if someone presented with a possible rabies exposure 20 years after their initial series.

“I hope this helps. You can explain to your members that there has been no way to actually test the efficacy of rabies vaccines in controlled trials. So it leaves us in this realm of trying to be certain we can prevent rabies, but not really knowing what that takes. I think since the earlier rabies vaccines were poorly immunogenic, it took a while to understand how good the current vaccines are”.

\* *Spelunking is another name for caving*  
– ED.

**Search for further information at:**  
[www.cdc.gov/mmwr](http://www.cdc.gov/mmwr)

### The WiPP ‘SNAPshot’ survey of practice nurses

A national survey of practice nurses across the UK sponsored by the Department of Health and funded Working in Partnership Programme (WiPP) has produced data about levels of professional development support in practice.

A total of 1,161 nurses participated anonymously in the online survey. The findings give an insight into factors that are associated with effective professional development and may therefore enhance

nursing competence and quality of care. These factors include employment standards, access to education and clinical supervision, GP/nurse relationships and nurses’ attitudes.

**Supporting nurses and practice. A national survey investigating employment conditions and professional development support for nurses in the UK is at:** [www.wipp.nhs.uk/uploads/GPN/Final%20Report%20SNAPshot%20Survey.pdf](http://www.wipp.nhs.uk/uploads/GPN/Final%20Report%20SNAPshot%20Survey.pdf)

## WORLD IN BRIEF

### RCN International Department

The World Health Organization marks its founding each year by drawing worldwide attention to a health issue of global importance. This year’s theme for World Health Day on 7 April was protecting health from climate change ([www.who.int/world-health-day/en](http://www.who.int/world-health-day/en)). It aimed to put health at the centre of a global dialogue and raise awareness of the key areas.

In 2006 the UK Government commissioned the former Chief Executive of the National Health Service, Lord Crisp, to review how it could contribute towards health in developing countries. His report, published in February 2007, set out 16 recommendations that the Government welcomed, highlighting how it will help end the shortage of nurses and doctors in the world’s poorest countries. See: [www.dfid.gov.uk/news/files/pressreleases/boost-health-workers.asp](http://www.dfid.gov.uk/news/files/pressreleases/boost-health-workers.asp)

The UK Government issued its formal response to Lord Crisp’s review in March 2008, accepting the recommendations and giving timescales, resources and lead responsibilities for nine of the 16 proposals. The response is at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_083509](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083509)

The report commits both the Department of Health and the Department for International Development to establishing a UK international health links centre, providing over £1 million annually for health links.

#### For more information contact:

- Gabrielle Levy, RCN European and International Information Assistant, at: [gabrielle.levy@rcn.org.uk](mailto:gabrielle.levy@rcn.org.uk)
- Susan Williams, RCN Head of International Affairs, at: [susan.williams@rcn.org.uk](mailto:susan.williams@rcn.org.uk)

# Good Samaritans: Are you covered?

The good intentions of the “Good Samaritan” may be honourable, but are they enough to protect you from litigation?

Many health professionals would respond to an emergency situation without thinking, whether or not they are legally covered. But with more people travelling further afield on aircraft, these situations may arise more often.

There’s relevant information in *Flying doctors: is protection plain?* – the Medical Protection Society United Kingdom Casebook, 16 (1), published in January 2008. You can download it at: [www.medicalprotection.org/uk/casebook/in-flight-emergencies](http://www.medicalprotection.org/uk/casebook/in-flight-emergencies)

## What does the RCN Legal Team think?

Nurses often act as “medics” for expeditions or may be asked for help in an emergency situation when they are participating members of a group holiday abroad. Doctors too are concerned about the legality of treating people or prescribing drugs in other countries.

I wrote to Chris Cox of RCN Legal Services to ask where we stand in the event of having to perform a good Samaritan act.

### Here’s Chris Cox’s reply:

“I refer to your email raising a number of questions about the RCN indemnity insurance scheme. I can advise as follows:

1. RCN members are covered when performing a ‘professional nursing service acceptable to the RCN’. I have no doubt that a nurse traveller would, in general, satisfy that definition when giving treatment or aid to an injured traveller.
2. Assuming that it is, cover is available *anywhere in the world*, save in respect of a *claim arising in the USA or Canada*. In relation to those

**So far as the RCN scheme is concerned, there is simply a blanket ban on coverage in relation to US/Canadian claims. 9**

exclusions, it doesn’t matter whether the incident/accident in fact happened in either country. The exclusion applies *where the claim is launched in either country* (the law on which country has jurisdiction to deal with an accident, either which arises on its territory or which affects a citizen abroad, is a complicated matter of ‘private international law’). But so far as the RCN scheme is concerned, there is simply a **blanket ban** on coverage in relation to US/Canadian claims.

3. As you say, where the nurse traveller is accompanying an organised group or working for an organisation, it is possible that the organisation will have insurance cover to deal with any incident affecting a member of the group, though that will not always be the case. We would encourage organisations to obtain cover in these circumstances. An organisation will be liable for an employee’s actions so if the nurse is employed by that organisation, then I would expect the latter to have its own insurance cover.
4. Where the RCN member has cover through the RCN and there is group cover for the same risk (that is, two or more insurance arrangements for the same risk), who ultimately pays will be determined by the terms of the insurance contracts and insurance law.
5. The RCN scheme protects any good Samaritan who goes to the rescue of someone who has been injured.

6. In general, nurses should not undertake any role/task for which they feel that they are not competent. In an emergency situation, where no other support is available, the nurse would probably be covered by the good Samaritan provisions if undertaking a procedure to try to safeguard life.

7. The law on the supply and administration of medicines varies throughout the world. In general, nurses working abroad should check on whether the law permits them to perform a particular task/role in respect of any particular country in which they are likely to be travelling. They should then abide by the relevant local law (obviously, the law applicable in the UK is irrelevant for this purpose). This is very important as it may be a criminal offence for a nurse to perform certain tasks in relation to medicines in certain countries.

The RCN scheme will only cover accidental injury and hence criminal offences are not generally covered. However, in an emergency situation, where the nurse was asked to administer a drug in circumstances where he/she felt confident to do so, but was not technically covered by legislation in the UK to do so (and it wasn’t a criminal offence in the country in question), I believe that the RCN scheme would apply.”

## STOP PRESS

The forum is sponsoring two places to attend CISTM11 in Budapest (see page 24). Download an application form at <http://www.rcn.org.uk/travelhealth/1234>  
**Deadline: 23 December 2008.**

# TRAVELLERS' TALES CONTINUES FROM PAGE ONE



“When can you start?” By 2.30pm consultations were underway.

### Multi-national and multi-skilled

Our multi-national team was comprised of two doctors (Scotland and Canada), three dentists (Scotland and Isle of Man), one nurse (Scotland), one medical student (Scotland), one translator (England), and one translator and medical student (Trinidad and Tobago) – along with a Peruvian doctor, nurse, midwife, laboratory technician and translator.

Amazingly and reassuringly, our broad skills mix of general practice, travel medicine, emergency paediatrics, operating theatre work and dentistry were complementary and met the medical needs of the indigenous village populations which ranged from the acutely ill adult/child requiring intravenous therapy to the more mundane.

A typical day could begin at 5.30am with an optional exercise class, then morning devotions (7am), breakfast (7.30am), a village walk (8.30am), consultations (9.30am–1pm), lunch, more consultations 2.30–4.30/5pm), football/volleyball match in the village (usually losing), dinner 7pm and staying awake until 9pm (on a good night!).

The boat would move on to another village location in the evening, early morning or occasionally at lunchtime.

### Bonding as a team

The Peruvian medical team, translator and boat crew (captain, engineer, cook et al) were extremely supportive and helpful. They were not only fellow work companions, but also became our good friends – essential in such a close working environment with 23 of us in total sharing confined facilities aboard ship. Although there were physical and psychological stresses to endure we bonded as a team and “felt special”.

During our nine days on AH2, over 850 indigenous Amazonian villagers attended the boat for medical treatment. Conditions



a typical drug formulary onboard ship, prescribing policy, common illness presentations, recommended immunisations, health advice and a “kit” list.

Also – alarmingly – I found the protocols in the event of severe or life threatening illness or accident in the local people or in members of the medical team (evacuation by seaplane), all rounded off with the Australian Management of Snake Bite! Although comprehensive, there remained many unanswered questions.

The outward journey began at 3 am UK time and ended at 12.30pm Peru time the next day, encompassing a total of 39 hours. This included the time shift (+six hours), three flights, four hours in bed and a final three and a half hours on a fast boat to reach the AH2.

We had lunch on arrival, then were asked:

*It was a great opportunity for the medical enthusiast, for minimal “high tech” interventionist medicine and certainly for maximum use of age-old medical skills, like basic history taking and clinical examination. ♪*



Linda, De, Ele, Moira, Jon, Seen, Heather & John - the team!

treated ranged from snake bite, the acute abdomen, the “fitting” child, life-threatening dehydration, osteomyelitis, abscesses, and malaria to the removal of a bullet. There were also as many cases of skin infections/ infestations, and diarrhoea and vomiting.

The diagnostic breakdown (approximate) was gastro-intestinal 15 per cent, anaemia 12 per cent, musculo-skeletal 10 per cent, urogenital seven per cent and “other” 36 per cent, many with multiple diagnoses.

Everyone attending was treated for parasitosis (an additional 732) and we also provided childhood immunisations and antenatal care. The dentists carried out over 100 fillings and 250 tooth extractions.

**Reaching the poorest**

There were conditions which were outside the scope of our treatment resources, but it was a comfort to be able to advise that as from 1 August 2007 a law had been passed in Peru such that medical treatment is to be freely available to the poorest.

This still leaves the problem of transport and associated costs in getting to Iquitos, the largest jungle city in the world which is accessible by boat/plane but not by road. This is the nearest and only available medical facility.

There were times when we all felt inadequate and overwhelmed by the sheer scale and nature of the problems we encountered. Perhaps we gained a relevant



The team – on station

perspective faced with the reality of the Amazon at Iquitos, some 2,000 miles from the Atlantic and yet still over a mile wide with a drop in level of 30-50 feet between the wet and dry seasons. One of nature’s true “giants”.

Suddenly the nine days, which initially seemed to stretch ahead in an almost impossibly daunting timeframe, came to an end. The boat took one and a half days sailing to arrive back in Iquitos and there we visited the clinic in Belen and the residential school for orphan boys



Peruvian boys

CONTINUES ON PAGE 19

## FEATURE

Thanks to ALEXANDRA JORDAN for sharing her unforgettable experiences.

# My Galapagos dream

The Galapagos Archipelago consists of 14 large islands (greater than 10km<sup>2</sup>) and more than 120 smaller islets and rocks. It is well isolated from other land masses – South America is 960km away and Coco Island, Central America, is 720km away. The total land mass is 8,000km<sup>2</sup> and the marine reserve is 138,000km<sup>2</sup>.

In April 2006 I managed to co-ordinate annual leave, finances and a tour company that would organise a trip to the Galapagos that would meet my needs. I had dreamt of travelling there since learning about Charles Darwin and *The Origin of species* during Biology A level so it was a very long time coming.

I was soon to discover that actually getting to and from the islands would be an odyssey in itself!

It started with a 40 minute flight from Heathrow to Amsterdam, then a nine hour flight to Bonaire, Dutch Antilles for a refuelling stop. Another two and a half hours to Guayaquil, Ecuador, the country's biggest city and main port, and a further half hour to Quito, the capital. (The return journey completed the loop via Guayaquil.)

### A brilliant hotel for recovering

I stayed two nights in the Café Cultura Hotel, right in the centre of town. This wonderful place was my bolt-hole for recovery after travelling from the UK.

The former home of one of Quito's oldest families, it subsequently became the French Cultural Centre. A post-colonial building with whitewashed walls and traditional terracotta roof, it is surrounded by a beautiful lush garden with resident hummingbirds.

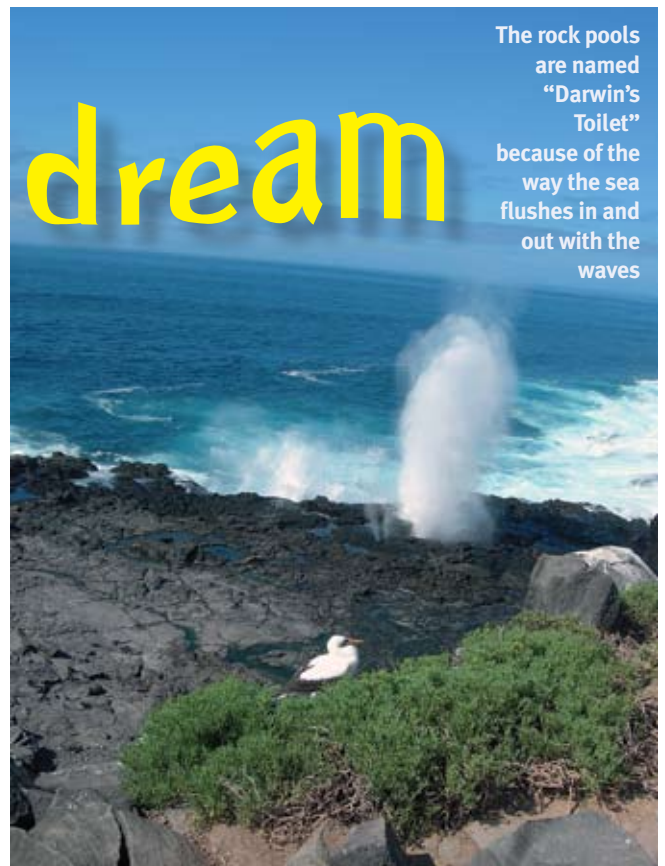
Inside is wood panelled floors and deep sofa comfort. Fires are lit every night in the large stone fireplaces, creating a cosy comfortable atmosphere. Modern frescoes have been painted on the walls, most notably on the main staircase. The restaurant food and service could not have been bettered in any five star establishment anywhere in the world.

Here I gathered my strength for the expedition to the Galapagos and looked forward to returning before flying home.

### From 2,743m to sea level

I had the opportunity to go out and see a bit of the city. However, this was my first time at high altitude (Quito is 2,743m above sea level) and I suffered some mild effects, making me feel somewhat strange, and I did not sleep well.

On the morning of day four I was taken to Quito for an internal flight to Guayaquil, where we changed to another flight to San



Cristobal Island. There we transferred via Zodiac (rigid inflatable boat or RIB) to the M/V Galapagos Explorer II. Our main luggage followed later.

Explorer II carries a crew of 68 and 100 passengers, including Guides for the National Park (NPGs) of the Galapagos Islands. Transfer to the ship involved wearing a life jacket, taking a tight grasp of the Guide's hand and jumping into the Zodiac from the jetty/shore/rock at the right moment.

This was how we got on and off the islands throughout the cruise. It involved a certain level of skill and several hairy moments when the sea was rough!

### First stop the shower!

On the first day, during our transfer to the ship a seven-year old boy next to me proceeded to vomit all over my trousers and rucksack! His poor mother was so embarrassed and tried in vain to clean me up with a scrap of tissue. Duly christened, thus I arrived in the Galapagos Islands.

On board ship, in addition to that much-needed shower, facilities included a restaurant, piano bar, naturalist/research centre, souvenir shop, glass bottom boat and 24 hour tea/coffee station. Fellow passengers were a mix of nationalities and ages: British, American, German, Italian and Ukrainian, ranging from seven to 70 years.

Once we'd found our cabin our first duty was to attend a passengers meeting. We were introduced to the crew and the NPGs who would be showing us around the islands, then had a lifejacket demonstration and evacuation drill.



### Getting our sea legs

The importance of this was highlighted by the story that the ship had rescued passengers from another vessel in trouble during the night, only two weeks previously, resulting in the crew receiving a commendation for bravery. I made certain that I knew the evacuation procedure and how to fasten the buckles on my jacket.

The Head Guide introduced the programme and how it would work, and addressed some of the wildlife that we would see. Thus life on board ship quickly settled into a daily routine, mainly sailing between the islands at night and then a mixture of landings, depending on whether your feet got wet or not when you disembarked. “Wet” saw us landing in the shallows and wading up the beach (sea shoes recommended) and “dry” meant getting off onto rocks (walking boots required).

Most of the time the sea was calm, but being rocked from side to side while in bed took some getting used to.

### Beyond expectations

Everything you read about the Galapagos tells of the amazing wildlife, but I hadn’t appreciated *how* amazing until I went there and saw it for myself.

The beaches are covered with marine iguanas and marine lizards in a vast array of colours. Sea lion females and pups lounge in the sun while the males exert their territorial authority with their size and incredible roars. Sally Lightfoot crabs provide flashes of colour as they scuttle among the black rocks. Penguins sit and watch the world go by.

On Fernandina, flightless cormorants sit in the sun and dry out their pathetic little wings that



have withered away with disuse over generations. On Rabida massive brown pelicans incubate their eggs in the nest in the salt brush right next to the beach.



In the dry interior of the islands, land iguanas and giant tortoises lumber along looking like dinosaurs, while a multitude of finches flit between the cacti and thorny bushes.

On Espaniola huge albatrosses make a big production of their courtship ritual.

The male frigate birds soar on the air currents, puffing out their massive red throat pouch to attract females while the blue footed booby does a little dance to show off his fantastic feet.

### The scenery is not to be outdone either!

On Santa Cruz we visited a massive lava tunnel created during a volcanic flow. As the outer lava cooled the inner lava continued flowing. It felt like being inside a volcano. On Espaniola the sea shoots up in a great rush through a blow hole.

Bartholemew has a volcanic peak, 114m high, which was a



challenging and vertigo-inducing climb through the cloud mist. Once you get to the top there is a spectacular view of Pinnacle Rock that looks like it has sheared away from the cliff.

All in all, including flights and transit time it took me 36 hours to get there and the same to get

home, but my week on board the M/V Galapagos Explorer II was the most amazing thing I have done – so far!

### Responsible tourism

Tourists have been criticised for going to places like the Galapagos Islands and destroying the ecosystem. However, I have nothing but admiration for the sensitive and responsible manner in which the Guides presented this unique national park to us.

It is through the financial support and wider promotion of the wonders of this fabulous place by visitors like me that organisations like the Charles Darwin Foundation are able to protect and continue to learn about this most precious World Heritage Site.

#### More information at

- Charles Darwin Foundation: [www.darwinfoundation.org](http://www.darwinfoundation.org)
- Galapagos Conservation Trust: [www.gct.org/about.html](http://www.gct.org/about.html)

## HEALTHCARE COMMISSION

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SARAH BUCKLEY guides us through the process of opening an independent travel clinic.

# Getting your independent travel clinic through the Healthcare Commission process

Are you considering opening a travel clinic? If so, and you are based in England or Wales, you will need to register with the Healthcare Commission (HC). This body oversees all independent health care providers, including private hospitals and residential homes, private doctors, hyperbaric oxygen chambers and beauticians using laser treatments.

When registering a travel clinic, applications by either a doctor or nurse will be dealt with under the sub-section

HC will not complete your registration until they have seen a copy of the signed lease for the premises.

The concept of a travel clinic may be new to town or county planners. If the current lease for your proposed premises doesn't include use as a clinic and they have no "case history", they may request an application for change of use. Your solicitor will not complete your lease until this is approved.

passed at the end of June, but registration could not be completed until the lease was signed. This was held up by the planning application, and delayed opening until mid-August, causing six weeks of utter frustration.

In my defence I had been given erroneous advice by a government business advice organisation. Instead of relying on third-party advice, I should have checked with the council earlier.

All the required information can be accessed from the quick links on the HC website home page through "Independent Healthcare".

Application forms and the National Minimum Standards can be downloaded, but as this publication is going to be your "bible" you may find it useful to have a hard copy, available from the Stationery Office (TSO). There are links to the various government acts which you should know about.

**Healthcare Commission staff are there to help you through the process, not to trip you up. Remember, they have a vested interest in helping your application succeed. 🐣**

of "Private Doctors" and you will have to prove compliance with National Minimum Standards and Regulations for Independent Health Care, a statement published by the Secretary of State under section 23(1) of the Care Standards Act 2000.

If you propose setting up an independent clinic, you cannot open or operate until registration is completed. Allow three-to-four months from application submission to an inspection of premises, bearing in mind that the

### **What if I don't get the planning application? What if the HC refuses my application?**

If you are ultra-cautious, these issues are a real worry. Unfortunately, unless you have premises set up and ready to go, your HC application will not be passed.

On a personal note, I submitted my application to the HC in mid-March and moved into my premises at the beginning of May. My application was provisionally

### **First things first**

First you need to submit application Form R1, together with the registration fee (£990 for 2007–2008). The checklist states very clearly that the HC will not process incomplete applications, although in practice they recognise that you may not be in your premises or have the completed lease.

Documentation regarding the premises is the only thing you can postpone at this stage (although you must have the clinic address) and this includes insurance arrangements, lease and site plans. The HC must possess details of everything relating to those who will provide the services, and the services themselves, or they will not proceed.

They also require a financial reference from your business bank manager. By this stage you should have:

- opened a business account, even if no deposit has been made
- produced a business plan
- organised a business loan if required.

As the applicant, you are deemed to be the “Responsible Individual”, but you also need a “Registered Manager” (that is, a business manager). If you are setting up as a sole trader, you can apply to be both. The HC will also want information on the person who will stand in as manager if you are absent. You will need to provide a current CV, photo, evidence of professional qualifications and a completed medical declaration for each person.

You need to provide a “statement of purpose” for the establishment, a draft of your proposed patient guide and a copy of your business plan (including a cash flow forecast).

## Now what exactly do you plan to do?

The application form will ask what services you are applying to register. Do include all services you will provide on opening and are planning for later. Will you cater for children? If so, you must state this. If you intend offering non travel-related vaccines such as the rotavirus vaccine, for example, which can be given from the age of six months, then you will need to state that you aim to treat children from the age of six months onwards.

The “statement of purpose” expands on the services you will provide and can appear overwhelming. It includes:

- aims and objectives
- staff and their qualifications
- organisational structure
- treatments and services
- meeting client needs
- facilities for the benefit of clients
- client consultation
- privacy and dignity of clients
- complaints.

Don't be daunted by the jargon – advice and guidance are on the website and HC staff are there to help you through the process, not to trip you up. Remember, they have a vested interest in helping your application to succeed.

## Think of the “patient guide” as your business “brochure”

It should include a précis of the statement of purpose, plus information that patients will need, including:

- what services you offer
- how to find your premises
- what to expect at a consultation
- your prices
- how to complain.

A first draft is sufficient for the HC at this stage, but this patient guide will eventually need to become a printed brochure or available via your website.

At the application stage you need to state how you will comply with the Disability Discrimination Act – for example, this may include wheelchair access and a loop induction system for the hard of hearing. Also, how will you handle and store patient records? You must state how you will provide staff training and development, and what arrangements you have made for personal clinical supervision.

Further, you must provide a list of policies and procedures that will be in place by the time of your inspection. Guidance on policy requirements is on the HC website as well as in the National Minimum Standards document.

As the Responsible Individual, your Criminal Records Bureau (CRB)

check must be done by the HC. You may wait until your site visit to get this countersigned, but you cannot be registered until the CRB check is completed, which takes at least four weeks. Alternatively, you can travel to London and get authorisation early on.

## Yet another form!

Hidden near the bottom of the application form checklist is a small line reminding you to complete and enclose the relevant sections of Form R2. This is service specific so you need to complete only those parts related to independent clinics. Some sections are a repetition (just state “As detailed in Form R1”), but some are new and will include details of:

- your supervising physician
- referral pathways
- diagnostic tests
- resuscitation procedures
- disposal of clinical waste
- prescribing arrangements (including patient group directions)
- clinical governance.

Again, don't be daunted. Just state your provisional arrangements. If, for example, you have not yet made arrangements for your clinical waste, state that it will be disposed of by an accredited local company and forward details once this is done.

Given all this, you will have realised by now that completing the HC forms will be time consuming and cannot be completed in an evening. Work steadily on them when time is available and you should complete in one or two weeks. It will pay dividends to complete them in a measured and considered manner. Copy everything you send to the HC and send it by registered post.

Provided you have sent all the required documentation, you will shortly receive a confirmatory letter and be assigned an inspector who will contact you to arrange a site visit. Once you have selected a date, your mind will become focused on writing policies and preparing the premises.

## HEALTHCARE COMMISSION CONTINUED FROM PAGE 17

### The visit may be weeks or months away

But in the meantime you have to move into your premises and undertake all the practical work required there as well as carry on with your normal job. The premises must be as ready as if you were expecting to open that day – that means your vaccine fridge installed and working, towels in the dispenser, files in the cabinet, pillow on the couch.

If you haven't already forwarded site plans and copies of insurance arrangements, then do it now. Keep an eye on how the planning application and the lease are progressing too. Business leases can involve more solicitor time than buying a house, another good reason to get started well ahead of time.

Writing policies can be challenging if you haven't tackled it before, but you should know how many are required and have an idea of the subjects. You may find that some policies can be neatly dovetailed together into one rather than two or three separate ones.

Don't worry if your final policy list is not exactly the one previously supplied to the HC. As long as everything is covered, that's not a problem.

### Now you will need to focus clearly

Start on the longest and most important policies:

- arrangements for assessing patients
- child protection
- medicines management
- consent to treatment
- health and safety
- infection control.

Arm yourself with plenty of information – the NSPCC and HSE websites are excellent. Don't try to write them from scratch. Search the Internet for policies and adapt them to your needs. Then, as you complete each policy, email it to your inspector and you should receive useful feedback.

I found this stage the most stressful, with so much to do and what appeared to be

little time in which to do it. Make sure you eat properly at least once each day and factor in some time off every week.

### Coming down to the wire

Although you may be proposing a small establishment with few staff, the HC will want to see that you comply fully with health and safety legislation. Your site visit will be shorter if you have carried out a full premises and fire risk assessment before the inspection. Formal fire inspections are not a statutory requirement, but you will need to have had a visit from a reputable supplier of fire-fighting equipment who will issue a visit record.

Before the inspection, you will be asked to complete a "Fit person assessment interview pro-forma" and return this to your inspector. During the inspection you will be questioned further on the contents. The pro-forma uses jargon like "How will patients be engaged in the process of creating an appropriate environment?" In other words, how will you get the views of patients so you can continue to improve your facilities?

This questionnaire takes a few hours to complete properly so don't rush it – if you have done a good job on the paper pro-forma, the site visit will not be as nerve-racking.

### Then finally it's D-Day!

The site visit may take up to five hours. Look smart – if you are going to be in uniform, then wear it for the inspection. During the first part, the two inspectors will go over your premises thoroughly and may make suggestions for improvement, but this doesn't mean you'll fail the inspection.

They will look at your policies and PGDs so if they have already seen your policies, you have an advantage as it won't take as long. Have your completed premises and fire risk assessments to hand so the inspectors do not have to carry these out themselves.

The second part of the inspection

comprises the fit person interview when you will be questioned on the contents of the pro-forma.

Following the inspection, you will receive a letter informing you if there are any outstanding tasks to be completed before you can be registered. This does not normally involve a second site visit, but you may need to email your inspector stating you have completed anything which was outstanding.

### A few days later you will receive your certificate ...

Should you want to use the HC logo on your letterhead and stationery, you need to request permission and your inspector will tell you who to contact.

Above all, talk to others who have been through the process. They will have tales to tell about their experience of the registration process and some of the stories will help you. Generally people are happy to help.

The whole process is one huge learning curve, but you will gain from it – all the knowledge you require to take on the responsibility of premises, staff and patients. And, of course, a huge sense of achievement.

It is worth it – just try to enjoy the journey!

**You can also contact Sarah at:**  
[sarahbuckley1@btconnect.com](mailto:sarahbuckley1@btconnect.com)

#### Resources:

Healthcare Commission:  
[www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)  
Check regularly for updates and changes.  
*Independent Health Care – National Minimum Standards*: ISBN 0 11 322572 5 (The Stationery Office)  
The Stationery Office:  
[www.tsoshop.co.uk](http://www.tsoshop.co.uk)  
NSPCC (National Society for the Prevention of Cruelty to Children):  
[www.nspcc.org.uk](http://www.nspcc.org.uk)  
Health and Safety Executive (HSE):  
[www.hse.gov.uk](http://www.hse.gov.uk)

## SPOTLIGHT:

# The Healthcare Commission

The Healthcare Commission (HC) is the health watchdog in England, inspecting health services to ensure that they are meeting standards in a range of areas.

Last December they published a State of Healthcare Report, which indicated health care services in England provide care for 50.7 million people. During 2006/2007, people in England:

- visited their GP practices almost 300 million times
- made around 19 million visits to accident and emergency departments
- made over five million calls to NHS Direct
- attended nearly 1.2 million appointments with independent inpatient, day case and surgical outpatient services
- made over three million visits to independent outpatient services.

### Wales

Responsibility for inspection and investigation of NHS bodies and the independent sector in Wales rests with Healthcare Inspectorate Wales (HIW). However, the HC has certain statutory functions in Wales which include producing an annual report on the state of health care, national improvement reviews in England and Wales, and working with HIW to ensure that relevant cross-border issues are managed effectively.

### Scotland and NI

The HC does not cover Scotland as this is the remit of its own body, NHS Quality Improvement Scotland (QIS). [www.nhshealthquality.org/nhsqis](http://www.nhshealthquality.org/nhsqis)

The Regulation and Quality Improvement Authority (RQIA) undertakes regular reviews of the quality of services in Northern Ireland. [www.rqia.org.uk](http://www.rqia.org.uk)

### Read State of healthcare at:

<http://2007ratings.healthcarecommission.org.uk/patientsandthepublic/stateofhealthcare2007.cfm>

## TRAVELLERS' TALES

CONTINUES FROM PAGE 13

at Puerto Allegria, facilities run by Scripture Union Peru, an associate partner of the Vine Trust in Peru.

### Then time to leave – and reflect

For some it was straight back to the UK and for others, a few days to take in the tourist sites of Lake Titicaca, Machu Picchu or Cuzco before returning.



Morning wash

The whole experience, although personally and professionally testing, was hugely rewarding. It engendered great admiration for the dedicated, local medical and support team who undertake this work on board ship every three months with unknown alternate UK and USA teams of volunteers and who, between times

work in the Belen Clinic, a district of abject poverty and squalor in Iquitos.



Paediatrician at play

It was a great opportunity for the medical enthusiast, for minimal “high tech” interventionist medicine and certainly for maximum use of age-old medical skills, like basic history

taking and clinical examination. And with it came a realisation that although the local problems seem almost insurmountable, even small contributions can make a difference.

And finally there was the humbling experience of a generous smile or a token piece of handicraft from people who have such a small share of the resources of our world – people who have so little access to health care facilities and yet exude such genuine appreciation for the efforts of the medical team.



Local school children

More about the work of Vine Trust at: [www.vinetrust.org](http://www.vinetrust.org)



Patients arriving

## BULLETIN BOARD

## Jailed for not vaccinating children

Parents in Belgium who failed to have their children vaccinated against polio have been convicted, fined and sentenced to five months in prison. Polio vaccination is compulsory in Belgium and although the parents failed to appear in court, they were convicted on police reports. The prison sentences were suspended pending vaccination of the children.

In Belgium the doctor administering the vaccine gives parents a proof of vaccination certificate for notification to local community officials. If the 18 month deadline is not met, local officials send reminders and if parents still refuse, the district attorney is notified.

Parents can appeal against conviction, but judges prefer them to return to court to explain their motivation for refusing vaccination. Belgian law allows exceptions only with proof of the likely risk of adverse events for the child following polio immunisation.

## New hep A and B vaccine

A new combined hepatitis A and B vaccine has been introduced by GlaxoSmithKline. Ambirix® is indicated for those from one year up to and including 15 years, and is identical to Twinrix Adult (HAV 720/HBV 20mcg). Ambirix® is indicated when the risk from hepatitis B is relatively low during the course of vaccine and where assurance of course completion can be gained.

## Name change for TBE vaccine

The FSME Immune (tick-borne encephalitis) vaccine, manufactured by Baxter, has been re-named TicoVac and TicoVac Junior. No change has been made to the vaccine itself. Refer to the new SPCs for information.

- [www.nathnac.org/pro/factsheets/tick\\_borne.htm#Vaccine](http://www.nathnac.org/pro/factsheets/tick_borne.htm#Vaccine)

- [www.travax.scot.nhs.uk/registered/index-wn.asp](http://www.travax.scot.nhs.uk/registered/index-wn.asp)
- [www.dh.gov.uk/en/PublicHealth/Healthprotection/Immunisation/Greenbook/DH\\_4097254?CONTENT\\_ID=4097254&chk=isTfGX](http://www.dh.gov.uk/en/PublicHealth/Healthprotection/Immunisation/Greenbook/DH_4097254?CONTENT_ID=4097254&chk=isTfGX)

## Fit to fly

A guide to help medical professionals assess patients' fitness to fly has been published by the Civil Aviation Authority (CAA) Aviation Health Unit. It's at: [www.caa.co.uk/fitnesstofly](http://www.caa.co.uk/fitnesstofly)

## Keep kids' immunisation record online

The Department of Health website on immunisation has been updated and redesigned. A new feature is the facility for parents to create a personal immunisation record chart for their child. It's at: [www.immunisation.nhs.uk](http://www.immunisation.nhs.uk)

## Masks for Beijing Olympics

Sports scientists and doctors advise that British athletes competing in outdoor events at the Olympic Games in Beijing will be offered high-tech anti-pollution masks to avoid respiratory problems. Under Olympic rules masks must be removed in competitions, but athletes will be encouraged to wear them in training and the warming up stage, especially if air quality is poor. The Beijing organising committee is confident that measures being taken to cut pollution will be successful and that good air will be ensured.

## How green was my cruiser?

Just when travellers were aiming to reduce their carbon footprint by abandoning air travel and taking to the high seas, environmental campaigners now say that cruise ships produce three times more carbon emissions than aircraft. Many passengers fly to reach their ship, further increasing their

contribution to global warming. The Passenger Shipping Association (PSA) is conducting a study to find out how much CO<sub>2</sub> it takes to drive a ship and will release the findings later in the year. Check [www.responsibletravel.com](http://www.responsibletravel.com) for a directory of holidays which minimise damage.

## Chinese currency at PO

Following high demand for the Chinese Yuan, the Post Office is making them available at their main outlets. Publicity about the Olympic Games has made holidays to China more popular.

## Climate change UK style

The Department of Health, in association with the Health Protection Agency, has published a report on the possible health effects of climate change that identifies the possible health consequences if no action is taken to avoid significant climate change.

- By 2012 there will be a one in 40 chance that the South East of England will experience a serious heatwave causing 3,000 immediate heat-related deaths.
- While malaria outbreaks in Britain are likely to remain rare and easily controlled, health authorities need to remain alert to the possibility of larger outbreaks in continental Europe and the emergence of more deadly European strains of mosquitoes in wetland areas of Britain.
- Tick-borne diseases such as Lyme disease are likely to become more common due to changes in land management and an increase in outside leisure time.
- Increased exposure to sunlight will lead to a rise in skin cancers.
- The number of people at a high risk from flooding is set to rise from 1.5 million to 3.5 million by 2100.
- There will be up to 14,000 (14.5 per cent) more cases of food poisoning, including salmonella, per year.

But the good news is ... Winter deaths will continue to decline as the climate warms.

Download *Health effects of climate change in the UK* at:

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_080702](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080702)

## Start screening the coral?

Scientists in Italy believe that 10 per cent of coral reefs are threatened by bleaching caused by chemicals in sunscreens. Around 4,000–6,000 tonnes of sunscreen wash off swimmers annually in oceans, mostly in the popular tropical areas. Climate change is also playing a part as increased sea surface temperatures also causes bleaching. Australian scientists are considering covering sections of the Barrier Reef with canopies to reduce the destruction. A two-year trial which concluded in 2006 showed encouraging results.

## Still not learning

The Foreign and Commonwealth Office (FCO) reported that an estimated one in 10 British skiers suffers an injury on the slopes and almost a third of Britons fail to take out insurance adequate enough to cover the sports they intend to take part in.

## UN figures on HIV and AIDS

The annual United Nations figures on worldwide rates of HIV and AIDS were released in November 2007. They showed a marked decline in the number of people living with HIV worldwide, with the latest estimate down from 40 million to 33.2 million. **But** statistics show that most of the decline is the result of better data collection and subsequent lowering of estimates in six badly affected countries – Angola, India, Kenya, Mozambique, Nigeria and Zimbabwe.

Instead of fewer people succumbing to HIV and AIDS, the new figures suggest that fewer people were infected in the first place. Previously tests were based on pregnant women attending antenatal clinics, mainly in city locations. These tests were useful for tracking trends, but not for measuring the actual size of the epidemic.

Since 2000 a group of 20 countries in Sub-Saharan Africa (SSA) have conducted household surveys with HIV testing nationwide, including rural antenatal clinics. This wider data collection led researchers to discover that the prevalence of HIV infection was lower than previously thought.

Sadly some of this decline in prevalence can be attributed to high death rates due to lack of access to antiretroviral drugs, poor diet and poverty. This means they are unregistered in the overall number of people living with HIV and AIDS. Experts working with people affected by HIV and AIDS are concerned that the debate about statistics might distract from the urgency of tackling the epidemic which still claims many lives, especially in SSA where AIDS is still the primary cause of death.

Related links:

- [www.actionaid.org.uk/hiv](http://www.actionaid.org.uk/hiv)
- [http://data.unaids.org/pub/EPISlides/2007/071119\\_epi\\_pressrelease\\_en.pdf](http://data.unaids.org/pub/EPISlides/2007/071119_epi_pressrelease_en.pdf)

## Condom recall

The fight against AIDS in South Africa may be severely affected by the suspension of a major vaccine trial and the recall of defective free condoms issued by the Government. In August 2007 locally manufactured condoms were recalled amid allegations of bribery and fraud, causing widespread panic and political scandal. Of the initial 20 million recalled, an estimated seven million were compromised.

In October a second batch of condoms was withdrawn and South Africa

halted the AIDS vaccine trial, amid fears that the drug increased rather than reduced the transmission of HIV. Public confidence in condom use has been severely damaged and the health authorities are working to find a way of limiting the damage and restoring confidence in using condoms. The AIDS Vaccine Advocacy Coalition is at: [www.avac.org](http://www.avac.org)

## PGDs

Patient group directions have been developed by the RCN and the Department of Health to help practitioners and managers understand clinical governance issues relating to PGDs in sexual health. More at: [www.pgd.nhs.uk](http://www.pgd.nhs.uk)

## New course on sexual health skills

The University of Greenwich in collaboration with the RCN is offering a new e-learning sexual health skills course. A prospectus for all the sexual health courses at the University of Greenwich (including the new one, formerly from the RCN) is now available. There is also a new BSc (Hons) in sexual health, and new graduate and post graduate awards – all the way up to MA. David Evans, who addressed our conference last year, has developed and is managing this course. Email: [sexualhealthskills@gre.ac.uk](mailto:sexualhealthskills@gre.ac.uk)

## Pandemic flu

The Cabinet Office and Department of Health have published a national framework for responding to an influenza pandemic at:

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_080734](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080734)

Meanwhile the Health and Safety Executive has produced guidelines for the workplace at: [www.hse.gov.uk/biosafety/diseases/pandflu.htm](http://www.hse.gov.uk/biosafety/diseases/pandflu.htm)

## BULLETIN BOARD

### Safety issues on Goan beaches

Fatal accidents involving foreign visitors, including a 15 year old British girl, have prompted the Tourist Authority in Goa to announce plans to spend £20 million on trained lifeguards and equipment for beaches. Jagged rocks and strong currents make swimming dangerous, and many people drown there each year. Even if they are rescued, medical facilities are lacking.

### Travel at high altitude



In spite of ongoing research and education into the risks and effects of travelling at high altitude, tragic deaths from severe altitude-related mountain sickness

continue to happen.

That's why Medical Expeditions and Medex, two organisations with a common link, have produced a booklet which looks at the effects that travelling at altitude can have on the body. They aim to inform travellers about risks and avoidance strategies, and what to do in the event of acquiring an altitude-related illness.

**Medical Expeditions**, established in 1992, consists of doctors who study altitude illness to share the information. They have achieved an international respect for their research and educational work. Their aims are to:

- investigate all aspects of altitude-related illness
- educate mountaineers and trekkers, and their doctors, about the nature and avoidance of altitude-related illness.

**Medex**, which supports the work of Medical Expeditions, is a club which organises adventurous expeditions

worldwide and provides a link between those interested in adventure and adventure medicine.

This pocket-sized booklet contains important information and useful links for both high altitude travellers and those advising them. It also contains information on the Diploma in Mountain Medicine Course. *[We will provide copies for delegates to our conference in September -ED.]*

It is available to download in various formats, along with promotional flyers and other information at:  
[www.medex.org.uk/medex\\_book.htm](http://www.medex.org.uk/medex_book.htm)

### Visa for Bolivia

From December 2007 immigration authorities of the Republic of Bolivia have required USA citizens travelling there as tourists to have a visa. For country requirements see:

- [www.nathnac.org/ds/c\\_pages/country\\_page\\_BO.htm](http://www.nathnac.org/ds/c_pages/country_page_BO.htm)
- [www.travax.scot.nhs.uk/registered/index-wn.asp](http://www.travax.scot.nhs.uk/registered/index-wn.asp)

### Visa for Zambia anyone?

In January Zambia abolished the visa waiver previously available to British citizens and introduced new charges with immediate effect. The Finance Ministry said that increased charges were in response to the UK's high fees for visitors from Zambia, now £63. A single-entry visa to Zambia now costs £75 and a multiple-entry visa £240.

Irish travellers are not charged and a single entry visa costs other EU nationals £25, Canadians £28 and US travellers £67.

The levy is already causing problems for visitors. A group of sixth-formers from Bucks almost cancelled plans for a charitable trip to Zambia as they faced an extra £2,000 in charges. They had already raised their £19,000 target to take computers and other equipment out to help schools, leaving the goods behind to support the local people.

They then had to rely on the goodwill of their school and local people who lent them the money to allow the trip to go ahead.

Tour operators are concerned that the tourist industry will be damaged. Travellers have already reported concerns over visits to Victoria Falls where crossing to Zambia from other countries involves the visa fee which must be paid in cash, using either Sterling or US dollars. See:  
[www.zambian.com](http://www.zambian.com)

### Make mine shorter and more often

The traditional two-week holiday has become less popular than frequent short breaks. According to a poll of 5,000 conducted by the hotel chain Holiday Inn, 52 per cent of families will not take a two-week holiday this year.

### Flight tracking

Information on every flight departing from the UK can be tracked via a new independent website. The site also carries news on special offers and is a partner of the FCO "Know Before You Go" Campaign. It's at:  
[www.airlinedestinations.co.uk](http://www.airlinedestinations.co.uk)

### Get TREC-ing

Did you attend the TREC (Travel Related Education and Care) Conference in Glasgow? Find information on that and forthcoming events on:  
[www.trectravelhealth.co.uk](http://www.trectravelhealth.co.uk)

### Never too late for a gap year

If you are over 40 and missed out on a gap year in your youth, how about volunteering for a project in Africa or elsewhere with Gaps for Grumpies? You can combine work with pleasure and put your skills to good use. You have to pay, but just think what you might achieve! More at: [www.gapsforgrumpies.com](http://www.gapsforgrumpies.com) or call for a brochure on 0191 269 9492.

# From the journals

## Travel health service

Designed to meet the needs of travellers and advisers, this service was established in 2005. The Cheshire-based company provides travel health and immunisation training for health professionals of all disciplines throughout the UK. Travel health seminars are offered to groups such as business travellers or those on organised school trips. Phone: 07783 300089 or visit: [www.travelfit.co.uk](http://www.travelfit.co.uk)

## Yellow Carded?

A nationwide pilot scheme has been encouraging the public to report adverse drug reactions under the "Yellow Card" reporting scheme. The arrangement is now permanent and the Medicines and Healthcare Regulatory Agency (MHRA) want pharmacists to raise awareness. These updated reporting systems include a redesigned paper form for patients and a new electronic form (at [www.yellowcard.gov.uk](http://www.yellowcard.gov.uk)) for use by both health care professionals and patients. Anyone in England, Scotland, Wales and Northern Ireland can make a yellow card report. See: [www.pharmj.com/Editorial/20080216/news/news\\_yellowcard.html](http://www.pharmj.com/Editorial/20080216/news/news_yellowcard.html)

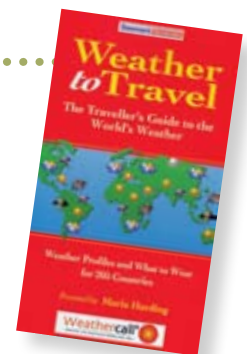
## Rainforest holiday

Conservation International, an environmental organisation, has produced a guide in an attempt to reduce damage done by tourists to fragile habitats. Primarily aimed at tour operators, it includes a checklist to evaluate the extent to which their policies benefit or harm rainforests. It is hoped that people will become more aware of the effects of tourism on rainforests and use operators who adhere to the recommendations. Responsible Travel will distribute the guide to tour operators in the UK. View at: <http://tourism.jot.com/WikiHome/MainstreamBiodiv>

- Writing committee of the second World Health Organization consultation on clinical aspects of human infection with avian influenza A (H5N1) Virus (2008) Update on Avian Influenza A (H5N1) Virus Infection in Humans, *NEJM*, 358 (3), pp.261–273.
- Hill N, Lenglet A, Arnez AM and Carneiro I (2007) Plant based insect repellent and insecticide treated bednets to protect against malaria in areas of early evening biting vectors: double blind randomized placebo controlled clinical trial in the Bolivian Amazon, *BMJ*, 335, pp.1023–1025. Published on [www.bmj.com](http://www.bmj.com)
- Gould EA and Solomon T (2008) Pathogenic flaviviruses, *The Lancet*, 371, pp.500–509.
- Tonks A (2007) Lyme wars, *BMJ*, 335, pp.910–912.
- Monath TP (2007) Dengue and yellow fever – challenges for the development and use of vaccines, *NEJM*, 357 (22), pp.2222–2225.
- Yamada T (2008). In search of new ideas for global health, *NEJM*, 358 (13), pp.1324–1325.
- World Health Organization (2007) The World Health Report 2007, A safer future: global health in the 21st century, Geneva: WHO.
- Chiodini J (2008) A model travel health consultation, *Practice Nurse*, 35 (6), pp.42–47.
- Grieve S (2008) Air travel and health, *Practice Nursing*, 19 (3), pp.140–144.
- Chiodini J (2008) The challenging traveller, *Practice Nurse*, 35 (7), pp.41–48.
- Chiodini J (2008) Mosquito-borne viral infections and the traveller, *Nursing Standard*, 22 (35), pp.50–57.
- Chaisson RE and Martinson NA (2008) Tuberculosis in Africa – combating an HIV-driven crisis, *NEJM*, 358 (11), pp.1089–1092.
- Shaw MTM, Leggat PA and Borwein S (2007) Travelling to China for the Beijing Olympics and Paralympic Games, *Travel Medicine and Infectious Disease*, 5, pp.365–373.

## BOOK REVIEW

*Weather to travel: the traveller's guide to the world's weather* is a useful resource on what to expect at your destination. Are you travelling during the hurricane season? Will it be too hot when you hit the beach? Find out before you go. Here's a review by JOYCE SKEET.



## And what's the weather like today?

This helpful book by Maria Harding provides an A – Z country-by-country review of the world's weather. Each country listed has a climate colour coded guide and some countries like China have as many as five climates, ranging from high mountain to tropical monsoon because of its size. Oman has only one – hot desert (no surprises there).

Below each country map are profiles of rainfall, sunshine and daylight hours and a useful comfort profile to alert the traveller to just how hot, sticky or cold their planned destination may be.

There is also a "what to pack" section for each country which is highlighted with a little suitcase. The altitude of the capital city and local time expressed in hours behind (–) or ahead (+) of Greenwich Mean Time (GMT) is listed and this is so useful for the health care professional advising on insulin dose adjustment.

This book is a must for health care professionals advising travellers on what climate they can expect at their planned destination.

Two copies will be raffled at our annual conference in September – ED.

## DATES FOR YOUR DIARY

**14 June 2008**

### British Travel Health Association

MacDonald Burlington Hotel  
Birmingham  
Contact: [www.btha.org](http://www.btha.org)

**9–11 July 2008**

### Celebrating 25 years: now going for gold

RCN Practice Nurse Association  
Annual Conference  
City Hall, Cardiff  
Email: [practicenurse@rcn.org.uk](mailto:practicenurse@rcn.org.uk)  
Website: [www.rcn.org.uk/events/pna25](http://www.rcn.org.uk/events/pna25)

**4–15 August 2008**

### The Gorgas Institute Expert Course

Two weeks of bedside clinical experience on a 36-bed tropical disease unit.  
Email: [info@gorgas.org](mailto:info@gorgas.org)

**28 August 2008**

### Prevention and progression

RCN Independent School Nurses Sub-Group – Annual Conference and Exhibition  
Thistle Marble Arch Hotel, London  
Email: [laura.benfield@rcn.org.uk](mailto:laura.benfield@rcn.org.uk)  
Website: [www.rcn.org.uk/events](http://www.rcn.org.uk/events)

**15–17 September 2008**

### Health Protection Agency

University of Warwick  
Website: [www.healthprotectionconference.org.uk](http://www.healthprotectionconference.org.uk)

**3–7 October 2008**

### Travel medicine in Africa

The South African Society of Travel Medicine  
Zanzibar  
Website: [www.sastm.org.za](http://www.sastm.org.za)

**4–5 November 2008**

### Quaynote 3rd Annual Aviation Health Conference

Holiday Inn (Kensington Park Forum), London  
Website: [www.quaynote.com/ankiti/www/?code=uk14&f=home](http://www.quaynote.com/ankiti/www/?code=uk14&f=home)

**14 November 2008**

### MASTA

Annual Study Day  
Royal College of Physicians, London  
Website: [www.masta.org](http://www.masta.org)  
Email: [nicola.davison@masta.org](mailto:nicola.davison@masta.org)

**10–14 May 2009**

### RCN Congress

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

**24–28 May 2009**

### CISTM11

11th Conference of the International Society of Travel Medicine  
ELTE University Conference Centre  
Budapest, Hungary  
Email: [cistm11@istm.org](mailto:cistm11@istm.org)  
Website: [www.istm.org](http://www.istm.org)

## Footprints around the world

Funding available for three lucky members!

### RCN Travel Health Forum Annual Conference

Royal College of Physicians  
London

**25 September 2008**

That's right – we are funding **three** registrations for attendance at this conference. You need to be an RCN and Travel Health Forum member to apply and you cannot have received RCN funding in the last five years.

To apply, complete a Funding Form, available on the website at: <http://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.

There is still time to apply. We understand there have been problems downloading the application form so if problems persist, contact the Editor for a copy.

**The closing date is Monday 28 July.**

**Full details of the conference in the enclosed flyer – or contact [kathryn.clark@rcn.org.uk](mailto:kathryn.clark@rcn.org.uk)**

THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

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