



## The President's Column

I write to you from a city that was until recently in the middle of political chaos, Kathmandu, Nepal. But travelers continue to come despite the political troubles, recognizing that no place on earth can be considered absolutely safe and trouble-free anymore. Although people around the world are closer to each other than ever before thanks to instant global communications, the world we live in is becoming increasingly complicated. (Fortunately, the situation here in Nepal has improved now and life is slowly returning to normal.)

ISTM as a Society is moving on with speed. We have several new initiatives. To coincide with the Northern European Conference on Travel Medicine (NECTM) being held in Edinburgh this June, ISTM will be holding a European Summit meeting together with our friends in the European Societies to explore ways to further mutual understanding and collaboration.

Keeping in mind repeated requests from membership to hold a preparatory course for the Certificate of Travel Health (CTH) examination, such a course is being offered in North America and in Europe in early 2007. It is hoped that at some point in the future, the course can be offered in other parts of the world as well. Persons wishing to take the CTH examination may benefit from taking such a course. The ISTM CTH examination

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### Northern European Conference on Travel

**Don't miss NECTM in Edinburgh!**

## Edinburgh "By Royal Appointment"



The International Society of Travel Medicine is greatly pleased and honoured to be able to announce that Her Royal Highness, the Princess Royal (Princess Anne) will attend the 2<sup>nd</sup> Regional Conference of the ISTM - the Northern European Conference in Travel Medicine in June in Edinburgh. Her Royal Highness will be giving a plenary talk during the conference, detailing her fascinating work on behalf of voluntary agencies overseas. The Princess Royal is the second child and only daughter of Queen Elizabeth and The Duke of Edinburgh.

Save the Children Fund, of which the Princess has been President since 1970, was the first major charity with which she became closely associated, and this association has given her great insight into the needs of children worldwide. However, she also holds a very wide range of charitable appointments, to which she devotes a large part of her working life. In addition, the Princess carries out up to three overseas tours each year for the Foreign and Commonwealth Office in support of British interests overseas. The Princess Royal is a very accomplished public speaker and projects a great passion for her charitable work – certainly worth a listen.

Other highlights of the conference include four plenary sessions, the first focusing on how changes to the environment can affect international travel and human health, given by two United Kingdom experts, Dr James Willis and Dr Sari Kovats. Also, at this session, Dr Eric Noji from CDC will discuss how to prepare for natural disasters.

The plenary on Day Two focuses on the more mainstream topic of risks and benefits from vaccinations, specifically the vaccines used to prevent gastro-intestinal infections (by Professor Robert Steffen), rabies (by Dr Francois-Xavier Meslin, WHO) and respiratory tract infections (by Professor David Hill).

Day Three will have a distinctly European feel with sessions by Professor Victor Maleyev and Dr Øystein Sjøbstad on infection risks in Scandinavia, Russia and the Baltic states, and a presentation by Professor Karl Ekdahl from the European Centre for Disease Prevention and Control.

The closing plenary finds our Scandinavian colleagues Dr Eilif Dahl and Professor Heikki Peltola presenting a fascinating insight into sea travel, past and present.

To supplement the plenary talks there is a wide and varied programme of symposia. These include sessions on health risks related to mode of travel, malaria prevention, exploration and adventure travel, risk assessment, travellers with chronic diseases and underlying health problems, coping with difficult situations in the travel clinic, travel to extreme environments, animal- and tick-borne infections, and the very popular regional perspectives. There are also three scheduled sponsored symposia considering issues surrounding cholera/Japanese encephalitis, hepatitis, and clinical dilemmas.

Workshops add a further dimension, and there are eight to choose from, tackling topics ranging from how to increase awareness of security and accidents, to the current situation regarding H5N1 influenza. There are also four free communication sessions, and a display of posters for delegates to browse.

No conference would be complete (or truly memorable!) without a lively social programme, and in true Scottish style, a Welcome Get-Together is being held on the opening evening, Wednesday, June 7<sup>th</sup>. Scottish hospitality that evening will include traditional pipes and drums, Scottish dancers and a sensational ceilidh band (dancing optional!). Other more light-hearted events over the three days include early morning talks on the history and culture of Scotland, a family and friends evening of music, and a golf challenge.

For full details on the Scientific and Social programme for Edinburgh, including registration details and hotel and travel options, please visit the conference website: [www.nectm.com](http://www.nectm.com).

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will be offered in Vancouver in 2007.

We are moving forward to collaborate with the World Health Organization in a productive way. ISTM has been asked to coordinate efforts to give suggestions for the WHO International Travel and Health (ITH) book and website update.

The Journal of Travel Medicine is reaching libraries across the world. I hope that you find the new cover refreshing and the content stimulating. Manuscript submission and review is now so much simpler thanks to Manuscript Central's shorter turnaround time for manuscripts. This should encourage our members to publish more with JTM.

Preparations are underway for CISTM 10 to be held in May 2007 in Vancouver. The Scientific Program Committee met recently to chalk out the details of the program, taking into account suggestions from Society members. The scientific program for the conference is not one that you will want to miss. The local organizing committee too has many valuable ideas that will complement the excellent scientific program at the conference.

I look forward to seeing you all in Edinburgh this year and in Vancouver in 2007. If you have any ideas/suggestions to improve the Society, please send them along to me at: pandey@mos.com.np or istm@istm.org.

Thank you.

*With best wishes,  
Prativa*

## Letter to the Editors

Dear Editor,

The World Tourism Organization has established a code of ethics to promote sustainable and respectful tourism. Promoting respectful behavior of travelers will help reduce the growing resentment toward tourists in host countries, preserve host countries' cultures and environments, and ensure a safer and more rewarding experience for all travelers.

The International Society of Travel Medicine has already embarked on such an initiative with our Responsible Traveler initiative and we are playing a key role by disseminating educational information on travel ethics.

**However, it is time to take the next step. I propose that ISTM and an organization such as The International Association of Film and Television Schools (CILECT)** [CILECT is a french acronym] ([www.cilect.org](http://www.cilect.org)) sponsor a competition to encourage film and video makers to produce media that encourages responsible travel. These productions would be aimed at inexperienced travelers going to developing countries. Films and videos would be submitted to ISTM and reviewed for quality and content that support the principles of The Responsible Traveler. After preliminary evaluation the best of these productions could be viewed and voted on by ISTM members at the ISTM bi-annual meetings or over the Internet.

I have discussed this idea with Larry Engle ([lbe1@columbia.edu](mailto:lbe1@columbia.edu)), a filmmaker and teacher

at the Columbia University School of Visual Arts in New York City. He felt that "this was too good an idea not to pursue."

*Here are some thoughts to consider:*

- The winning production (and perhaps, even some of the runner-ups) can be used to promote responsible travel by ISTM and its members and by the media.
- We can have ISTM and CILECT members submit films, videos and Internet productions that they have viewed and think would interest others, have media producers submit their productions, or both.
- We can start small and see what happens. The competition could be every two or three years?
- Perhaps we could get sponsors and/or publicity from the following groups: television programs devoted to travel, companies that sell airline tickets on the Internet, travel health information services, pharmaceutical companies, and private foundations, for example.
- Subjects could include anything from preventing malaria to how to use Asian toilet.

Sincerely,

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Phone: (732) 657-8447  
[ms112@columbia.edu](mailto:ms112@columbia.edu)*

## Help Wanted. United Kingdom

### **Medical Consultant/Lead in Travel Medicine, Health Protection Scotland, Glasgow, United Kingdom**

**Advance notice of a unique job opportunity.** Due to retirement of the current postholder, the Travel Medicine Section of Health Protection Scotland (HPS) will very soon be looking to appoint a Medical Consultant/Lead in Travel Medicine. It is expected that formal notice and advertisement of this post will be placed in the *Lancet* and *British Medical Journal* during May/June 2006.

HPS is part of the National Health Service in Scotland (<http://www.show.scot.nhs.uk/scieh>) and is committed to work in partnership with others, to protect the Scottish public from being exposed to hazards which damage their health, and to limit any impact on health when such exposures occur. The Travel Medicine team of HPS aims to reduce the incidence and consequences of travel related infections and other health problems in Scotland.

The Consultant in Travel Medicine will act as clinical lead for the multi-disciplinary Travel Medicine team, providing expert advice and consultancy to a wide variety of external bodies, and engaging in the strategic planning, development and implementation of a broad range of initiatives aimed at raising standards of practice and improving health protection activity in Travel Medicine. He/she will provide input into other HPS's services especially where they overlap with travel medicine (e.g. immunisation, emerging infections) and will play a lead role in taking forward health protection services linked to travel (e.g. immigration and port health). Examples of major initiatives currently undertaken by the Travel Medicine Section include provision of Travax® (not to be confused with Shoreland's Travax®) and the Diploma/Foundation courses in Travel Medicine (Glasgow).

Due to the unique remit of this post, suitably qualified applicants from outwith the UK will be considered.

For further information, contact Fiona Genasi, Travel Medicine Section Co-ordinator. ([Fiona.Genasi@hps.scot.nhs.uk](mailto:Fiona.Genasi@hps.scot.nhs.uk))

# Accreditation of Scientific Travel Medicine Conferences by the International Society of Travel Medicine

Many individuals – ISTM members and others – ask the ISTM Board for permission to use the ISTM name and logo for marketing travel medicine conferences with which the individuals are associated.

As a result, the Board has considered how the ISTM name and logo should be used while insuring the following:

- Appropriateness and clarity of material used in marketing the conference,
- Realistic advertising of the event, and
- A suitable faculty for the event advertised.

This process of accreditation requires the organiser of the conference to provide set criteria and information: sponsorship and/or funding, invited speakers and their affiliations, CME accreditation, timetable of progress, the programme for the conferences, and evidence of an evaluation process.

The application will be reviewed by at least two members of boards or committees of the ISTM. When accreditation is bestowed, and with the permission of the Publication Com-

mittee, the ISTM endorsement and logo can be applied to printed material of the organization in question. The application can be undertaken using an on-line form, available from the ISTM website. The process of review will probably require about four or more weeks.

**Please include as an attachment the following:**

1. Course aims and objectives as well as a definition of the intended audience
2. Describe the intended Continuing Medical Education accreditation to be sought. Include the name and contact information of the intended accrediting body(s). Proof of CME accreditation should be provided when obtained but not later than 1 month prior to the conference.
3. List of key confirmed invited speakers with their professional affiliations
4. A timetable showing key deadlines for submission and review of scientific materials to the conference and deadlines for participant registration
5. A list of current and prospective funding

sources and industry sponsorship for the activity and a statement of any involvement of sponsors in the program development or the selection of faculty.

6. A copy of the course evaluation form not later than 1 month prior to the conference.
7. A copy of previous course assessments for previously held conferences in the same series by the same organizing body.

**In a cover letter include:**

- A statement promising to apprise ISTM of any un-named funding sources procured at a date after any ISTM accreditation is awarded.
- A statement promising to apprise ISTM immediately of any substantive changes in conference content, faculty, venue, or sponsoring body.
- A statement promising to distribute ISTM brochures to delegates at the time of the conference.
- A statement that the conference organizers will in no way represent the activity as an official ISTM organized or sponsored conference.

**Conflicts:** Any conference that in the subjective judgment of the ISTM has the potential to conflict with official ISTM organized activities will not be eligible for accreditation.

**Final Accreditation:** Accreditation will be provided by ISTM conditional upon withdrawal if material circumstances surrounding the conference change. In general, use of the ISTM logo will be restricted to display on the back of any brochures or bottom of any web pages and must be placed together with the statement “Accredited by the International Society of Travel Medicine.” Any reference to ISTM in the text of promotional materials should be limited to the statement “Accredited by the International Society of Travel Medicine.” Each use and placement of the ISTM logo or statements specifying ISTM accreditation in any printed or electronic form is subject to specific approval by the ISTM Publications Committee. Application for such use should be made well before printing and other deadlines.

Electronic submission preferred to:  
admindir@istm.org

## APPLICATION FOR ACCREDITATION OF A SCIENTIFIC CONFERENCE BY THE INTERNATIONAL SOCIETY OF TRAVEL MEDICINE

*Please allow up to 4 weeks for the review process to be completed. (aligned text here)*

Name of Conference: \_\_\_\_\_

Conference Organizer: \_\_\_\_\_

Email: \_\_\_\_\_

Dates of activity: \_\_\_\_\_

Place of activity: \_\_\_\_\_

Primary Sponsor of Conference (i.e., University, Professional Society or Scientific Foundation): \_\_\_\_\_

*[Note: Conferences where ISTM is the primary sponsor are initiated by ISTM itself; in order for ISTM to accredit a non-ISTM conference there should be an independent primary sponsor.]*

# Decompression Illness in SCUBA Divers

Gary Podolsky and Karl Neumann



Travelers planning trips to exotic beach resorts should be asked about their intentions of going scuba diving and if so, whether they understand the health issues involved and are aware of the subtle signs of early decompression illness. Like any sport, scuba diving involves the risk of injuries. There are between three and four illness/injuries reported for every 10,000 dives, with the vast majority of them minor, with complete resolution and no impact on future diving activities. Permanent sequelae are rare.

Decompression illness (DCI) includes two conditions, decompression sickness (DCS) (also known as the bends or caisson disease), and arterial gas embolism (AGE). DCS is believed to be due to bubbles forming in body tissue, causing local damage. AGE results from bubbles entering the bloodstream, usually in the lungs, traveling through arteries and causing tissue damage at distant points by blocking blood flow in small vessels. Risk factors for both include deep/long dives, cold water, vigorous exercise at depth or immediately after surfacing, and rapid ascents. Obesity, dehydration, and pulmonary disease may play roles. And there are unknown factors involved;

divers not at risk and who follow all the safety guidelines are sometimes affected.

## Decompression Sickness

DCS results from inadequate decompression following exposure to increased pressure. The condition varies from mild with no immediate threat to serious injury requiring prompt treatment to ensure full recovery.

During a dive, the body tissues absorb nitrogen from the breathing gas in proportion to the surrounding pressure. As long as the diver remains at pressure, the gas presents no problem. If the pressure is reduced too quickly, nitrogen comes out of solution, forming bubbles in the tissues and bloodstream. This commonly occurs as a result of violating or approaching too closely to the diving table limits, but can occur when accepted guidelines are followed.

Bubbles forming in or near joints are the presumed cause of joint pain or "the bends." Bubbles forming in the spinal cord and brain may cause paralysis and other neurological symptoms. Bubbles entering the bloodstream can cause pulmonary and circulatory problems.

## Symptoms of DCS

Joint pain and numbness or tingling are common manifestations of DCS, followed by muscular weakness and inability to empty a full bladder. Severe DCS is easily diagnosed but most cases begin subtly, with minor joint aches or paresthesias in an extremity. Often the symptoms are ascribed to another cause such as overexertion, heavy lifting or a tight wetsuit. This delays seeking help and is why it is often said that the first symptom of DCS is denial.

Even symptoms that remain mild and disappear spontaneously should be investigated promptly. Severe DCS may result in permanent problems such as bladder dysfunction, sexual dysfunction and muscular weakness. Rarely, damage to the spinal cord may decrease the likelihood of recovery from subsequent bouts of DCS. Untreated joint pain that disappears may still cause small areas of bone damage (osteonecrosis). Future bouts of osteonecrosis may cause additional damages, making bones brittle and causing arthritis.

Signs of DCS usually appear within 15 minutes to 12 hours after surfacing; but in severe cases, symptoms may appear before surfacing or immediately afterwards. Delayed occurrence of symptoms is rare, but does occur, especially if air travel follows diving. Symptoms include: unusual fatigue; pruritis; pain in joints/muscles of the arms, legs or torso; dizziness; vertigo; ringing in the ears; numbness, tingling and paralysis; and shortness of breath.

Also associated with DCSR are the following: a blotchy rash on the skin, muscular weakness and paralysis, difficulty urinating, confusion, personality changes and bizarre behavior, amnesia and tremors, staggering gait, coughing up bloody and frothy sputum, and collapse or unconsciousness.

## Prevention

Recreational divers should dive conservatively, following guidelines set forth in dive tables or computers. This is highly recommended for all divers, especially when diving in cold water or when diving under strenuous conditions. There are also published guidelines for flying after diving. Different sources advocate waiting a minimum of 12 to 24 hours after an uncomplicated dive before flying.

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“Decompression Illness in Scuba Divers,” cont. from p. 4

## Arterial Gas Embolism (AGE)

This occurs when divers surface without exhaling. Air trapped in the lungs expands with ascent and may rupture lung tissue (pulmonary barotraumas) and release gas bubbles into the arterial circulation. Since the brain receives the highest proportion of blood flow, it receives the most bubbles. The bubbles become lodged in the small arteries of the brain and damage brain tissue. Pulmonary disease may be a predisposing factor.

AGE can occur even when ascents are apparently normal. The most dramatic presentation of air embolism is the diver who surfaces unconscious and remains so, or the diver who loses consciousness within 10 minutes of surfacing. Obviously, these are medical emergencies. Rapid evacuation to a treatment facility is paramount. But usually air emboli merely cause tingling or numbness, weakness without obvious paralysis, or difficulty in thinking without obvious confusion. Individuals are awake or easily aroused. In these cases, there is time for more thorough evaluations, preferably by a diving medical specialist who can rule out other causes of symptoms.

As with DCS, ascribing mild symptoms to a non-dive cause delays or results in no treatment, and symptoms resolve, though damage has occurred. This increases the risk of residual symptoms after a future bout of AGE, even if the later bout is treated.

The signs and symptoms of AGE include dizziness, blurring of vision, weakness and paralysis, areas of decreased sensation, chest pain, disorientation, bloody froth from the mouth or nose, seizures and unconsciousness.

The percent of diving problems due to AGE has decreased substantially over the years, from 18% of reported cases of DCL in the late 1980s to less than 10% now, probably due to the advent of dive computers, which help chart the rate of ascent, reminding divers to slow down.

## Preventing AGE

Breathing normally and relaxing during ascent helps prevent AGE. Asthma, respiratory infections, obstructive lung disease and other pulmonary pathology predispose divers to air embolism. Divers with these conditions should be evaluated by a physician knowledgeable in diving medicine.

## Treatment

The treatment for DCI (DCS and AGE) is recompression. Although divers with severe symptoms require urgent recompression, it is essential that they be stabilized at the nearest medical facility before transportation to a recompression chamber. Oxygen may reduce symptoms substantially but should not change the treatment plan. Symptoms often clear after initial oxygen therapy, but may reappear later. A dive physician should always be contacted even if the symptoms and signs appear to resolve.

## Care of the Diver with Decompression Illness

### I. Determine the Urgency of the Injury

Make an initial evaluation at the dive site. Suspect DCI if signs occur within 24 hours of surfacing. The initial state of the affected diver will determine the order and urgency of the actions taken. The U.S. Navy uses a three-part category system:

- Category A. Emergency
- Category B. Urgent
- Category C. Timely

### Category A - Emergency

Symptoms are severe and appear rapidly, within an hour or so of surfacing. Unconsciousness may occur. Symptoms may be progressing. The diver is obviously ill, may be profoundly dizzy, have trouble breathing or altered consciousness and abnormal gait or weakness.

If indicated, begin CPR and arrange for immediate evacuation. Check for foreign bodies in the airway. If ventilatory or cardiac resuscitation is required, the injured diver must be supine. Vomiting in this position, however, is extremely dangerous; if it occurs, quickly turn the diver to the side until the airway is cleared and resuscitation can resume in the supine position.

Caregivers should use supplemental oxygen if available during ventilatory support to the injured diver. Even if CPR is successful and the diver regains consciousness, 100 percent oxygen should be provided and continued until the diver arrives at a medical facility. Advanced divers are also encouraged to take oxygen provider course.

If trained healthcare personnel are available, an IV with isotonic fluids without dextrose should be started. Give an initial rapid infu-

sion of 1 liter over 30 minutes to correct any dehydration and reduce hemoconcentration. Then reduce the rate of administration to 100-175 cc/hour maintenance rate. Additional fluids may be required to further correct dehydration and maintain blood pressure but only after weighing complications of fluid overload and discomfort from urinary retention. If possible, insert a urinary catheter.

Definitive treatment requires a facility with a recompression chamber. The Divers Alert Network (DAN) can assist in locating one. And DAN medical experts can contact the receiving facility to assist in diagnosis and, if necessary, treatment. This should be done even if the diver appears to be improving on oxygen. While awaiting evacuation, take as detailed a history as possible and try to evaluate and record the diver's neurological status. If air evacuation is used, cabin pressure should be maintained near sea level and not exceed 800 feet/244 meters unless aircraft safety is compromised.

Place the diver in the lateral recumbent position, also known as the recovery position. This puts the person on one side (usually left) with head supported at a low angle and the upper leg bent at the knee. If vomiting occurs in this position, gravity will assist in keeping airway clear.

### Category B - Urgent Cases of DCI

Here, the only obvious symptom is severe continuous pain, no other signs of distress, and no obvious neurological signs, though a careful history and physical may elicit some findings.

Give the injured diver 100 percent oxygen and fluids by mouth. Do not treat pain with analgesics until advised to do so by experienced medical personnel. Continue oxygen until arrival at the medical treatment facility. Even if symptoms improve, contact a medical facility or DAN on what sort of transport is indicated. Emergency air transport may not be necessary. As with category A patients, take a history and evaluate and chart neurological status.

### Category C - Timely Cases of DCI

Symptoms are vague, perhaps complaint of some pain or abnormal sensations over a few days. The diagnosis of DCI may be in ques-

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“Decompression Illness in Scuba Divers,” cont. from p. 5

## Learning to screen candidates for diving can be very useful for travel medicine practitioners.

tion. Take a complete diving history and do a neurological evaluation. Call the nearest medical facility or DAN for advice, or go to the nearest medical facility, if nearby, for evaluation.

### In all cases of DCI try to document the 48 hours preceding the injury:

- Depths/times of dives, ascent rates, intervals between dives, breathing gases, problems or symptoms at any time before, during or after dives;
- Times of onset of symptoms and progression after the diver surfaced from last dive;
- First aid measures taken (times, method, and percent of oxygen delivery) and their effect on symptoms since the injury;
- Results of on-site neurological examination;

- Joint or other musculoskeletal pain including: location, intensity and changes with movement or weight-bearing;
- Distribution of rashes; and
- Traumatic injuries before, during or after the dive.

Information regarding the injured diver's neurological status will be useful to medical personnel in not only deciding the initial course of treatment but also in the effectiveness of treatment.

### Returned Travelers

Although unlikely, with modern transport it is possible that travel medicine practitioners will see a returned traveler with symptoms of DCI. Such patients should receive oxygen immediately and be sent to an emergency facility for assessment for hyperbaric treatment.

### Finding a Dive Physician

Dive physician may be available through local military hospitals. Many Navy and Air Force physicians are knowledgeable about the subject and so are some occupational medicine, emergency medicine and sports physicians. Practitioners may vary in experience from doing simple dive physical clearances to full certification in hyperbaric medicine.

### Becoming a Dive Physician

Learning to screen candidates for diving can be very useful for travel medicine practitioners. Guidelines for diving fitness are straightforward although there are some differences in the American, British and Australian definitions of fitness and precluding conditions (see references). Introductory courses in Dive Medicine are regularly scheduled through the Divers Alert Network.

### Advocating Safe Diving

Many dive related injuries are also associated with poor technique and with “quickie instructions at resorts.” Proper certification by qualified dive shops can decrease this risk.

### Divers and Malaria

Mefloquine has been associated with a decrease in fine motor reflexes and is listed as a contraindicated medication for divers (although some authors dispute this). It is best to use an alternative antimalarial in divers.

### References:

- 1) Dive and Marine Medicine (3rd Conference. March 2000, sponsored by The Undersea and Hyperbaric Medical Society.
- 2) Dive and Travel Medical Guide Ed Thalmann, Editor, Revised 1999, published by D.A.N.
- 3) Bore, Alfred A and Davis, Jefferson C. (1990) Pub W.B Saunders. Diving Medicine.
- 4) Edmonds (1978) Diving and Sub Aquatic Medicine 2nd Edition. 6) Divers Alert Network. Report on Decompression Illness and Diving Fatalities 2000 Edition.
- 5) Undersea and Hyperbaric Medical Society Inc. (July 21, 1995) Published meeting. Are Asthmatics Fit to Dive?
- 6) D.A.N Website link: <http://www.diversalertnetwork.org/>

*Gary lives in Winnipeg, Canada where he operates a travel clinic. Karl is the editor of this Newsletter. We thank DAN for allowing us to freely use their information and data. Gary adapted the material for travel medicine practitioners.*

### About Dan

Divers Alert Network (DAN) is non-profit medical and research organization dedicated to the safety and health of recreational scuba divers and travelers. Associated with Duke University Medical Center (DUMC), DAN is supported by the largest association of recreational divers in the world.

Founded in 1980, DAN has served as a lifeline for the recreational scuba industry by operating scuba diving's only 24-hour emergency hotline, a lifesaving service for injured divers. DAN members have access to full-time travel assistance and emergency medical evacuation as well as help with legal, personal and travel information.

Additionally, DAN operates a diving medical information line, conducts vital diving medical research, and develops and provides a number of educational programs for everyone from beginning divers to medical professionals.

DAN also supports, through education and training, a network of recompression chambers worldwide for the treatment of injured divers.

Divers Alert Network is supported by membership dues and donations. In return, members receive a number of important benefits including \$100,000 emergency medical evacuation assistance, DAN educational publications, a subscription to Alert Diver magazine, and access to diving's first and foremost accident insurance coverage.

## Contact DAN

- DAN America
- DAN Europe
- DAN Japan
- DAN Southeast Asia-Pacific
- DAN Southern Africa

### DAN America (International Headquarters)

United States and Canada, with regional IDAN responsibility for Central and South America, the Caribbean, Polynesia, Micronesia and Melanesia (except Fiji), and any other area not designated below.

The Peter B Bennett Center  
6 West Colony Place  
Durham, NC 27705-5588  
USA

1-800-446-2671 Toll-Free  
1-919-684-2948 General Inquiries  
1-919-490-6630 Fax  
1-919-493-3040 Medical Fax

### Diving Emergencies

*DAN America*  
1-919-684-8111  
1-919-684-4326 (accepts collect calls)

*DAN Latin America*  
1-919-684-9111 (accepts collect calls)

### Non-Diving Emergencies & TravelAssist Services

1-800-326-3822 (1-800-DAN-EVAC)  
1-919-684-3483 (Call collect if outside the USA, Canada, Puerto Rico, Bahamas, British or U.S. Virgin Islands)

### DAN Europe

Geographical Europe, European Territories, and Protectorates, with regional IDAN responsibility for the countries of the Mediterranean Basin, the countries on the shores of the Red Sea, the Middle East including the Persian Gulf, the countries on the shores of the Indian Ocean north of the Equator, as well as the related overseas territories, districts, and protectorates.

P.O. Box DAN  
64026 Roseto (Te)  
ITALY  
39-085-893-0333  
39-085-893-0050 fax

### Diving Emergencies

*DAN Europe*  
39-039-605-7858

### Non-Diving Emergencies and TravelAssist Services

39-039-605-7858

### DAN Japan

Japanese mainland and islands, with regional IDAN responsibility for Northeast Asia-Pacific.

Japan Marine Recreation Association  
Kowa-Ota-Machi Bldg, 2F, 47 Ota-Machi 4-Chome  
Nakaku, Yokohama City, Kagawa 231-0011  
Japan  
81-45-228-3066  
81-45-228-3063 fax

### Diving Emergencies

*DAN Japan*  
81-3-3812-4999

### DAN Southeast Asia-Pacific (SEAP)

Australia and New Zealand, with regional IDAN responsibility for Papua New Guinea, Fiji, Indonesia, Malaysia, Vietnam, Singapore, Cambodia, Myanmar, Philippines, Vanuatu, India, Solomon Islands, Brunei, Thailand, Hong Kong, Korea, China and Taiwan.

P.O. Box 384  
Ashburton, Victoria 3147  
AUSTRALIA  
61-3-9886-9166  
61-3-9886-9155 Fax

### Diving Emergencies

*DES Australia*  
1-800-088-200 (within Australia)  
61-8-8212-9242 (outside Australia)

*DAN / DES New Zealand*  
0800-4DES111

*Singapore Naval Medicine & Hyperbaric Center*  
67-58-1733

*DAN SEAP - Philippines*  
02-632-1077

*DAN SEAP - Malaysia*  
05-930-4114

*DAN SEAP - Korea*  
82-010-4500-9113

### DAN Southern Africa

South Africa, Swaziland, Lesotho, Namibia, Botswana, Zimbabwe, Mozambique, Angola, Zambia, Zaire, Malawi, Tanzania, Kenya, Madagascar, Comoros, Seychelles, and Mauritius.

Private Bag X 197  
Halfway House, 1685  
SOUTHERN AFRICA  
2711-254-1991 or 2711-254-1992  
2711-254-1993 fax

### Diving Emergencies

*DAN Southern Africa*  
0800-020111 (within South Africa)  
27-11-254-1112 (outside South Africa)

# Best Ethical Travel Destinations

Jeff Greenwald and Kiran Auerbach



During the past 20 years, the phrases "ecotravel" and "ethical travel" have entered the globetrotter's lexicon. The first term has been so co-opted and abused that it's practically stripped of meaning; even huge luxury hotels and cruise ships tout money-saving tactics like "gray water" reuse and energy-saving laundry practices as evidence of their commitment to ecotourism.

Ethical travel is a more recent concept, and a much more demanding one. It fulfills both individual and collective ideals: a traveler experiences environmental beauty and cultural immersion while actually contributing to the ecological preservation and social development of their host country. This brand of travel combines ecotourism with broader environmental and social issues. It can even be used as an economic carrot, to support and reward countries pursuing high standards in these areas. It's also more demanding of service providers; hotels and carriers can't simply tweak a few ecopolices and award themselves gold stars. For a country to be considered a good ethical travel candidate, the government must demonstrate a strong commitment not just to the environment, but to the well-being of its population as well.

Ethical Traveler recently conducted a study to learn where Americans tend to travel in the developing world, and how this compares with

the most environmentally and socially progressive places to actually spend our tourism dollars. The results were surprising - and instructive.

Ethical Traveler's goal was to formulate a list of the "Best Ethical Travel Destinations," specifically geared to outbound American leisure travelers. The idea was not just to come up with a list of countries, but also to choose places that Americans would actually want to visit.

Here, alphabetically, are the most popular developing-country destinations for American tourists:

## Most Popular Developing World Destinations

Bahamas  
Brazil  
China  
Costa Rica  
Dominican Republic  
India  
Jamaica  
Mexico  
Philippines  
South Korea  
Taiwan  
Thailand  
Trinidad and Tobago

After compiling this data from the US Department of Commerce, Ethical Traveler took a look at the rest of the developing world, including two continents not on the list: Africa and Europe. (Europe, the most popular destination for American travelers, is not considered "developing," but several of the new Eastern European nations do fit that description.)

To determine "ethicalness," they investigated three categories: ecotourism practices, environmental standards, and social development indicators. Their research was conducted at Stanford University, using information from a variety of national and international sources.

## Ecotourism

Over the past 20 years, the meaning of ecotourism has evolved. But even though many organizations have different definitions, key principles remain universal: conservation of the natural environment, low visitor impact, and benefit to the local population.

Since ecotourism is such an attractive policy, many governments loudly profess their commitment towards the industry. As a result, it's often difficult to separate spin from reality. Still, credible agencies like The International Ecotourism Society (TIES) have singled out countries with strong commitments to preservation. Belize (for its Mayan sites), Brazil (national parks), Ecuador (Galapagos Islands and Amazonian rainforest), Kenya (wildlife reserves), Nepal (mountain trekking), Peru (bird watching), and South Africa (game and nature reserves) all make the grade.

The best-known ecotourism destinations are probably Costa Rica and Bhutan. With a vibrant tourism industry that centers around its cloud forests, turtles, and volcanoes, Costa Rica has served as an inspiration for other Latin American countries, such as Ecuador, Peru, and Honduras. Bhutan, though, is the "poster child" for ecotourism. Their entire tourism industry is based on sustainability, and an effort to attract "low volume, high quality" visitors willing to pay a handsome fee for the privilege of visiting the pristine Himalayan kingdom.

Because of its direct link between the local environment and population, ecotourism was the single most important factor Ethical Traveler used in determining "ethicalness." But even countries with strong ecotourism values are

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sometimes careless of broader human rights issues. That's why it's also crucial to examine the environmental and social progress of a country.

### Environmental Protection

Ethical Traveler's environmental evaluation took into account six factors: Carbon dioxide emissions, energy efficiency, percentage of protected land, percentage of mammals under threat, the environmental sustainability index, and the number of major international environmental treaties ratified. This was an attempt to learn how serious, ecotourism industry aside, a country is in protecting its environment.

Seven countries earned very high environmental ratings: Argentina, Bhutan, Brazil, Costa Rica, Peru, Sri Lanka, and Uruguay. All boast low CO<sub>2</sub> emissions, steady progress in energy efficiency, and a policy of signing treaties designed to protect the Earth's ecosphere. Tourist favorites that came out on the negative side included Kenya, with extremely poor energy efficiency, as well as Trinidad and Tobago. Ironically, the five countries with the highest percentage of threatened wildlife (above 20%) also rank among the most popular US travel destinations: The Dominican Republic, Jamaica, India, the Philippines, and South Korea.

### Social Development

While it's true that ecotourism benefits the local population, it's usually a very local population. The inhabitants of a tract of rainforest may thrive from the sale of creams made from their plant extracts, but this doesn't do much for people in the urban centers - or even the neighboring tribes. Thus, ethical travel has to include a country's overall social development, to determine how committed the government is to its entire citizenry.

Social development was the broadest of the three categories, with seven factors to consider. Ethical Traveler put income distribution, health, and education under the microscope, using reports from the UN and the WHO, among others. But they also took into account crime, government corruption, and the status of women. Finally, as a gnomon of ongoing progress, they looked at how many international human rights and international labor rights treaties each country had ratified. The results were sometimes counter-intuitive. They found that Sri Lanka, Nepal, Croatia, and Slovenia all relatively low levels of inequality - while South Africa, Panama, and El Salvador have high disparities.

Healthwise, the Bahamas, Costa Rica, Barbados, Sri Lanka, and Uruguay took highest rankings (though both India and China have made big improvements in this area). Kenya was again a disappointment; its mortality rate

for children under five actually increased between 1990 and 2003. In education, Barbados, South Korea, Slovenia, and Uruguay excel, as does Argentina. Women's status is strong in Jamaica, Mexico, South Africa, Sri Lanka, and Uruguay. It's poorest in Egypt, India, and Nepal.

The worst commitment to human and labor rights was measured in Thailand (which also has the highest government corruption index) - and, unexpectedly, Bhutan. The Kingdom of Bhutan has failed to ratify five human rights treaties, and has not approved a single international labor rights convention.

### Best Ethical Travel Destinations

Argentina  
Barbados  
Belize  
Brazil  
Costa Rica  
Croatia  
Ecuador  
Kenya  
Peru  
Slovenia  
Sri Lanka  
South Africa  
Uruguay

The most provocative results of the social category, in fact are the abysmally low rankings of Bhutan, especially in light of its forward-looking ecotourism practices. On the other hand, high social development was a crowning achievement for Argentina, Barbados, Costa Rica, Sri Lanka, and Uruguay.

### Conclusion

The final list of ethical destinations in the developing world was compiled with care, and should serve as a practical guide for American tourists looking for vacations that are both self-rewarding and supportive of the people and environments we visit.

The most notable and unexpected result is that Latin America emerges as the leader in ethical travel. While certain recommended destinations are already popular (Brazil, Costa Rica, and Peru), other top countries (Argentina, Barbados, Belize, Ecuador, and Uruguay) also have much to offer American tourists. Argentina has a vast array of natural wonders: from glaciers in the Andes to pre-Columbian villages in the North. Belize hosts Mayan ruins, as well as a lush rainforest. Uruguay, not as

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well known, contains spectacular beaches as well as trekking in the interior.

Croatia's beautiful beaches make it a viable alternative to Italy, France, or Greece. Slovenia is also a great destination, with impressive underground caves, thermal springs, alpine skiing, and nature trails.

Sri Lanka, recovering from the Indian Ocean tsunami, is outdoing India in both environmental and social development standards. And though South Africa and Kenya lag a bit in both environmental and certain social measures, good ecotourism values are their redemption. Ethical Traveler included these countries as a nod to their valiant strides in ecotourism, and in the hope that American travelers will help support a region that the international community habitually neglects.

Ethical travel to developing countries offers a positive, symbiotic exchange between travelers and their destination. By "voting with our wings," tourists give their economic support to such societies, raise the standard of living for the population, and reinforce programs that protect the environment. The reward travelers receive is also worthwhile: a memorable vacation, and the realization that, although the world is getting smaller, some parts of it are actually getting better.

About Ethical Traveler. Ethical Traveler is a grass-roots alliance uniting adventurers, tourists, travel agencies, and outfitters - everyone who loves to travel, and sees travel as a positive force in the world. Ethical Traveler feels that all travelers are, in effect, freelance ambassadors. They also believe that we have the ability to join our voices, and to use our economic power to strengthen human rights and protect the environment.

About the Authors. Researcher and co-author Kiran Auerbach received her B.A. in International Relations from Stanford University in 2005. She currently resides in Vienna, Austria, where she is studying violin and interning at the Ludwig Boltzman Institut für Menschenrechte (Institute for Human Rights) in Vienna.

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the Newsletter of the International Society of Travel Medicine

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