



Travel Medicine: Down, But Far From Out How September 11th Affected Travel Medicine

We asked ISTM members around the world how the terrorism attacks affected them. Here are representative answers:

...We are travel medicine specialists – not interventional cardiologists. How can our daily lives not change? Our travel clinic sits practically at a standstill. The robustness of a travel clinic practice is a major reflection of the economy and the joie de vivre (or lack thereof) of the population it serves. While we hope and expect that with time things will settle down and that travel will again be more commonplace, we may not be able to count on the logarithmic growth that we have seen in the last decades.

...Travel will return and, likely, faster than we anticipate. “Travel” reflects important instincts in the human psyche: curiosity, self-betterment, recreation, and pleasure, to name a few. The downturn in travel that we are witnessing is a reflex reaction to an incalculable calamity: fear that such events may recur, disillusionment with the world that people perform such deeds, and guilt about going about our business and pleasures at a time when many are grieving. ...As travel health professionals we should help counteract the psychological trauma, as we do for fear of flying, for example. We need to reassure the public that hysteria is not the solution to a disaster, that travel is reasonably safe, and that travel is important for our own well being and for the psychological and economic well being of the world.

...Globalization of the world’s economy, the result of advances in electronic communication and technology, depends on travel. Before too long we will see a return in business travel, and then in leisure travel.

...It may be time for us to re-focus our skills and talents and broaden our view of travel medicine to include others who have not shared center stage with vacationers and business travelers. I am referring to the migrants and refugees whose numbers are only likely to increase during these times - a cause which has been championed by a small but vocal constituency of the ISTM, including some of its more prominent members. Our expertise can also be utilized by those who are involved in military deployment - our advice on health issues related to military travel can be quite valuable.

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Statistics for Beginners (part II)

By Ed Ryan MD DTM&H

(Part I appeared in the September/October issue of NewsShare)

This article will not review in detail which statistical test should be chosen for data analysis; however, it will make some broad statements on data type and how to approach data analysis. Data can be either categorical or continuous. An example of continuous data is blood pressure where a range of values can be observed. Categorical data is data that are not continuous in nature. Categorical data can be further subdivided into nominal data and ordinal data. Nominal data is data for which there is a name and which can not be ordered from high to low or large to small. Eye color or race would be an example of nominal data. Ordinal data are data that can be placed in an order and that is not continuous in nature. Level of dehydration (none, mild, moderate, severe) would be an example of such data. At analysis, continuous data can be broken down into categorical categories (but not vice versa). For instance, if one knows the serum bicarbonate level for all patients in a study, during analysis, the values can be compared continuously (serum bicarb in group A:

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Come to New York for CISTM8



It is a twist of destiny that CISTM8 will be held in New York (May 7-11, 2003). We are pleased to report that the planning for the meeting is on track, on target, and on schedule. The events of September 11th have energized our commitment to make CISTM8 a truly memorable conference scientifically, culturally and socially.

New York is the city that never sleeps and is now more alive, awake, and vibrant than ever. The spirit of the people is catching and electrifying. Visiting New York is now a “must,” not only for all the traditional attractions, but because visitors, by their presence, make a symbolic statement for freedom and justice.

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...The ISTM is strong. Travel medicine is strong. Our skills and expertise will continue to be needed. Let us use the strength of our numbers to get the message to our membership that the ISTM will be there standing behind every member during these difficult times.

...A member from California is looking for a locum tenens to cover his practice while he is called up to serve in the military.

...I share the optimism that the current turn down in travel is temporary. We should be prudent, but we should not overreact. The terrorists would prefer that we overreact.

...Last week-end, I visited an Art Gallery here in Montreal. When I asked about an expensive piece, the owner commented: “This year, many families are going to spend large amount of money on art instead of travel. It’s much safer, isn’t it?”

...In the past few days there have been many calls regarding getting smallpox and anthrax vaccine... Over the past few years we had calls from military reservists trying to AVOID the anthrax vaccine.

...Our corporation (in New York) lost 5 employees and a building. Our business travel has been greatly curtailed although a few trips are still on. For now, there seems to be more reliance on teleconferencing and email. A large group of expatriates that was going to have orientation and pre-travel care in New York is going directly to the foreign assignment country, so I have spent a large amount of time evaluating people by email and telephone. I have counseled them about which immunizations they need, facilitated referrals on short notice to travel health care providers in their areas, and tried to make them aware of health risks and health resources abroad... Now we see in the clinic people who witnessed the disaster and are suffering from somatic problems. For some, there is the fear of flying again, of helping their families to be comfortable with the resumption of business travel. Our staff has tried to help by listening, sharing practical information for dealing with post-trauma stress, and referring employees to group support sessions which we have set up.

...We should not rush to decisions now regarding CISTM8, our Conference in New York in 2003. There is a good chance that conditions will be much improved by then.

...It is difficult to predict what the world will be like in the year 2003, let alone in New York, but I have no doubt tourism will rebound. It already has. The American Society of Travel Agents (ASTA) scheduled to hold their 70th World Congress in Seville, Spain next month announced they are pulling out of Seville and moving their conference to New York the first week in November.

...ISTM is already looking into methods of insuring CISTM8 in case the meeting has to be cancelled... The finances of our Society are heavily dependent on our conference. We must also use this as a wake-up call to look at other ways to diversify our income sources... perhaps obtaining Foundation grants to fund research and training in some of the humanitarian specialties of travel medicine such as migration and refugee medicine.

...We should take out insurance to protect our 2003 New York meeting against cancellation due to terrorism. However, such policies are now more expensive and have “exclusions” which are conditions under which a claim is not recognized. War is chief among these. Cancellation insurance, which previously cost about \$8-10K for our event budget size has doubled since the attacks. In addition, there are now “terrorism exclusions” which relates to any actual act or fear of such an act or any retaliatory action by any person, state or country... However, insurance is still the prudent purchase as it will protect ISTM from other unforeseen event that might hinder attendance and threaten revenues - strikes, weather, loss of facilities, for example.

...Coming soon after the royal massacre here in Nepal, the bombings in New York and Washington left everyone numb for the second time. In the wake of this, hotel and trip cancellations have approached 50%. The tourism sector is laying off people or cutting their salaries. Tourism is the number one foreign exchange earner for our country.

...My practice is predominately infectious diseases in an academic setting. Travel medicine is a sort of avocation, albeit a very important one. We can adjust easily to a smaller case load of travelers without laying off anyone.

... The downturn in travel will be relatively temporary. A lot will depend on evolving circumstances and the perception by travelers of whatever action the U.S. government takes. Aggressive military action might actually increase the fear of traveling.

...Everyone here in London is very pessimistic about the immediate future of the travel industry; and whether this is the end of carefree international travel as we know it... We get several enquiries a day about anthrax vaccine and antibiotic prophylaxis.

...Leisure travel is down in the U.K. but many of the journalists I look after are on the move, and I hope and pray that they will be safe. I cannot bring myself to be remotely concerned about the business side of things just yet, given the horrendous loss of life and suffering in New York, and whatever may be yet to come. It makes some of the health risks we worry about seem pathetically insignificant.

...How wonderful that the next meeting of the ISTM will be in New York.

...There certainly has been a decline in the number of both business and pleasure travelers seen in my clinic (Canada), perhaps by about 30%. Many of the pleasure travelers I see labor over the idea of whether or not to go. Many do not have cancellation insurance. “Ethnic” travelers have decreased particularly. I see many Muslims who travel to East Africa and Pakistan.

...I can recall other times when travel seemed unsafe - Y2K, the Gulf War – it creates a pent up demand, as most of those people will eventually travel and spend their money when things blow over. One only hopes that they blow over this time.

...Some companies here in South Africa have suspended their corporate travel, though there are others who absolutely

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need to be “on site” as part of their work. Many companies have set dates – the end of October, for example, to resume travel.

...Here in Sweden, both corporate executives and backpackers who come to our travel clinic are asking a question that we almost never heard before, “Am I doing the right thing in traveling abroad?”

...There has been a significant decrease in travel to Israel, which already had decreased during the previous year because of the Intifada. Now Israelis are traveling abroad less. Several airlines have changed their flight schedule to avoid their aircrews staying overnight in Israel. This increases the atmosphere of tension and uncertainty. The terrorist attack has had a profound effect, as the perpetrators surmised it would.

... Our organization sponsors more than 6,000 international travels per year. Our employees are from 50 different countries, and although everyone condemned the attack, there are large cultural differences in the way they have reacted. We live in a country (Pacific Rim) where terrorism is almost routine. Some of our staff have witnessed terrorism in this country or while on mission. In the month since 9/11 we haven't noted any difference in the pre or post travel pathologies, and the number of psychologically effected staff has remained very marginal. We have cancelled travel to countries surrounding Afghanistan, but other destinations travels have remained unchanged. The slightly higher level of air travel stress after Sept 11 returned to normal in less than 3 weeks. Everyone is aware of the higher risk that may effect international travel over the next few months, but almost everyone is also confident that tightened security measures will control the risk.

Summary of other replies, from Austria, Canada, France, Germany, Nepal, Spain, Sweden, and the US: ... about a 30% drop in visits in the weeks after September 11th, and a further drop after the bombings of Afghanistan... Some travelers are returning home sooner than planned... Decrease in travel greater among the wealthy than among backpackers...



Announcements

From Robert Steffen, past President of ISTM:

The 4th Asia Pacific Travel Health Conference will take place October 21-23, 2002 in Shanghai, China. The Conference will be preceded (on October 20th) by a one-day basic travel medicine course, featuring many of the internationally best known «gurus» who will present a state-of-the art account of the ABCs in the practice of our field.

The Scientific Chairs, Eli Schwartz (Israel) and Santanu Chatterjee (India/ISTM Councillor), together with the Asia Pacific Travel Health Association Executives, Hanny Moniaga (Secretary/Indonesia and Nor Shahidah Khairullah (President-Elect/Malaysia), and a large and most competent group of the Chinese Organizing Committee developed the program at a special meeting in mid-August.

Let me just comment that this was one of the most constructive meetings I have ever attended. Those who will come to this conference next fall can expect a veritable «East meets West,» including news on available and future vaccines and malaria medication developed in Asia, so far unknown even to travel medicine veterans. Descriptions of the epidemiological situation in the Asia Pacific region will provide many with the «need to know» for daily practice.

At least as important, however, is what I have been able to experience as the «Spirit of Shanghai» in an atmosphere of superb hospitality. I do not just refer to truly authentic Chinese kitchen, but the possibility to discuss matters of common interest with many colleagues from other parts of one world. And all visitors will have an option to visit what I believe to be not only the largest Travel Clinic in the world, but probably the most beautiful one - or do any of you have a facility with its own large lily pond?

From David Freedman, Chair, ISTM Electronic Communications Committee:

We are very pleased to announce that through a collaboration with a prominent ISTM member in Japan at the National Institutes of Health, TravelMed postings are now being distributed in Japanese. Those Japanese members interested in joining this network should contact Dr. Mikio Kimura directly. Dr. Kimura is also on the Program Committee for the Asia Pacific Travel Health Conference in Shanghai in 2002, which is being jointly sponsored by ISTM. We look forward to increased relations with our travel medicine colleagues in Japan.

From Dr. Kimura:

Japanese TravelMed was recently launched by Dr. Yuka Ujita and myself. (You may remember Dr. Ujita from the Innsbruck Conference which she attended with her 7-month old baby! She is also the regional editor of the ISTM NewsShare.

The postings are distributed on a Listserv named JOHAC FORUM. The Listserv includes 136 members, mainly physicians and nurses, with most of them involved in health issues of travelers and long-term expatriates. Presently, not all of the postings are summarized due to the lack of manpower. However, I am optimistic that we can recruit more members to do the work.

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Summary of the Minutes of Executive Committee Meeting

May 31 – June 2, 2001, Lake Achensee, Austria

The ISTM Executive Board met in Austria in early June, immediately after the conclusion of our highly successful CISTM7 in Innsbruck. Many issues were discussed, most of them dealing with the continuing smooth functioning of our Society.

As the result of the initiative and dynamism of many of our members, our Society has grown rapidly and we have become active in many new areas. But this success necessitates that we pay more attention to strengthening our present structure and ensure that we meet the legal and financial requirements of a non-profit organization. This task was begun by our previous president, Charles Ericsson, and we are continuing it.

Much discussion went into the strategy we should establish for the selection of conference sites and conference management and organisation. An ad hoc committee has been nominated to formulate a model of organisation and planning future Conferences. Although the ISTM had seriously considered Israel for the CISTM-9 in 2005, in view of the current political unrest and security situation in that country, the board decided against holding the meeting there. The ad hoc committee will develop guidelines for the selection of venues for future conferences, starting with the conference in 2005.

The Board decided that the society's financial management needs more openness. A statement of the Society's income and expenses will be provided for the membership annually via Newsletter and the annual mailing. This is already done by the Society's treasurer at the business meeting of each conference. Since many non-American members may not know that the business meeting is the Society's assembly, the business meeting will now be known as the "membership assembly." This assembly will be a time dedicated for open communications between the executive board and the membership about the ongoing activities of ISTM, and



for the executive board to respond to questions and suggestions.

In order to broaden the scope of the ISTM, it was decided to add the word "migrants" to the ISTM mission statement: *...the promotion and protection of the health of travelers and migrants* The committee on migrant health suggested that the name of the Society could be changed to include migration medicine. This matter should be discussed further with the membership through the NewsShare.

The electronic communication committee - in close collaboration with Shoreland - will work on the membership directory on the webpage, to allow members to make their own information changes.

GeoSentinel, remains a very productive initiative of the ISTM and works in close collaboration with the CDC. Regular data collection from the various sites located around the world gives opportunities not only for surveillance but also for potential research by members of the network. It also allows for early detection of disease outbreaks, such as the recent epidemic of leptospirosis observed among the participants of the Ecochallenge in Borneo. TropNet Europe is also very active in the surveillance of a selected number of diseases, and alerts its members of increased disease activity in specific destination such as falciparum malaria in the Dominican Republic. Establishing closer collaboration between the two networks through a GeoSentinel board of governors

and guidelines on ownership of data will be developed.

Increasing the membership is a constant concern of the ISTM. But many technical problems hinder a successful solution. Many members of national societies can't afford to pay another membership fee to the ISTM. In many parts of the world, some travel medicine practitioners do have a good command of English. The membership committee is presently studying various proposals: discounts for multiple year membership, corporate membership, buddy membership, reduced rates for members from developing countries, and working with our sponsors for supporting membership. Negotiation with national societies of travel medicine need to continue with innovative solutions. It is a difficult area with unexpected legal and financial implications. A great deal of discussion lies ahead.

The host countries committee has come up with several suggestions to promote travel medicine in host countries. Copies of the JTM issues will be sent to universities to let them know what ISTM has to offer. Projects need to be prioritised and more focussed on one location or on one sector in order to make the most of the resources available. Some funds were made available to invite and financially help participants to come to the Innsbruck conference. This program proved very effective and should continue for the next conference.

It was decided that the editorship of the Journal of Travel Medicine (JTM) will be transferred from Dr. Ericsson to Dr. Steffen, moving the editorship from North America to Europe. Under the leadership of Dr Ericsson the JTM has become a listed journal in the Index Medicus and has gained visibility and recognition.

A new and larger clinic directory will be developed in a written version.

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“Summary of the Minutes,”
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The travel industry and public education committee has been working on promoting public awareness of health issues related to travel. Further discussion will take place on several organisational and financial issues related to the Coalition for Healthy Travel.

The professional education committee has been working hard at producing a body of knowledge that will be posted on the website of the ISTM. This document gives an overview of the various fields of travel medicine and will serve as the basis of content for the exam for a certificate to be issued under the auspices of the ISTM. The ISTM will not conduct courses in order to prepare for the examination.

The industry liaison committee chair will continue to ensure that the society presents a unified message to industry. Maintaining close and productive collaboration with our partners is of key importance for the society.

The ISTM is providing support to the Asia Pacific Travel Health Society in the organisation of their October 2002 Shanghai conference. The support is both financial (in the form of a loan) and in providing help in the planning of the program of the conference. The board expressed its willingness to attend the meeting with active participation in the scientific program of the conference.

This is only a summary of the numerous activities underway in the ISTM. With limited resources, a lot has been accomplished, but a lot remains to be done. Most of the activities that we have undertaken requires the active participation of volunteers dedicated to enhancing the ISTM image. The society is very grateful to all members for the great work accomplished.

Other members willing to participate are more than welcomed.

“The society is very grateful to all members for the great work accomplished.”

“Statistics for Beginners (part II),” continued from page 1

13.2 mmol/L and in group B: 22.0 mmol/L) or one can subdivide the continuous data analysis into categorical values (for instance, proportion of individuals with a bicarbonate values less than 15 mmol/L).

In choosing a statistical test, one should understand whether the data to be analyzed are parametric (symmetric) or non-parametric in distribution. Parametric data are also referred to as normally distributed data. A classic example of normally distributed data is a bell shaped curve; for instance, a population based I.Q. evaluation. One can also imagine that data will not be bell shaped in distribution. A thumb nail rule for establishing whether data should be interpreted as parametric or a non-parametric is to compare the standard deviation of the data to the mean of the data. If the standard deviation is greater than 50% of the mean, one should analyze the data as non-parametric data. Categorical data can be analyzed by the chi² test (or $m \times 2$ tables if more than two groups are being analyzed). Continuous data that are normally distributed can be analyzed by parametric tests, including the T test for comparing means and Pearson's correlation. Non-parametric methods include the Mann-Whitney U Test, the Kruskal-Wallis and the Wilcoxon matched rank test, among others. The ANOVA test (analysis of variance) can be used to judge more than two groups that are normally distributed. The Mann-Whitney U test is used for evaluating two groups that are non-normally distributed and the Kruskal-Wallis test can be used for evaluating more than two groups that are not normally distributed.

The three most common errors of statistical significance testing are:

1. A failure to state the hypothesis before conducting the study.
2. A failure to interpret the results of statistical significance correctly by not considering type I error.
3. A failure to interpret the results of statistical significance correctly by not considering type II error.

Type I error (also known as the alpha level) is the fact that the null hypothesis may be **rejected when it is** in fact true. By convention, studies have usually used a 5% chance of incorrectly accepting the rejection of the null hypothesis as being statistically significant; however, this is a statistical statement that there is a <5% chance; it is not 100% proof that the null hypothesis can be rejected. **Type II error** refers to the fact that a failure to reject the null hypothesis does not necessarily mean that no true difference exists between the compared groups in the larger population. It may be that the study was of insufficient size to detect a difference, or that individuals were followed for an insufficient amount of time, for true differences between the groups to become apparent. Most well designed studies aim for a type II error rate between 10 and 20%. **A statistical power of a study** is one minus the type II error rate. Therefore, most studies aim for a 80-90% power (an 80-90% chance that if the null hypothesis is not rejected that that is correct).

Once an association is recognized in a study, the next question is “how strong is that association”. An association can be referred to as a risk factor (however, one must remember that an association does not explicitly mean a cause and effect relationship).

The relative risk is the probability of an outcome if a risk factor/association is present divided by the probability of the outcome if the risk factor/association is absent. For instance, let's imagine a study in which we have followed a thousand individuals who smoke and a thousand individuals who don't smoke and we have measured the incidence of lung cancer in both groups. If 30 individuals who smoke develop lung cancer in our study time period, and three individuals who don't smoke develop lung cancer in the study time period, the probability of developing lung cancer if the risk factor is present is 30 divided by 1,000 (or 0.03). The probability of developing lung cancer if one does not smoke is 3 divided by 1,000

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“An informal survey of our members showed that many would like to improve their understanding of statistics. This is the second part of a three-part article.”

(or 0.003). The relative risk is, therefore, 0.03 divided by 0.003 or 10. A relative risk of 10 implies that individuals who smoke are ten times more likely to develop lung cancer than individuals who don't smoke. A relative risk can be calculated for cohort studies.

An approximation of the relative risk for case control studies is an odds ratio. In case control studies, the number of individuals who have and do not have a disease does not necessarily reflect the natural frequency of that disease in the general population. In a case control study, it is the researcher who determines how many study patients are being evaluated and how many control patients are being evaluated, and so a true disease frequency in the population as a whole can not be established. To understand the difference between a risk and an odds ratio (which is an approximation of the risk), one should think of the probability (or ~j~) of drawing an ace from a deck of cards (4 from 52, or 1 in 13). The odds of drawing an ace on the other hand will be the number of times an ace will be drawn divided by the number of times it will not be drawn or 4 to 48, or 1 to 12.

An odds ratio is, therefore, the odds of developing an outcome if an association is present, divided by the odds of an outcome if the association is absent.

If one wants to quantitate the difference of an association (relative risk [RR] or odds ratio [OR]) between two groups, it is termed a point estimate of the strength of the association. Confidence intervals are a way of combining information about the strength of an association with information about the effects of chance in obtaining the observed results. A 95% confidence interval (CI) is most commonly used. So an association will be reported as an OR or RR with a 95% CI.

The next step in evaluating studies or research papers is interpreting the data. One must first decide whether statistically significant results are clinically important. If one, for instance, finds in a very large study that a mean PSA level of 10.5 is associated with high grade prostatic carcinoma, while a mean PSA value of 10.4 is associated with low grade prostatic carcinoma, that difference may be statistically significant; however, it is not clinically useful to a clinician holding a specific PSA value in his or her hand. One must also evaluate the strength of an association as judged by the size of the relative risk. One would also evaluate the consistency of that evaluation. Ideally one would also evaluate the biological possibility of a given finding. One would also hope that, if applicable, there would be a dose response relationship. This would allow an observation of whether various levels of exposure of the risk factor were associated with a change in frequency of disease in a consistent fashion.

The final stage of analyzing a study is extrapolation. One can extrapolate to an individual or to a group. For instance, based on a study with a relative risk or odds ratio —‘of 10 of tobacco use and lung cancer, if an individual smokes, he/she is ten times more likely to develop lung cancer than if he/she did not smoke. One can also speak of an attributable risk

percentage. The advantage of this concept is that it allows one to think of a percentage of developing disease that may be eliminated among those whose risk factor is removed. Attributable risk percentage can be thought of as:

$$(\text{relative risk} - 1 / \text{relative risk}) \times 100\%$$

An example: let's imagine that smoking is associated with a relative risk of 1.5 of developing lung cancer. This may not seem like a large risk of developing lung cancer; however, 1.5 minus 1 divided by 1.5 x 100% equals 33%. This means that the attributable risk percentage for smoking is 33% (which translates into the fact that if an individual does not smoke that they may decrease their risk of developing lung cancer by 33%).

Before we turn away from study analysis, there are two additional types of studies that we should mention: data based research studies (also called non-concurrent cohort studies, also called outcomes research) and meta-analyses. The former are an extension of chart reviews, and have grown out of the ability to access and analyze large data base files with computer programs. One could use a computer based filing system, for instance, to identify (in 1999) individuals who in 1990 had a given procedure. We could then identify appropriate control subjects and follow those two groups for outcome longitudinally through the computer.

A meta-analysis is a way of analyzing information from many single investigations for the purposes of reaching conclusions or addressing questions that were not addressed due to the size of the single investigations. The most useful types of meta-analyses are hypothesis driven. Relevant studies must be carefully identified and included. Draw-backs include the likelihood that all relevant studies may not have been identified as well as confounding influences relating to differences in quality of available data that are included. In addition, meta-analyses do not include unpublished studies that failed to document an association, so bias can exist.

Message from the President

Louis Loutan

Dear Members,

The September terrorist attacks and the ongoing deliberate release of biological agents have shaken us and made a reality of what we would have thought could occur only in second rate horror films. This tragedy, intended to hit at the very heart of the western world, particularly the United States, has been successful in generating terror and distrust and eroding confidence in governments, and challenging our way of living, especially our freedom of mobility.

Terrorism is part of the dark side of globalization, and we are entering an age where we will have to learn how to live with it. For the many of us who live in the security of western countries, these are new risks we shall have to adjust to. We will have to learn how to deal with the risks, without underestimating or exaggerating them – even when the media tends to amplify them. Many members of our Society are confronted with insecurity every day in their own countries, and have been able to cope with it. These attacks reveal the vulnerability of globalization, as based on the extensive mobility of people, goods and information. Travel medicine is also shaken as it is intimately linked to the mobility of individuals and populations. People are afraid of boarding airplanes, are canceling domestic or overseas travel, and reorienting their priorities.

While we are still under the shock of the New York attack, it is difficult to predict how much our way of living will change, and how fast things will return to normal. We are in a defensive and reacting phase, aiming at retaliation, searching for the individuals and groups responsible for the attacks in order to neutralize them and prevent them from causing further terror. In the face of such a diffuse threat, it is better not to seek total victory over the devil, but rather his containment and reduction of his ability to do harm.

Soon we'll have to look at the root causes of terrorism. It can be generated by madly insane individuals, but in the majority of

cases it emerges in countries and places where poverty, social exclusion, unemployment, despair of the future, and humiliation are predominant. These scourges lead to the emergence of militant and fanatic groups, which may engage in desperate actions and create martyrs. Improving health and access to care are essential to counter this downward spiral. In many parts of the world rich countries are perceived as arrogant and unconcerned with the everyday difficulties faced by poor countries. Very often, tourists from the western world are the only ambassadors seen there. As travel medicine specialists we have essentially concentrated our efforts on protecting and promoting the health of travelers. While we immunize travelers and prescribe malaria prophylaxis for them to reduce their risk of acquiring diseases prevalent in the visited countries, we have not raised the local immunization coverage rate or addressed the health needs of the people living in these countries.

Should this continue? Or, as health professionals, do we have some responsibility for improving local conditions in host countries? The magnitude of the problems may be overwhelming and discourage us from doing anything. Nonetheless, we can play a significant role in making travelers more aware of local needs and undertaking concrete activities. As a significant number of our members practice in host countries, there may be opportunities to identify targeted interventions that would make a difference and link travel medicine with local initiatives. There are many possibilities: providing support to local health services, offering additional training to local doctors and nurses, generating specific projects for groups at risk, and participating actively in the promotion of sustainable tourism, for example.

ISTM has a committee on host countries lead by Dr. Santanu Chatterjee from Calcutta. Those of you who have innovative ideas should share them with us. In the coming months the board is certainly going to explore possibilities to diversify and expand areas of activities. This could be

one of the new programs to be looked at.

This crisis challenges us all. As the travel industry and airlines are seriously hit by the current situation, many of us have experienced a sharp reduction in activities and income, both in countries from which travelers depart and in visited countries. Some may even face closing their practice. Nobody knows how long this crisis will last.

This is not the first time that we have gone through such a critical time. Remember the Gulf War, the explosion of the Pan Am aircraft over Lockerbee or the waves of hijackings of airplanes in the 60s and 70s.

I strongly believe that eventually things will return to normal. This is not to say that we should return to our previous attitude; we should grow from the lessons learnt. ISTM needs to diversify the scope of its activities both in terms of groups of people we are concerned about and where we are active. Many of our members have skills that can be used in providing care for other groups, such as humanitarian workers and NGO personnel who are involved in relief operations or working with migrants domestically. We should pay more attention to the care of immigrants and refugees as they are becoming more of our daily life and practice, and promote migration medicine. Being in the forefront of vaccination programs, we can be more active in promoting them domestically and in the education of primary care providers. Many of us have skills in promoting health care, which can be used for the benefit of local communities.

At the same time as we are considering new horizons for our Society, we are actively working on the 8th CISTM, scheduled for May 2003, in New York. Board members will meet in mid-November in New York with the conference organizer, Dr. Brad Connor, who is hard at work on the conference. At this point we do not intend to change the location of the conference. New York remains very attractive with a vast array of possibilities for a

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Calendar: Travel Medicine Conferences, Courses, Educational Travel

2001 Conferences

**Nov
19-23**

54th World Congress of the World Thermalism and Climatology Federation (FEMTEC), 2nd Latin American Congress of Tourism and Health (FLT), and 3rd International Congress of Tourism and Health. Varadero, Cuba. November 19 – 23, 2001. The use of natural resources to promote health. Official languages: Spanish and English. Contact: Secretary to the Organizing Committee Margarita Roca Sardina, Ave. 43, No. 1418 Esq. a Calle 18, Miramar, Playa, Ciudad de la Habana, Cuba. Tel: (53 7) 24 7218. Fax: (53 7) 24 1330 Email: despacho@sermed.cha.cyt.cu Web address: www.cubanacan.cu/turismo/salud/index.html

**Nov
22**

Fourth National Seminar on Travel Medicine. Woluwe, Belgium (Near Brussels Airport.) 22 November 2001. Dangers of the Sea and the Wilderness. Topics that will be discussed include malaria, last-minute vaccinations, on-going epidemics, highlights from the ISTM meeting in Innsbruck, and wilderness subjects. Chairmen: Pr. A. Van Gompel and Pr. W. Peetermans. Information: Dr. F. Jacobs, Clinique des Maladies Infectieuses (Hôpital Erasme). Tél.: 02/555.67.46 Fax: 02/555.39.12 E-mail: erasmcmi@resulb.ulb.ac.be

**Nov
29 & 30**

12th Conference on the Health of International Travelers. Montreal, Canada. November 29 and 30, 2001. New vaccines, new clients with the growing popularity of mountain and adventure travels, DVT, HIV PEP for travelers and a broad overview of the latest in travel medicine from leaders in the field. Includes lectures, workshops and case studies. Conferences in English or French - with simultaneous interpretation. Contact: Mrs Nicole Côté or Dr Dominique Tessier, 500, Sherbrooke street West, suite 1100,

Montreal (Quebec) Canada H3A 3C6. Tel: (514) 499-2777-248 Fax: (514) 845-4842. Email: nicco@xchg.medisys.ca . Web site: csvm.ca.

2002 Conferences

**Feb
10-13**

Winter Wilderness and Travel Medicine Course. Big Sky, Montana, February 10-13, 2002. Cold weather aspects of travel and wilderness medicine. WMS, 3695 E. Fountain Blvd., Ste. A1, Colorado Springs, Co 80910. Contact WMS Meetings Plus 1-800-800-6819. Email: wms@wms.org Web address: www.wms.org

**Feb 25-
March 1**

8th Swiss International Short Course on Travellers' Health. Basel, Switzerland. February 25 – March 1, 2002. Organized by the Swiss Tropical Institute and under the patronage of the International Society of Travel Medicine A 1-week course providing comprehensive training in all aspects of travel medicine. Official language: English. Contact: Swiss Tropical Institute, Course Secretariat, Socinstrasse 57, CH – 4002 Basel, Switzerland. Tel: +41 61 284 82 80. Fax: +41 61 284 81 06. Email courses-sti@unibas.ch Web address: www.sti.unibas.ch

**April
13-17**

International Conference on Travel Medicine and 2nd International SHEA (Society for Healthcare Epidemiology of America) Training Course in Healthcare Epidemiology. Riyadh, Kingdom of Saudi Arabia. April 13-17, 2002. "Global Travel: The Raptures, The Risks." Topic to be discussed: travel epidemiology; venomous snakes. Hajj-related diseases; drug resistant diseases. International faculty includes president and two past presidents of ISTM. Conference organized in collaboration with WHO, ISTM, and other organizations. Contact: Conference Coordinator, Academic Affairs, P.O. Box 22490, Riyadh 11426,

Saudi Arabia. Tel: 252-0088 ext 2328 Fax: 252-0040 E-mail accaff1@ngha.med.sa Website: http://academic.ngha.med.sa

**May
15-18**

III European Conference on Travel Medicine: Travel and Epidemics. Florence, Italy. May 15-18, 2002. A broad overview of the latest in travel medicine from leaders in the field. Sponsor: WHO Collaborating Centre for Tourist Health. Official Language: English. Contact: Dr. Walter Pasini Viale Dardanelli, 64 47900 Rimini, Italy Tel. +39-0541-24301 or +39-0541-53209. Fax +39-0541-25748. E-mail: wpassini@rimini.com. Or contact: Conference Secretariat: Travel Agency Girovagare, Viale Milton n. 81, 1- 50129 Firenze, Italy. Tel: 39 055 494949. Fax: 39 055 476393.

**May
22-24**

3rd Scandinavian Forum for Travel Medicine 2002. Copenhagen, Denmark. May 22-24, 2002. Sponsors: Travel medicine societies in Denmark, Sweden and Norway in collaboration with WHO. A focus on the scientific basis for travel medicine through state-of-the-art reviews, symposia, and free communications. Health risks when traveling to Eastern European countries. Official language: English - with parallel sessions in Scandinavian languages. Contact: Conference secretariat: ICS A/S Copenhagen, Strandvejen 171, P.O. Box 41, DK-2900 Hellerup Denmark. Tel: +45 3946 0500 Fax: +45 3946 0515. Email: forum2002@ics.dk Web address: www.ics.dk

**Sept
8-12**

Third European Congress on Tropical Medicine and International Health. Lisbon, Portugal September 8-12, 2002. "Tropical Medicine: A Global Challenge." Under the auspices of the Federation of the European Societies for Tropical Medicine and International Health. Hosted by the Instituto de Higiene e Medicina Tropical. his Conference will

Calendar (continued)

concentrate on tropical medicine, travel medicine, migration, medicine, and international health, involving different experts to explore future innovative collaboration. Official language: English. Local Committee Chairman: Professor Dr. F. Antunes, Instituto de Higiene e Medicina Tropical, Rua da Junqueira, 96 PT-1600 Lisbon Tel: ++351-21-365-2638 Fax: ++351-21-797-6242 Email: ip231874@ip.pt www.kit.de/tropical2002/

**Oct
22-25**

IV Biennial Asia Pacific Travel Health Conference. Shanghai, China: October 22-25, 2002.

Travel Health in the Asia Pacific Region: New Frontiers and Challenges. Sponsor: Asia Pacific Travel Health Society Official language: Official language: English – with simultaneous translation of the plenary meetings into Chinese. Contact: Ms. Zhou Yifan, Secretariat of 4APTHC, Room 1705, No. 2669 Xie Tu Road, Shanghai 200030 China. Tel: 86-21 64398193. Fax: 86-21 64398194. Email: apthc2002@sh163.net Web address: www.2002APTHC.NET

**May
7-11**

CISTM8 8th Conference of the International Society of Travel Medicine. New York. May 7-11, 2003. Contact:

CISTM8 Conference Secretariat: Talley Management Group, Inc., 19 Mantua Rd. Mt. Royal, NJ 08061 USA. Tel: (856) 423-7222 Ext 218. Fax: (856) 423-3420. Web address: www.istm.org.

Courses/Educational Travel

**Feb
15-25**

Siem Reap (Angkor Wat), Cambodia. Conference date: February 18-22, 2002. (Travelling date: February 15-25, 2002.)

CME on Travel and Tropical Medicine. Accredited by the University of Toronto. Sponsored by The Centre for Travel and Tropical Medicine, Department of Medicine, Toronto General Hospital. Course organizer: Kevin C. Kain, MD, FRCPC, Director, Centre for Travel

and Tropical Medicine, EN G-224, Toronto General Hospital, 200 Elizabeth Street. Toronto, ON, Canada M5G 2C4, Kevin.kain@uhn.on.ca Travel arrangement through: Yue Chi, Concepts East Travel, 120 Eglinton Avenue East, Suite 904 Toronto, Ontario, Canada M4P 1E2 Tel: 416-322-3387 or 1-888-302-1222. Fax: 416-322-3129. E-mail: chiyue@idirect.com

**Jan
28 -
March
29**

The Gorgas Course in Clinical Tropical Medicine Lima, and the Andes and Amazon regions, Peru. January 28 - March 29, 2002 Waiting list only for this date.

Course scheduled for 2003 and 2004. Sponsored by the University of Alabama and the IAMAT Foundation. Includes lectures, case conferences, diagnostic laboratory procedures, and bedside teaching in a 36-bed tropical medicine unit. Official language: English. International Faculty. 380 contact hours. Contact: David O. Freedman, M.D. Gorgas Memorial Institute, University of Alabama at Birmingham, 530 Third Avenue South, BBRB 203, Birmingham, AL 35294. Fax: 205-934-5600 Or call: The Division of Continuing Medical Education at 800-UAB-MIST (U.S.) or 205-934-2687 (from overseas) Email: info@gorgas.org Web address: www.gorgas.org.

**Feb
3-15**

Tropical Medicine Expeditions to East Africa.

Kenya, February 3 - 15, 2002. Uganda. February 24 - March 2002. Sponsors: Tropical Medicine Center, Cologne, Germany, University of Nairobi, Kenya, and University of Makerere, Kampala, Uganda. Official language: English. Expedition designed for a limited number of physicians, public health experts, nurses. Visits to many hospitals and projects in urban and rural areas. Includes bedside teaching, laboratory work, and lectures in the epidemiology, clinical manifestations, diagnosis, treatment and control of all important tropical diseases. 50 contact hours. Contact: Kay Schaefer,

MD. Fax: +49 221-340 49 05. E-Mail: contact@tropmedex.com Website: www.tropmedex.com

**June
8-28**

Medical Practice with Limited Resources.

Ifakara, Tanzania. June 8-28, 2002. Organized by the Swiss Tropical Institute. Three-week course to teach clinical tropical medicine within the health facilities of tropical countries. Official language: English. Contact: Swiss Tropical Institute, Course Secretariat, Socinstrasse 57, CH - 4002 Basel, Switzerland. Tel: +4161 284 82 80. Fax: +41 61 284 81 06. Email: courses-sti@unibas.ch Web address: www.sti.unibas.ch

Announcements, cont.

Body of Knowledge Posted on the ISTM Website

The Body of Knowledge for Travel Medicine has been completed and is posted in outline form on our website. Experts from around the world have weighed the various topics in terms of their importance in our daily practices. This Body of Knowledge will be useful to anyone considering practicing travel medicine, and for those developing courses or other teaching tools.

This Body of Knowledge will serve as the basis for an examination being developed for all travel health professionals. This exam will be administered prior to the opening of the CISTM 8 in New York in May 2003. Practitioners who successfully complete this examination will be awarded a Certificate of Knowledge in Travel Medicine by the ISTM. Additional information and registration details will appear in NewsShare and be posted on the ISTM website (www.istm.org) as soon as they are available.

— “Message from the President,” —
continued from page 7

very successful conference. The 8th CISTM is a good opportunity to explore new opportunities for travel medicine. Your suggestions are invaluable to make the ISTM grow.

To conclude, I would like to bring hope for those facing a difficult situation. I would like to say that I am convinced that travel medicine is not collapsing, and will continue to thrive. This crisis offers us an opportunity to make the ISTM stronger with each member playing an important role.

As members of our Society may have lost friends or relatives in the destruction of the Twin Towers in New York, let me express again personally and on behalf of all of us in the ISTM a sense of grief and condolence for all their suffering and pain. We extend deep feelings of solidarity with them.

Vaccine Shortages

Over the past months, many of our members have experienced vaccine shortages. This has happened all over the world. It is very disruptive for our everyday activities. It also undermines our credibility and is counterproductive. First we urge people to be immunized, then we do not have vaccines to give them. There have been shortages of polio, yellow fever, Japanese encephalitis, and meningitis. Flu vaccine shortages occurred last winter, ruining the efforts to promote it.

The ISTM executive board is very concerned about this situation. The ISTM industry liaison person, Prof. Robert Steffen, has contacted our industry partners and shared our concern with them. At the next conference we intend to hold talks with industry representatives on the various issues related to production and regular supply of vaccines. This will allow for a better understanding of each other's constraints and concerns, and, hopefully improve the current situation.

Best regards,
Louis Loutan

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