

# Travel Medicine NewsShare

NEWS, VIEWS AND NOTICES FROM THE INTERNATIONAL SOCIETY OF TRAVEL MEDICINE

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The aim of NewsShare is to allow easy exchange of information between members of ISTM in the form of news, view and notices. It must be noted that the views expressed by contributors are not necessarily those of the editors, the ISTM executive or its various committees unless stated to be so.

## NEWS ABOUT OUR MONTRÉAL CONFERENCE

### Some words from the Conference Organisers

Dear ISTM Members,

I can't think of any good excuse not to come to the 6<sup>th</sup> Conference of the International Society of Travel Medicine, CISTM6 in Montréal.

The Scientific Program is now completed and, I must say, looking very exciting: New subjects, new speakers and the one's you have always appreciated over the years at previous CISTM.

Many posters have been accepted. To allow participants to really appreciate them, they will all be posted during the whole conference. Not to be missed!

The support of the industry will be obvious during the Conference, with many satellite symposia and a large exhibit room. Without their support, it would be impossible to put together such a conference at an affordable price for participants.

The venue is right in the heart of the beautiful city of Montréal. The Palais des Congrès is equipped with all the services you can expect from a modern conference centre. And the Canadian Dollar... Well! It's the only "low" I can think of for this Conference. But for most of you, it will mean more for less.

Looking forward to seeing you in Montréal.

Dominique Tessier, MD  
Chair – CISTM6



## Travel tips for Montréal

Montréal is beautiful early June. The average temperature is 24° C (78° F).

Montréal may be the largest francophone city in America, you should be impressed by the ease we all usually « guess » when to speak in English to a customer. Montréal is also rich with its well established multicultural communities. The dress code at the Conference and in restaurants is casual. Some fancy restaurants may require a tie.

Life is inexpensive in Montréal. A coffee costs around 1.00\$ CDN, an espresso 1.50\$ and a large bowl of cafe latte (my favourite) less than 3.00\$. You can expect to pay 5 to 10.00\$ for a full breakfast, american type (more in hotels) and for lunch around 10.00\$ (table d'hôte). For dinner, it will depend where you feel like going. Many excellent restaurants in Montréal can be more pricey if you include wine and 5 services. You will find all type of cuisine. If you come with your kids, don't miss the Biodôme. Le Cirque du Soleil just opened a new show. Nobody should spend a whole life without seeing them once.

Remember that a beautiful Concert with Music for all hearts will be played at the Notre-Dame Cathedral on Tuesday, June 8<sup>th</sup>. At one block from the Palais des Congrès, the Cathedral offers not only a page of Montréal history but also a surprisingly good acoustic.

Bring your walking shoes... and roller blades if you are into it. In the Old Montréal, you will find a few miles of walking/biking/rolling path along the St-Lawrence River. All the trees should still be blooming.

The Grand Prix de Montréal will follow right after CISTM6. The fan's already know that. But make firm reservations with your hotel if you want to avoid sleeping under one of our bridges. Certainly not as romantic as Parisian Bridges. For more information, please visit the CISTM6 Website at: [http://istm.org/istm\\_c6.html](http://istm.org/istm_c6.html) or the city of Montréal Website at: <http://ville.montreal.qc.ca>

Dominique Tessier, MD  
Chair – CISTM6

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## A glimpse at the scientific programme of the CISTM6

The Scientific Programme of the CISTM6 offers a wide scope of various topics covered by specialists in travel and migration medicine.

The overture of this Canadian Concerto will be composed by two stimulating pre-conference events on *Caring for the Globally Mobile Expatriate Community on a Shoe String* and on *Health Care on the Move the Practitioners Perspective on Migration Medicine*. There are some places left in both symposia, so get enrolled quickly. The 6<sup>th</sup> Conference of the International Society of Travel Medicine will be officially opened on Sunday, June 6<sup>th</sup>, with a keynote address given by the ISTM president, Prof. Michel Rey, on the *Challenges for the Future, including Guest-Host Relationships*.

The first movement of the Conference Programme starts on Monday with the Jonathan Mann Memorial Lecture, held by Daniel Tarantola on the *Impact of Travel and Migration on the Spread of HIV*. This lecture remembers our most esteemed colleague and friend who has given major inputs for the benefit of the ISTM. The first plenary of the Conference deals with innovative topics concerning malaria. The following symposium on relief workers introduces an established line of interest of the Society, along with a free communication session and two workshops. Monday afternoon opens the field for *Special needs*, the *Military, Airline*, and two free communications sessions, seconded by workshops on *Women's issues*, *Malaria Skin* and *Computer-www Resources in Travel Medicine*.

The second movement on Tuesday is launched with a well known and highly acclaimed tune, the *Meet the Professor* session, which will also boost the morning enthusiasm during the following days. A plenary on *Migrant Health* then precedes two symposia on *Drug Resistance* and *Cruise Ships*, again supported by a string of free communication sessions and workshops on *Fever* and *Computer. The Tick* is next on the list, the other afternoon symposium is on *Adoption*. Workshops on *Children Malaria Treatment*, *Travellers' Diarrhoea* and *Geosentinel* round up the programme.

The third movement on Wednesday tackles issues of a *Changing World* in the plenary session. The symposia on *Jet Lag*, *News on Infections* and *Safe Food and Water* (afternoon) provide the latest knowledge and a variety of workshop topics, including *Refugee Health*, *Chronic Diarrhoea*, *The immunocompromised Traveller*, *The Nursing Working Group*, *STDs* and *Extreme Travel* stimulate the participants who do not visit the free communications sessions.

Every day is hosting one or more satellite symposia.

Long breaks between the morning sessions and during the lunch hour allow for interactions between the participants and for carefully studying the colourful set of posters which will be exposed during the entire duration of the conference to foster discussions between the presenters and the public. Incidentally, we hope that the participants will help us in selecting the best poster and the best oral presentation of the Conference which will be awarded during the closing ceremony. The final movement includes symposia on *Travellers Diarrhoea* and *Coping with Airline Emergencies*, seconded by late breakers in the free communication session and a workshop on *Malaria*.

The finale hosts the trumpets of a plenary on *Vaccines* and the Closing Ceremony before we have to leave the floor to the roaring Formula One cracks on the weekend.

Make sure you get one of the pole positions ... for the CISTM6!



Abstract Deadline May 24  
Late Breakers in Travel Medicine Session  
Thursday June 10, CISTM-6, Montreal

This session is specifically designed for presentation of high impact new data of importance to travel medicine clinicians but which was obtained after the closing date for regular abstract submission. Reports of outbreaks, suspected emerging pathogens or of newly available data from sizeable clinical studies are appropriate. Abstracts of 250 words or less (see below for format) MUST be submitted by e-mail to David O. Freedman <freedman@uab.edu>, Session Chair, no later than Monday May 24. Eight ten-minute papers will be selected and presenters will be notified by e-mail before June 1. Copies of accepted abstracts will be included in the CISTM-6 registration packets. Informal e-mailed enquiries as to the suitability of potential papers for presentation are highly encouraged.

Abstract Format

1. Must not exceed 250 words (excluding title and author information).
2. Title must be in CAPITAL letters on the first line. Author's(s) name(s), institution, city and country are to be typed under the title, with initials preceding surname(s). Do not include degrees or professional titles (M.D., Dr., Prof., etc). A maximum of six co-authors may be listed.
3. Place an asterisk after the name of the presenting author. Include an e-mail address, for the presenter only, in parentheses.
4. Leave one line between the title/author block and the body of the abstract. Do not indent paragraphs and do not leave blank lines between paragraphs.

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**NEWS FROM THE SOCIETY**  
Setting the Standard of Care:  
A Certificate of Knowledge in Travel Medicine??

Dear ISTM Member,

At the recommendation of the ISTM Executive Board, a committee was formed to explore the possibility and interest of the ISTM in developing an international examination in travel medicine. The committee met in April and was made up of 15 ISTM members representing various geographic regions, practice types, and occupations, along with a representative from a professional testing service. The meeting was made possible by an educational grant from Merck and Co., Inc.

It has been noted by many travel health advisors, and in particular members of the ISTM, that the body of knowledge that encompasses travel medicine has not been well defined. As a result of the increasing demand for travel health information, numerous individuals dispense what they consider travel health advice with minimal expertise, and thus a need has arisen for setting a standard of care for the practice of this new and growing specialty. A number of medical societies have expressed interest in collaborating with the ISTM to confer a certificate of knowledge (or the equivalent) upon those who pass an examination in travel health, and we are aware that nurses within the ISTM have been exploring this issue as well. In addition, a number of travel medicine courses include exams, and a number of Board examinations also include questions on travel health.

The ISTM Executive Board decided to address this issue by recognizing that our Society as a whole would be the appropriate one to determine the scope of knowledge of travel medicine, as well as to set the standard of care. The issue now becomes, how do we accomplish this enormous task? The new committee felt that it was important to first define the body of knowledge within travel medicine, and then to consider whether an exam is desirable. It became clear that the Society would not choose to proceed with the development of an examination without hearing first from its membership, and certainly the Society would not proceed without the knowledge that the members were behind such an endeavor. The task is time-consuming and expensive for the ISTM, as well as time-intensive for all participating in the process, and thus your thoughts are essential. Reasons for considering an examination are the following: 1. it would promote professional development, 2. it would serve the public by enhancing patient care, 3. it would establish internationally recognized standards, and 4. it would recognize individual excellence. The exam would be for nurses, physicians, and others who practice pre-travel health care and would test very basic knowledge in travel medicine. If surveying the ISTM membership results in a positive response, next steps will be to designate knowledge areas in travel medicine and develop teams to move through the exam development process. Be aware that throughout this process, the Board remains very sensitive to the geographic and occupational diversity of the Society membership.

Please find within this newsletter a survey to explore your ideas about the importance of an examination for certification from the ISTM. It is very important that we have the opinion of all of our members, so please complete the survey and return it to the secretariate (fax number: 770-736-6732) as soon as possible. We will inform you of the survey results when available. Thank you for your time.

Very Sincerely,  
Phyllis Kozarsky,  
On behalf of the committee



## GeoSentinel - The ISTM Role in Global Surveillance of Emerging Infections

Almost a decade ago, various national and international organizations as well as the global scientific community identified emerging and reemerging infectious diseases as major threats. The recognition of international travel as a leading player in the introduction of these illnesses into susceptible populations became a concept more familiar to members of the ISTM than probably to any other medical society worldwide. It was with this basic understanding that GeoSentinel was established as an emerging infections sentinel network in July 1995 by a working group of nine U.S.- based travel/tropical medicine clinic members of ISTM. ISTM support for the establishment of such a network was strong, and in May 1996 GeoSentinel was also awarded competitive funding through the Division of Quarantine, National Centers for Infectious Diseases, Centers for Disease Control and Prevention (CDC) under an initiative to strengthen surveillance and respond to emerging pathogens. The unique global perspective offered by ISTM clinicians and their patient base was a key element in considering GeoSentinel as a critical piece in the surveillance of infectious diseases.



GeoSentinel Site Directors Annual Meeting  
CDC - Atlanta, USA, June 1998

With the current volume and speed of travel, any place in the world can be reached from any other within 36 hours. The travel and tropical medicine practitioner appreciates that since this is shorter than the incubation period of many infections, we can no longer rely exclusively on screening at ports of entry to detect disease occurrence in mobile populations. Post-travel care focuses on the management of all travelers who acquire medical problems, and particularly infectious diseases, due to the increasing propensity for exotic travel to ever more remote areas. In addition, refugees, displaced persons, and immigrants will remain some of the highest risk populations for acquisition of numerous medical problems.

GeoSentinel is based on the concept that travel/tropical medicine clinics, because of their unique patient populations, are ideally situated to detect geographic and temporal trends in morbidity among travelers. It links geographically dispersed sites, now totaling 22, into a reporting network which aggregates anonymous data from all post-travel patients, be they asymptomatic individuals

presenting for post-travel screening, returning ill travelers, immigrants, or refugees. The surveillance tool used by the sites is a single-page faxable form completed on every eligible patient; simple demographic data, travel itineraries, reasons for travel, chief complaints, and working and final diagnoses are reported. Data are collated and processed in Atlanta by support personnel. GeoSentinel site directors participate in annual meetings and receive quarterly reports summarizing data from their own sites as well as from the aggregated pool.

The priorities and accomplishments over the initial few years of GeoSentinel activity thus far have been: 1. to establish a global surveillance network, 2. to establish trends for travel-related infectious diseases, 3. to develop novel surveillance methodology, 4. to develop partnerships between ISTM and other government and non-government agencies, as well as health care providers worldwide, and 5. to develop an alert mechanism for alarming diagnoses. In addition, GeoSentinel has been able to establish the methodology for periodic urgent enquiries. In 1998, for example, an urgent enquiry to GeoSentinel core clinics resulted in the rapid collection of information about sufficient numbers of yellow fever vaccinees so that calculation of age-specific rates for adverse events were able to be determined for the first time. (See poster session in Montreal for details.) Enquiries can also be expanded to our larger family of ISTM clinics, as our electronic communication now covers over 1,000 clinics in 55 countries. Indeed, we feel that GeoSentinel has played a role in helping to place the ISTM "on the map" with regard to global surveillance.

Goals of GeoSentinel over the next several years are: 1. to continue expansion of our worldwide communications network, 2. to continue to monitor global trends in disease occurrence in travelers, 3. to ascertain risk factors and morbidity in various groups of travelers, 4. to respond to urgent public health queries from a variety of organizations, 5. to help identify travel health educational priorities, 6. to continue to develop innovative data collection methodologies, 7. to achieve electronic submission of data, and 8. to expand the capability for effecting a rapid public health response by electronically disseminating alerts to surveillance sites, as well as to public health authorities and other key partners. The continued support of the ISTM, as well as support through our cooperative agreement with CDC will assist us in accomplishing these goals. Though the CDC cooperative agreement was recently renewed for another 5 years, we hope to identify additional sources of revenue that will help insure our ability to expand further. We fully realize that surveillance on a global scale will not be the result of our one network, but rather will depend on the concept of "a network of networks;" a major by-product of GeoSentinel, and now one of its strongest assets, is the growth of partnerships worldwide.

We urge you to read the review of GeoSentinel that will be published in the June issue of the *Journal of Travel Medicine* and we urge you to attend the GeoSentinel Working Group session at the Montreal conference, particularly if you have an interest in your clinic becoming a GeoSentinel site. Targets for new sites and partnerships include, but are not limited to, travel/tropical medicine clinics that fill geographic gaps, missionary organizations, refugee clinics, corporate medical departments, governmental agencies, and military organizations.



## International Society of Travel Medicine (ISTM)

### TRAVELMED, The ISTM Listserv

For those who want to electronically interact in a regular manner within the discipline of travel medicine TRAVELMED, the ISTM Listserv is available. This is a moderated discussion group (Y. Fortin, Montreal Canada moderator), restricted to ISTM members that must be actively joined. Requests from non-ISTM members will be automatically rejected.

To join: Send an e-mail message to [listserv@yorku.ca](mailto:listserv@yorku.ca) with the words "subscribe travelmed (type your name)" in the body, not the subject line, of the message. Once accepted for membership, you will automatically receive further instructions from the server.

The most important thing to understand is that items (called postings) for potential dissemination to the entire group will then need to be sent to the e-mail address [travelmed@yorku.ca](mailto:travelmed@yorku.ca). The [listserv@yorku.ca](mailto:listserv@yorku.ca) address above is only for administrative commands to the computer.

### TRAVELMED Charter

1. General announcements of relevance to the ISTM.
2. Professional dialog, discussion group whereby we can 'safely' discuss some of our more unusual clinical cases without the worry of personal patient details being passed on or being leaked to the public.
3. Discussion of pre-travel medical issues and cases, including use of drugs and biologicals.
4. Research results which members might like to share with colleagues.
5. Announcements of relevant conferences & short courses.
6. Announcements of new publications and new net sites.
7. Individual requests for assistance. (Requests from non-ISTM members will be rigorously screened to allow only requests of universal relevance to be posted.)
8. Dissemination of highly topical information collected from other Web sites, other listservs, or from authoritative non-internet sources and publications.

For information on becoming a member of ISTM, contact the ISTM Secretariat at [bcbistm@aol.com](mailto:bcbistm@aol.com)

Send questions, comments or suggestions to ISTM. © 1996 ISTM. All rights reserved. Revision

## The Journal of Travel Medicine

Dear ISTM member:

I am happy to remind you, in case you had not heard via another communication, that our Journal of Travel Medicine is now indexed on Medline. However, I must also report that submissions to JTM have dropped precipitously over the last few months. It almost seems everyone has relaxed once they heard our journal was indexed. I urge you all to continue to use JTM as the primary vehicle for your travel medicine publications. We had been poised to switch to an every other month publication schedule, but I have had to put that plan on hold until I see submissions pick up. I apologize to those of you whose publications were delayed a little in order to try to get us into good shape for switching; you will note that June's issue will be overly large to try to catch up. We have a back log to guarantee us another journal issue or two. After that our success will depend in large part on your responses to this plea for submissions.

Please encourage your colleagues, who might not be members, both to join ISTM and to consider JTM as a home for their publications. Please do not hesitate to contact me if you have an interest in serving JTM either as an editor or as a reviewer.

Warm regards,

Charles Ericsson, Editor, JTM



**Pasteur  
Merieux  
New Ad**





## NEWS AND VIEWS FROM AROUND THE WORLD

1. Outbreak of Acute Respiratory Illness aboard Cruise ships with ports of call in the Caribbean
2. 34 Million People protected from river blindness in West Africa success story
3. The World on the Brink of eradicating Polio, WHO says
4. The Kosovo Crisis
5. Acute Haemorrhagic Fever Syndrome in the Democratic Republic of Congo
6. Intradermal Rabies Vaccination
7. Peanuts Served on Aircraft
8. Polio in Angola
9. Tuberculosis Transmission



### Outbreak of Acute Respiratory Illness aboard Cruise ships with ports of call in the Caribbean

The following alert is based on communications received from the Quarantine Division of the US Centers for Disease Control and Prevention [CDC] on January 28, 1999.

Since January 22, the Quarantine Division of the US CDC has been notified of significantly increased morbidity due to acute febrile respiratory illness both among the passengers and crew of three cruise ships that have ports of call in the Caribbean. Attack rates, among the passengers and crew aboard one of these ships, were recorded at 7 and 6 percent, respectively, over the 11-day cruise.

These cruise ships belong to three different cruise lines and our information indicates that the itinerary for one of these cruise ships includes ports in St. Thomas, US Virgin Islands; St. Christopher [Kitts]; Trinidad and Tobago; and Aruba.

While the symptom profile is predominantly one of an upper respiratory tract infection, a few cases of febrile pneumonia have been reported. The CDC has indicated that the length of the incubation period together with the symptom profile is suggestive of influenza infection. Diagnostic testing of nasopharyngeal swabs using a rapid antigen detection kit has yielded positive results for influenza A aboard one ship.

Both influenza A and B viruses are currently circulating in the United States and the CDC has recently reported the occurrence of widespread influenza activity in New York city [MMWR: January 22, 1999]. Influenza A (H3N2) viruses have been predominant and these strains have been found to be antigenically similar to A/Sydney/5/97, the H3N2 component of the 1998-1999 influenza vaccine. All of the influenza B viruses are antigenically similar to B/Beijing/184/93, the recommended type B vaccine strain.

The use of antiviral agents such as amantadine and rimantadine may help to prevent and control influenza A but not influenza B, especially among persons in institutional settings such as nursing homes and those at high risk for influenza-related complications. These drugs are 70-90 % effective in preventing influenza A infections and reducing the severity and duration of symptoms when administered within 48 hours of onset of illness. Influenza vaccination, if available, is recommended for high-risk persons.

It should be noted that the potential for introduction and spread of influenza viruses in the Caribbean is real at this time, given that December to April represents the height of the Caribbean tourist season. Added opportunity is also provided, as some islands will attract large numbers of overseas visitors for their upcoming Carnival celebrations.



## 34 Million People protected from river blindness in West Africa success story

Ouagadougou, Burkina Faso. Through its 25 year history the Onchocerciasis\* Control Programme in West Africa (OCP) has protected more than 34 million people from onchocerciasis or “river blindness”. More than 400 000 cases of blindness have been prevented. At least 1.5 million people have been completely cured from infection, and over 11 million children born since 1974, when the Programme was launched, are not at risk of going blind due to river blindness.

Control of the disease has opened up 25 million hectares of fertile land for agricultural production, land which was previously deserted out of fear of the disease. This land can feed 17 million people annually applying traditional cultivation methods.

“These figures prove that OCP is one of the most successful projects in the field of health and development in Africa,” says OCP Director DR K. Yankum Dadzie.

The Programme has also contributed largely to manpower development in the region: 800 staff have acquired technical and managerial competence while serving OCP; around 500 have received high-level academic training and middle-level in-service training financed by the Programme.

The 25th anniversary of OCP was celebrated through ceremonies in Ouagadougou, Burkina Faso, as well as in other participating and donor countries between 8 and 13 February 1999. The high point of the anniversary celebrations were the unveiling of a commemorative river blindness statue by the President of the Republic of Burkina Faso.

Based on a partnership lasting 25 years between eleven West African countries (Benin, Burkina Faso, Côte d’Ivoire, Ghana, Guinea, Guinea Bissau, Mali, Niger, Senegal, Sierra Leone and Togo), 22 donors and institutions, including four United Nations Agencies (World Bank, FAO, WHO and UNDP), as well as the private sector, OCP is now approaching its end and handing over to the participating countries.

Before the creation of OCP in 1974, river blindness was a real blight in West Africa. Before 1974, the prevalence of onchocercal infection was in the order of 60% in the major part of the Programme area. In some villages, up to 10% of the population was blinded by the bite of the simuli. Today, the risk of onchocercal blindness has been eliminated throughout the OCP area.

In the areas treated for a long time, *i.e.* 60% of the total OCP area, where large-scale larviciding has ceased practically throughout, the risk of new cases has been virtually eliminated and the main activity is now limited to strict surveillance. In the remaining 40% of the area in which control operations started more than ten years later, larviciding is combined with the distribution of ivermectin or Mectizan(R), an effective drug against the disease provided free of cost by Merck & Co. Active research is underway to identify a drug which could kill the adult worm.

In most of the eleven Participating Countries there are now teams down to the district level capable of undertaking river blindness control.

“The best approach to consolidate the achievements of OCP is to make them known,” says Dr Dadzie. “The future challenge of the programme is to sustain the progress by integrating river blindness surveillance in a comprehensive surveillance system, including the main endemic diseases in the region, which could build upon the methods of work, the structures and the systems established by OCP.”

One of the objectives of the celebration of the anniversary is to mobilize the different partners, the concerned populations and the donors and increase their awareness of the need to retain the achievements of OCP so that river blindness shall never reemerge as a public health problem.

\* Onchocerciasis or river blindness is transmitted by the bite of the *simuli*. The disease is caused by the release of minute worms (microfilariae) in the skin of the victim by the adult, mature worms (macrofilariae). These minute worms give rise to unbearable itching, depigmentation of the skin and eventually blindness. Microfilariae can be treated by ivermectin a treatment to be continued during about 15 years until the death of the macrofilariae.

PRESS RELEASE WHO/8 - 5 FEBRUARY 1999

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## The World on the Brink of eradicating Polio, WHO says

DAVOS, Switzerland- With a last, forceful vaccination campaign, the world can eradicate poliomyelitis within two years, World Health Organization Director-General DR Gro Harlem Brundtland said here Saturday.

“Thanks to steady progress in vaccination, we are on the brink of eradicating this crippling disease – with an ambitious target of eradication by the end of next year,” she said in a speech to the World Economic Forum.

To achieve this goal, an estimated 370 million dollars is needed in addition to funds already secured in order to carry out the last essential vaccination campaigns. A world free of polio would save \$1.5 billion annually in vaccination costs.

“Think about it. A one-time investment of 370 million dollars will give savings of 1.5 billion dollars every year for as long as you can imagine. I can think of few investments with a better return than this one,” Dr Brundtland told world and business leaders.

Progress in polio eradication over the past 10 years has been remarkable. In 1988, virus circulated widely on all continents except Australia. By 1998, the Americas were polio-free, transmission has been interrupted in the Western Pacific Region





of WHO, including China, and in the European Region, except for a small focus in south-east Turkey. Only three major foci of transmission remain: South Asia (Afghanistan, Pakistan, India), West Africa (mainly Nigeria) and Central Africa (mainly Democratic Republic of Congo).

Polio is an infectious disease caused by a virus. It can strike at any age, but affects mainly children under three (over 50% of all cases). The disease causes paralysis, which is almost always irreversible. In the most severe cases, polio paralysis can lead to death by asphyxiation. The virus enters through the mouth and then multiplies inside the throat and intestines. The incubation period is 4-35 days and the initial symptoms include fever, fatigue, headaches, vomiting, constipation (or less commonly diarrhoea), stiffness in the neck, and pain in the limbs.

The global eradication strategy is four-pronged, involving:

- high routine immunization coverage with Oral Polio Vaccine supplementary immunization in the form of national immunization days;
- effective surveillance for Acute Flaccid Paralysis and wild poliovirus;
- door-to-door immunization ("mopping up" campaigns).

Among the most generous donors for polio vaccination are the Rotarians who have given or pledged nearly \$500 million for vaccination campaigns up to the end of this year.

The remaining campaigns will focus on 14 countries and areas that up to now have been hard to reach due to armed conflict or lack of central government infrastructure, such as the Democratic republic of the Congo and Liberia. Already, truces have been called for polio vaccination campaigns in Afghanistan, El Salvador, Peru, Philippines, Sri Lanka, Sudan and Tajikistan.

PRESS RELEASE WHO/5 - 30 JANUARY 1999

## The Kosovo Crisis

Some extracts, up until early May 1999, from the World Health Organisation's WebSite on health problems in the Balkans. The site is being regularly updated and may be of interest to NewsShare readers. Its address is <http://www.dk/cpa/Kosovo/welcome.htm>

### Vaccination programmes in Albania

About 68% vaccination coverage for measles, about 53% for polio. In a joint effort, WHO, UNICEF, the national health facilities and other agencies conducted a six-day immunization campaign in Kukës district (northern Albania). The total number of children immunized against measles was about 24,669 while the total against polio was about 11,122. The target group was all children (Kosovar and Albanian) between the ages of 6 months and 12 years. The vaccination campaign is now continuing in Has district (close to Kukës) that also has many refugees. (3 May 1999)

Communicable diseases among refugees in Macedonia.

Suspected cases of measles were not confirmed by WHO field laboratory investigation. However, enhanced surveillance for measles is highly recommended. There is an increased prevalence of diarrhoeal diseases due to inadequate sanitary conditions. (3 May 1999)

### Counselling among refugees

A team of WHO mental health experts will arrive in Albania at the beginning of May to initiate counselling activities in the refugee camps. They will train volunteers from among the refugees themselves, health workers and NGOs. WHO kits containing essential drugs to cover the needs of 2000 mental health patients for six months will be sent to Albania shortly. The Ministry of Health of Serbia reports more than 4,000 wounded civilians, 18 damaged district hospitals and 15 primary health centres since the start of the crisis (not confirmed by independent sources). WHO is sending new emergency health kits to Belgrade to meet the needs of a population of 100,000 people for three months, and TB kits for the treatment of 250 patients.

### Diarrhoea outbreaks

Frequent outbreaks of diarrhoeal diseases, including cholera, have occurred in the past in Albania and the surrounding areas. In order to be prepared for possible outbreaks among refugees, WHO will pre-position stocks of necessary drugs and supplies. In the immediate future, epidemic response kits will be sent to Albania and the Former Yugoslav Republic of Macedonia to treat 1500 and 1000 cases of severe diarrhoea respectively. (29 April 1999)

### Tuberculosis

WHO – in collaboration with the national tuberculosis programme of the Former Yugoslav Republic of Macedonia and international organizations – is in the process of developing guidelines for the management of tuberculosis patients among the refugees in the camps whose treatment has been interrupted. The national health authorities of the Federal Republic of Yugoslavia report the following current shortages: anaesthetics, antibiotics, anti-cancer drugs, tranquilizers, anti-tuberculosis drugs, HIV tests, microbiological tests and surgical sutures. (28 April 1999)

### Non-communicable diseases

Diabetes, asthma, hypertension and skin complaints, account for approximately 60% of refugee outpatient consultations



in the Former Yugoslav Republic of Macedonia. Drugs for chronic diseases are greatly needed. (28 April 1999)

Surveillance systems in place for emergency health problems

In collaboration with the national health authorities, WHO has launched a computerized emergency health surveillance system for the refugee population both in Albania and the Former Yugoslav Republic of Macedonia. The system includes reporting forms, case definitions and background documentation outlining the purpose of the surveillance system, rationale for diseases selected and reporting mechanisms.

The WHO global emergency health information system (HINAP) is now also covering the Kosovo crisis and includes a variety of health-related information on Albania and the Former Yugoslav Republic of Macedonia. Information links have been established with relief agencies and health surveillance systems for refugees. HINAP can be accessed from this Web site. (26 April 1999)

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## Acute Haemorrhagic Fever Syndrome in the Democratic Republic of Congo

An outbreak of suspected viral haemorrhagic fever has been reported in Durba, Watsa Zone, in the north-eastern Democratic Republic of Congo (DRC). Clinical features include fever, headache, lassitude, gastrointestinal bleeding, coughing up blood and agitation. The first cases are believed to have occurred in January 1999. Between January and 28 April, 50 cases, with 46 deaths have been recorded (CFR=92%). The earliest cases appear to have occurred in gold miners, but now cases are occurring among those living in the community. The WHO Office in DRC and the WHO Regional Office for Africa in Harare, Zimbabwe and MSF (Belgium and Holland) are preparing a team to investigate. The security situation in the area is poor and access to the affected area may be extremely difficult.

WHO APRIL 1999

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## Intradermal Rabies Vaccination

**Synopsis:** Children who received intradermal vaccination had lower rabies neutralising antibody levels than children intramuscularly immunized.

Concerned about the high cost of intramuscular rabies vaccine in developing countries, researchers in Thailand compared intradermal (lower volume and, hence, lower cost) and intramuscular use of purified Vero cell rabies vaccine as pre-exposure prophylaxis in children. Three doses of vaccine were given during a 28 day period to each of 190 children and a booster dose was given a year later. Follow up data were available from 82% of children one year after the primary series and from 62% of children two years following the booster dose. Children who received intradermal vaccination had lower rabies neutralizing antibody levels than children intramuscularly immunized. Nonetheless, "adequate" protective titres were achieved in nearly all (94-100 % at the different times tested) children whether they received intradermal or intramuscular vaccine. Side effects were generally minor and were similar in each treatment group.

Comment by Philip R Fischer, MD

Rabies is still a uniformly fatal illness, and there are more than 50 000 human deaths due to rabies each year. Most fatalities occur in children in Asia, South America and Africa, and exposure to rabid dogs is responsible for more than 99% of human rabies deaths worldwide. Human rabies is almost always associated with an actual bite wound, though other more subtle exposures have been reported. Control of animal rabies depends on vaccination of domestic dogs and elimination of stray dogs. Sadly, however, such control programmes require heavy, ongoing expenditures.

Effective rabies vaccines are available. Pre-exposure vaccination provides significant protection and simplifies the post-exposure therapy by obviating the need for rabies immune globulin following exposure to rabies and by decreasing the number of needed post-exposure vaccine doses to two.

There are still, however, several controversial issues in regard to rabies vaccination. Who should be vaccinated? Which vaccine should be used? By which route should vaccine be administered? Cost is a significant factor in determining responses to these questions, and this study from Thailand is, therefore, helpful in identifying a lower cost means of effectively administering rabies vaccines to masses of children at risk of rabies in areas of limited financial resources.

The decision about whether to vaccinate a traveller depends on several individualized factors: age (more risk in children), planned activity (more risk in veterinary workers and spelunkers), destination (most risk in Latin America and Asia, only a few countries risk free), duration of travel, access during travel to emergent administration of rabies immune globulin and financial resources (as well as local cost of the pre-exposure vaccines varies markedly from place to place). Whether immunized before the exposure, additional treatment is necessary following actual or presumed rabies exposure.



Until recently, there were two rabies vaccines available in the United States, Imovax is a human diploid cell rabies vaccine manufactured by Pasteur Merieux Connaught and has forms approved for intradermal and intramuscular use. Rabies Vaccine Adsorbed, produce by SmithKline Beecham, is available for intramuscular use. The FDA recently approved for marketing a new inactivated rabies vaccine (RabAvert, Chiron Corp) this is grown in primary cultures of chicken fibroblasts. It is the first new vaccine against rabies to be introduced in almost 10 years and has been approved for both pre-exposure prophylaxis and post-exposure vaccination. A purified Vero cell rabies vaccine from Pasteur Merieux Connaught was used in the Thai study but is not currently available in the United States.

REPRODUCED WITH ACKNOWLEDGMENT TO PROMED. (PROMED@USA.HEALTHNET.ORG)

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## Peanuts Served on Aircraft

With reference to Pat Dahlman's letter "Peanuts Served on Aircraft" (4<sup>th</sup> quarter 1998, Travel Medicine NewsShare, page 8), this topic has been the subject of serious debate amongst airline doctors for some years. Efforts by some carriers to totally ban peanuts from their flights have not been successful. Peanut snacks are ubiquitous and even when airlines stop providing them, there is no effective way of preventing passengers from bringing peanuts, peanut products, and foods cooked in peanut oil onto commercial flights. Even the efforts by some airlines to provide peanut free meals have resulted in failure and already one death has been reported when an international carrier gave a passenger the wrong meal, having promised it was peanut free.

Because of the serious nature of this problem, the only effective way of dealing with it is for the affected passenger to provide their own food on the flight and to carry suitable medications for use in the event of an adverse allergic reaction. The bottom line is that, sadly, there is no 100% effective way of ensuring that flights are peanut free and rather than induce a false sense of security in those who are unfortunate enough to suffer from this allergy, it is better to be up front about this and let those with the allergy make their own decisions on the wisdom of travel on commercial flights.

Airlines are always looking for ways to improve service to their customers and it would be interesting to hear from any ISTM members who may have new ideas on the subject.

Dr J C Merritt, Principal Medical Officer, Cathay Pacific Airways Ltd

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## Polio in Angola

On 23 March 1999, the paediatric hospital in Luanda reported that a total of 21 cases of acute flaccid paralysis with 3 deaths had been registered. An investigation by the Ministry of Health demonstrated that by 3 April, 102 cases of AFP had been recorded in Luanda and neighbouring areas of Bengo province. Cases were primarily in children aged <5 years and 90% of cases had received 2 doses or less of oral polio vaccine. Only 6% had received 4 doses.

On 8 April, the National Institute of Virology in South Africa reported that wild poliovirus type 3 had been isolated from 11 of 22 stool specimens taken from AFP cases in Angola. By 25 April, the number of polio cases was reported to be 661 with 41 deaths. Field investigation confirmed 6 cases of AF in children aged <5 years in Benguela, a city 500 km south of Luanda. In response OPV was administered to 634, 368 children in Luanda on 17<sup>th</sup> and 18<sup>th</sup> April. A national immunisation campaign is being planned to start in June.

WHO APRIL 1999

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## Tuberculosis Transmission

Your item on the new WHO Guidelines to address the risk of tuberculosis transmission during air travel was somewhat misleading. The guidelines make clear that no cases of active TB are known to have been acquired on aircraft. There have thus been no 'TB outbreaks' on airlines as suggested in paragraph 6. The guidelines are based on tuberculin skin test results of people who travelled on the same plane as a person who was subsequently identified as having infectious TB. These do indeed suggest that transmission of infection can occur in certain situations - hence the guidelines.

Jane Leese FRCP, Senior Medical Officer, HP3A Team, Department of Health, London

**ROCHE**

**AD**



## CONFERENCES AND COURSES

### CANADA

6<sup>TH</sup> Conference of the International Society of  
Travel Medicine

Montréal, Québec

6-10 June 1999

Information is available from: Dr Dominique  
Tessier, Centre de Médecine de Voyage du  
Québec, 1001 Saint-Denis, Montréal, Québec,  
Canada H2X 3H9.

Fax: 514 281 2189 or E-mail:  
tesd@generation.net

### AFRICA

Medical Practice with Limited Resources

7-25 June 1999

Course Secretariat: PO Box, CH-4002 Basel,  
Switzerland.

Telephone: +41 61 284 8280 or  
Fax: +41 61 284 8106. E-mail:  
sticourses@ubaclu.unibas.ch - [http://  
www.wb.unibas.ch.STI](http://www.wb.unibas.ch.STI)

### SCOTLAND

Parasitic Helminths from  
Genomes to Vaccines II

Edinburgh

8-11 July 1999

For further information contact: Dr Mark  
Baxter, Institute of Cell, Animal and Population  
Biology, Ashworth Laboratories, Room 311,  
King's Buildings, University of Edinburgh, West  
Mains Road, Edinburgh EH9 3JT.

Telephone: (+44) 131 650 6760 or  
Fax: (+44) 131 650 5450

### CANADA

The World Congress on Wilderness Medicine

Whistler, BC

7-12 August 1999

For further information contact: Wilderness  
Medical Society, 3595 East Fountain Blvd, Suite  
A-1, Colorado Springs, CO80910

Fax: 1 800 967 7494

### HONG KONG

The Asia Pacific Society of Infection Control  
(ASPIC)

9-11 August 1999

Pre-Congress Workshop will be held in Macau  
on 9 August

For further information contact:  
MV Destination Management Ltd.

Telephone: (852) 2735 8118 or  
Fax: (852) 2735 8282.

E-mail: [moreview@mvdmc.com](mailto:moreview@mvdmc.com)

### CUBA

Dengue Fever, a menace at the door of the year  
2000

Havana

23 August - 3 September 1999

Please contact: Professor Maria G Guzman,  
Instituto "Pedro Kouro", Autopista Novia del  
Mediodia, Km 6, PO Box Mnao 13, Ciudad  
Habana, Cuba

Telephone: 53 7 220450 or

Fax: 53 7 220633.

E-mail: [lupe@ipk.sld.cu](mailto:lupe@ipk.sld.cu)

### UNITED KINGDOM

Vaccines and Immunisation in the next  
millennium

Manchester

7-10 September 1999

For further information please contact: James  
Arthur. Telephone: +44 (0) 1625 624060 or Fax:  
+44 (0) 1625 430544.

E-mail: [james.arthur@cmc.co.uk](mailto:james.arthur@cmc.co.uk) or Web  
address: <http://www.immunise.man.ac.uk>

### USA

Review Course in Clinical Tropical Medicine and  
Hygiene (ASTMH)

American Society of Tropical Medicine and  
Hygiene

San Francisco, California

23-24 September 1999

For further information contact: ASTMH

Telephone: (847) 480 9592 or Fax  
(847) 480 9282. E-mail: [astmh.@astmh.org](mailto:astmh.@astmh.org)  
or <http://www.astmh.org>



### SWITZERLAND

Accidents due to Venomous and Poisonous Animals

Swiss Tropical Institute, Basel

27-30 September 1999

Course Secretariat: PO Box, CH-4002 Basel, Switzerland.

Telephone: +41 61 284 8280 or Fax: +41 61 284 8106. E-mail: [sticourses@ubaclu.unibas.ch](mailto:sticourses@ubaclu.unibas.ch) - <http://www.wb.unibas.ch.STI>

### GERMANY

Hallenser Travel Medicine Forum

Halle (Saale)

18 September 1999

For more information contact: Dr H J Deuber, Martin Luther University Halle, Wittenberg, Clinics for Internal Medicine, Department of Nephrology, Ernst Grube Strasse 40, 0-06120 Halle (Saale), Germany.

Telephone: +49 345 557 2717 or Fax: +49 345 557 2236.

E-mail: [brigitte.kassner@medizin.uni-halle.de](mailto:brigitte.kassner@medizin.uni-halle.de)

### UGANDA

5<sup>th</sup> Tropical Medicine Expedition

In collaboration with the University of Makerere, Uganda

7-19 November 1999

Secretariat: Kay Schaefer, Travel Medicine Center, Teutoburgerstr 14, 50678 Cologne, Germany.

Telephone/Fax: +49 221 3404905 or E-mail: [106021.2721@compuserve.com](mailto:106021.2721@compuserve.com)

### USA

Travel Related Vaccine, Preventable Illnesses  
American Society of Tropical Medicine and Hygiene

Hilton Washington and Towers; Washington DC

27-28 November, 1999

For further information contact: ASTMH

Telephone: (847) 480 9592 or Fax (847) 480 9282. E-mail: [astmh@astmh.org](mailto:astmh@astmh.org) or <http://www.astmh.org>

### BRAZIL

Fourth Annual Amazon International Health Update

The University of Alabama, Birmingham

22-29 January, 2000

For further information contact: International Expeditions Inc, One Enviorns Park, Helena, AL 35080 800 633 4734 or Fax: (205) 428 1714.

E-mail: [nature@ietravel.com](mailto:nature@ietravel.com) or <http://www.ietravel.com>

### PERU

Learn Tropical Medicine in the Tropics

The Gorgas Course in Clinical Tropical Medicine

Annual 9 week Diploma Course next available  
31 January - 31 March, 2000

For a full information package contact: David O Freedman, MD, The Gorgas Memorial Institute, University of Alabama at Birmingham, Birmingham, Alabama 35294 2170, USA.

Telephone: 800-UAB-MIST (US) or 205 934 2687 (from overseas) or Fax: 205 933 5671.

E-mail: [gorgas@geomed.dom.uab.edu](mailto:gorgas@geomed.dom.uab.edu) or [www: http://medinfo.dom.uab.edu/Gorgas/Course.html](http://medinfo.dom.uab.edu/Gorgas/Course.html)

### ARGENTINA

9<sup>th</sup> International Congress on Infectious Diseases

10-13 April 2000

For further information please contact: International Society for Infectious Diseases, 181 Longwood Avenue, Boston, MA 02115, USA.

Telephone: (617) 277 0551 or Fax: (617) 731 1541. E-mail: [isidbos@aol.com](mailto:isidbos@aol.com)

### ITALY

Infettivologia 2000

Infectious Diseases Past and Present

Casale Monferrato

15-19 May 2000

Organising Secretariat: Planet srl, Via Borgone 57-10139 Torino, Italy

Telephone: +39 11 3825357 or Fax: +39 11 3825682. E-mail: [planet@cse.it](mailto:planet@cse.it)





**HAVRIX**

**AD**

