## Letter from the Chair

As our hard working, dedicated Newsletter Editor Sandra was about to submit this publication, many new chapters for the Green Book were posted on the Department of Health website, along with news that the book format will be published in the New Year. That’s how fast moving travel medicine is, with new developments constantly happening and affecting us all. One of our main aims is to help forum members keep up to date and achieve standards of best practice.

The Professional Development Framework (PDF) represents a significant change to the structure of the RCN and will include the forums. We appreciate the RCN needs to develop and move with the times, but the committee is unsure of what the restructure will mean for our forum and, indeed, whether we’ll continue to exist in the present format after the consultation.

You were asked to comment on the PDF at www.rcn.org.uk/pdf by 6 January and I hope you did. It’s important to take an interest, as this will mean significant changes for you. To gather evidence of what the forum means to members, we’ve set up an email address to enable you to write and tell us what value the forum brings to you and why you think it should remain in existence. Although the official deadline will have passed by the time this newsletter reaches you, your input is crucial as we compose our response so do email us by the end of January at travelhealthforum@googlemail.com

Meanwhile, following the success of our Travel health service guidelines, published in the summer, we’ve already started work on competencies. Our biggest event this year is the Northern European Conference on Travel Medicine (7–10 June in Edinburgh) and we’re giving away five free registrations to forum members for this event. To enter the draw, just email your details (name, address, phone number and RCN number) to travelhealthforum@googlemail.com. The draw will be made on 9 February and the lucky winners notified by email.

Good luck – and a belated Happy New Year to all!

Jane Chiodini

## Letter from the Editor

Your committee has been very active and, although there’s some uncertainty surrounding the RCN forums, it’s business as usual for now. The prospect of a flu pandemic has been headline news for months so we need to keep vigilant and up to date on this important issue and the other changes happening around us.

It’s a bumper issue this time with some great guest articles. Among the highlights:

- we’re active participants in next year’s international travel health conference in Edinburgh, featured on page two and in the insert
- there’s an overview of meningitis, a serious threat to travellers in some countries, on page four
- a new book on adventure travel is previewed on page seven
- companies operating abroad have a role in the health of their employees, whether UK nationals or from the indigenous population. Andrew Dickson’s advice on Africa (page eight) will be relevant elsewhere
- is travel health advice worth the effort? Irmgard Bauer examines the issues on page 10
- if you’re thinking of setting up a private travel clinic, see page 14 where two nurses share their experiences.

Conference reports plus a wealth of information in Newsround and the Bulletin Board complete this edition. Thank you to our sponsors and all contributors – and belated best wishes for 2006.

Sandra Grieve
Erratum

In the summer edition of the newsletter, the information in Professor Gatrad’s article on the Hajj regarding Meningitis ACW135Y vaccine of two doses three months apart refers to the Ministry of Health of Saudi Arabia requirement for children under two years. For adults and children aged two years and over, a single dose provides protection for five years (for those over five years of age). Refer to the Summary of Product Characteristics (SPC).

Further information from:
www.nathnac.org/pro/clinical_updates/hajj_bmj.htm
www.travax.scot.nhs.uk
www.dh.gov.uk/traveladvice/hajj.htm
www.vaccines.co.uk

This information has also been corrected in the BMJ, 331 (7514), p. 442, where the original article was published.
**NEWSPREOUND**

**Travel Health Guidelines**
The RCN Travel Health Forum has produced a booklet outlining the minimum standards for delivering a travel health service. It's a useful guide to nurses who are expected to offer this service as part of their role. A copy was included with the summer edition of the newsletter – further copies are available from RCN Direct (0845 772 6100) or download yours from www.rcn.org.uk/publications/pdf/DeliveringTravelHealthServices.pdf

**RCN Professional Development Framework (PDF) consultation**
RCN members were asked to comment on proposals to transform the professional membership structure of the RCN. This follows the report of a review group set up last year to analyse existing structures. They identified seven key areas for change with the professional membership structure being the first to receive further consideration. The document, Consultation on a new RCN professional membership structure, maps out some possibilities. RCN Council asked all members to play a part in shaping the new structure and we hope you were able to voice your opinion. The online version of the document is at www.rcn.org.uk

**Immunisation training resources for health care professionals**
The Health Protection Agency (HPA) has announced new immunisation training resources for health care professionals. The National minimum standards for immunisation training and accompanying Core curriculum were developed by an advisory group led by the Centre for Infection's Immunisation Department as one of a range of initiatives to support the education of those undertaking immunisation delivery at a local level. The aim is to ensure consistency in the training provided across the country and to aid those responsible for providing training. Download these resources at www.hpa.org.uk/infections/topics_az/vaccination/training_menu.htm

**New chapters**
Several new draft chapters for the 2006 edition of Immunisation against infectious disease – the "Green Book" – are available on the DH website at http://tinyurl.com/38v34. The new edition will be available in the new year. In our next issue we will take a more in-depth look at the information relevant to travel.

**Commissioning a patient-led NHS**
This new report, produced by the Department of Health, explains how the number of PCTs, care trusts and strategic health authorities will be reconfigured to support practice-based commissioning. PCTs will be reorganised, the aim being to involve doctors and nurses in the design of services and how they are commissioned, and to reflect patient choice. In October the RCN called an emergency summit to address concerns amid fears and uncertainty about the proposals. As a result, in November the RCN issued an application for permission to apply for a judicial review of the Government's failure to carry out public consultation on the proposals for changing the role of PCTs in England. The case was settled out of court in December. Read more at www.rcn.org.uk/news

**HPA crisis simulation exercise**
The HPA is staging an EU-wide crisis simulation exercise to evaluate the ability of national and European level decision makers to co-ordinate their response to an influenza pandemic. Officials in command centres across Europe will react to imaginary scenarios, fed to them via the EU’s Early Warning and Response System (EWRS) and via EU-wide teleconferences. The exercise, dubbed “Common Ground”, was requested by the European Commission and will not involve any “real world” mobilisation of emergency services and health care staff, but will be command centre and desk-based. The Department of Health has funded the HPA to develop and run these exercises to test contingency plans and UK preparedness regarding public health related issues and to help identify improved ways of working, ensuring a wide range of organisations are ready to respond to health emergencies.


**Chief Medical Officer Update Issue 42: Preparing for pandemic influenza**
To strengthen national preparedness, an updated version of the UK influenza pandemic contingency plan was published in October. Operational guidance for Health Service planners on preparing for a flu pandemic, aimed at complementing the UK plan, sets out specific measures and actions required from health and other organisations. The HPA has been asked to prepare guidance on infection control and the clinical management of patients. PowerPoint presentations and information packs for frontline NHS staff are at www.dh.gov.uk/pandemicflu

Information and resources for health care professionals who advise travellers and for the general public are available from www.nathnac.org/pro/clinical_updates/avianinfluenza_advice_041105.htm and www.dh.gov.uk/PolicyAndGuidance/EmergencyPlanning/PandemicFlu/fs/en

**H5N1 avian influenza**
The UK Department for Environment Food and Rural Affairs (DEFRA) has stated that the risk of avian influenza in humans from migratory birds remains low for the UK and European populations. Outbreaks in poultry in Russia and Kazakhstan in August led the Netherlands to advise poultry farmers to keep stocks indoors until migration was over. WHO agrees with animal monitoring organisations that the control of avian influenza infection in wild bird populations is not feasible and should not be attempted. Experience in Southeast Asia indicates that human cases of infection are rare and that the virus does not transmit easily from poultry to humans. The expanding geographical presence of the virus is of concern as it creates opportunities for human exposure so travellers are advised to be vigilant when visiting countries with known poultry outbreaks. More at www.who.int
Meningococcal meningitis and septicaemia are systemic infections caused by Neisseria meningitides, a disease of humans with no insect or animal vector. There are 12 known serotypes (or strains). Groups A, B and C cause most cases, less commonly Y and W135.

In the past 30 years serogroups B and C have caused most cases in Europe and the Americas while serogroups A and C account for most cases in Africa. More recently serogroup Y has emerged as a cause of disease in Northern America and W135 has been linked to outbreaks in Saudi Arabia and Burkina Faso. Knowledge of the worldwide distribution of meningococcal disease is important when assessing the risk for travellers.

Risk to travellers
Meningitis risk for travellers is generally considered to be low. Sporadic cases occur throughout the world with localised outbreaks in confined crowded places. In the sub-Saharan African “meningitis belt” – an area stretching from Senegal to Ethiopia – large outbreaks and epidemics occur during the dry season (November–June). The dry season may vary and outbreaks can occur outside the meningitis belt.

Conducting a thorough pre-travel risk assessment can raise awareness of the disease and determine whether vaccination is appropriate for the individual. Identifying destinations, areas of high endemicity, season, length of stay and proximity to the local population will help identify those at increased risk. Travellers are at increased risk when they are going to endemic areas for long periods (a month or more), living and working closely with the local community or staying where outbreaks are occurring.

Transmission
Meningococci are spread by droplet or direct contact from infected carriers or those in the early stages of the disease but asymptomatic. Around 10 per cent of individuals carry the bacterium and usually infection with N. meningitidis is symptomless. The development of meningococcal disease is thought to occur when a pathogenic strain of N. meningitidis is transmitted to an individual from a nasopharyngeal carrier. Transmission is often associated with poor, overcrowded conditions.

Incubation
The incubation period is two–three days with abrupt onset of headache, fever, nausea and vomiting, neck stiffness and neurological signs of meningitis. Other symptoms may be irritability and photophobia. In infants symptoms may occur slowly and be non-specific with an absence of neck stiffness.

A typical haemorrhagic rash of meningococcal septicaemia may develop. Initially the rash may be non-specific and may be petechial or purpuric. The “glass test” can be diagnostic where applying gentle pressure on the rash produces no blanching. This has become more widely known through media campaigns. With early diagnosis and treatment, the case fatality rate is between five and 15 per cent.

Pilgrims to Hajj or Umrah
Outbreaks of serogroup A meningococcal disease associated with Hajj in 1987 and an outbreak of W135 in 2000 prompted the Ministry of Health of Saudi Arabia to introduce compulsory vaccination as a visa requirement for pilgrims to Hajj or Umrah. In the late 1980s the bivalent A+C vaccine was recommended, but the quadrivalent ACW135Y has been mandatory since 2002. Certified vaccination, valid for three years, administered at least ten days before departure, is required before visas are issued. The Ministry of Health of Saudi Arabia publishes their requirements annually before the Hajj season begins.

Vaccination
The conjugate vaccine against serogroup C is part of the UK vaccination programme, but does not provide protection against other serogroups. The bivalent A+C is no longer available. Quadrivalent vaccine ACW135Y is the recommended vaccine for travellers to sub-Saharan Africa and an immigration requirement for pilgrims to Hajj and Umrah. A single dose of this polysaccharide vaccine provides protection against serogroups A,C,W135 and Y for five years (for those over five years of age).

The Ministry of Health for Saudi Arabia requires proof of vaccination with ACW135Y for adults and children over two years of age. Children aged six months to two years are required to have two doses of the vaccine with an interval of three months between doses.

Diagnosis
As meningitis is potentially fatal, early diagnosis and treatment is important. The onset of disease is usually sudden with fever, intense headache, nausea and vomiting. Irritability and neck stiffness also feature. There are various ways of detecting the bacteria, usually by lumbar puncture and growing bacteria collected from cerebral spinal fluid (CSF). Appropriate antibiotic treatment should be started as soon as the diagnosis is confirmed.

Travellers visiting areas where meningitis is a known risk should be made aware of the disease, its transmission and how to protect themselves.
An overview

References


More at:
- www.dh.gov.uk/traveladvice/haj.htm
- www.nathnac.org
- www.flitfortravel.scot.nhs.uk
- www.meningitis.org (mainly directed towards Men C but travel included).

A friend collapsed while on a training exercise in deepest Wales. He had experienced flu-like symptoms and intense headache, and went off to bed. He awoke in the middle of the night with a blinding headache and knocked the door of a friend who fortunately recognised the condition immediately and summoned medical help. The next thing the patient knew he was waking up in intensive care four days later, surrounded by life-saving equipment and worried family members. Serogroup B, to which no vaccine is available, was identified as the cause – ED.

H5N1 vaccine?

Clinical trials of a vaccine being developed to protect humans against infection with H5N1 avian influenza have shown that the experimental vaccine evoked an immune response in a small group of healthy adults. The new findings reconfirm the feasibility of developing an H5N1-specific vaccine, but further trials are needed. See www.who.int

Swift intervention?

The much-heralded global influenza outbreak could be halted with concerted action and enough antiviral drugs. Britain would be “overwhelmed” if a deadly strain arrived here. According to the BMJ,* two research papers were published online in the journals Nature (www.nature.com) and Science (www.sciencemag.org). Both studies used computer simulations to assess the effectiveness of early intervention in pandemic outbreaks in Thailand. Both studies assumed that each infected person would transmit the disease to fewer than two people. H5N1 avian flu has very low virulence, but no one can predict the reproduction number of future flu pandemic strains as they could recombine with an existing highly virulent strain. Assuming a reproduction number of less than two, both models predict that an outbreak could be brought under control within three weeks.


Recreating deadly history?

The deadly virus responsible for the 1918 influenza pandemic has been resurrected from a strain preserved in the body of a frozen victim. The replica “Spanish Flu” virus shows how the pandemic was caused by a strain of bird flu to which humans had no immunity. The virus killed 50 million people worldwide. A row has been triggered as to whether the benefits of its resurrection outweigh the risks. Scientists revealed the genetic code claiming that the beneficial uses of this knowledge outweigh dangers of misuse. They hope to anticipate which viruses could cause a pandemic and develop new vaccines and treatments. The reconstructed virus is being kept under “stringent safety conditions” at Centers for Disease Control (CDC) in Atlanta. Dr Jeffery Taubenberger, who was involved in the project, reports that the virus had several mutations that are found in the H5N1 bird flu strain. The replica “Spanish Flu” virus shows how the pandemic was caused by a strain of bird flu to which humans had no immunity. The virus killed 50 million people worldwide. A row has been triggered as to whether the benefits of its resurrection outweigh the risks. Scientists revealed the genetic code claiming that the beneficial uses of this knowledge outweigh dangers of misuse. They hope to anticipate which viruses could cause a pandemic and develop new vaccines and treatments. The reconstructed virus is being kept under “stringent safety conditions” at Centers for Disease Control (CDC) in Atlanta. Dr Jeffery Taubenberger, who was involved in the project, reports that the virus had several mutations that are found in the H5N1 bird flu strain. The papers were published simultaneously on Nature and Science websites. See www.nature.com/nature/journal/v437/n7060/full/437794a.html for a discussion of the important implications of these findings and a link to the original Taubenberger’s paper (available free).

Great Depression re-visited?

Financial analysts warned that an outbreak of avian influenza could trigger an economic collapse similar to the Great Depression of the 1930s. The research report warns that the food, tourism and insurance industries could be devastated in a relatively short time. Analysts who work for a Canadian Bank said: “The combination of collapsing demand from China and India, and the likelihood of a collapse in the demand for housing and cars in some nations would mean prices of base metals and steel would plunge.” Companies would also be hit by panicking staff and absenteeism.
High workload
The Royal College of General Practitioners (RCGP) has asked the Government for clarification on vaccinating individuals should a flu pandemic strike. They say that the flu pandemic plan fails to take into account the increased workload for GPs.

Change in malaria chemoprophylaxis advice for southern Africa
Due to increasing drug resistance the current recommendation of proguanil and chloroquine is no longer felt to be appropriate. Travellers to malarial areas in Namibia, Botswana and Zimbabwe are now recommended to take mefloquine, doxycycline or atovaquone/proguanil (Malarone®) as malaria chemoprophylaxis. The choice of drug should be determined in consultation with the traveller, taking into account potential medical contraindications to individual agents. More at www.hpa.org.uk/infections/topics_az/malaria/guidelines.htm

HPA Advisory Committee on Malaria Prevention
This group does not recommend relying on herbal or homeopathic remedies for the prevention of malaria. Herbal remedies have not been tested for their ability to prevent or treat malaria and are not licensed for these uses. There is no scientific proof that homeopathic remedies are effective in either preventing or treating malaria. In addition, the Faculty of Homeopathy does not promote the use of homeopathic remedies for disease prevention; they note that their use in malaria prevention is unlikely to be acceptable to insurance providers. The medicine or medicines that should be taken to prevent malaria depend on the country or countries that will be visited. See www.hpa.org.uk/infections/topics_az/malaria/guidelines.htm

New look malaria website
The Malaria Reference Laboratory has a fresh look to its website with information and practical tips for reducing risks and avoiding malaria. Produced by the Suzy Lamplugh Trust, the video costs £7.50 plus £2.50 p&p, runs for 18 minutes and includes information and practical tips for reducing risks and avoiding danger. The guide costs £7.99 + p&p. See www.suzylamplugh.org

Looking ahead ...
Although it seems a long way off, look out for the announcement of dates for Malaria Awareness week in May 2006. The campaign is particularly designed to raise awareness among travellers. Information from www.malariahotspots.co.uk

British holidaymaker dies of rabies
A British woman became unwell after returning from a two-week holiday in Goa where she was bitten by a puppy on a lead. She was admitted to hospital for treatment and died of rabies. Debate in the medical press discussed the need for pre-exposure rabies vaccine for all travellers to the Indian sub-continent. Source: BMJ (2005) 331 (7511), p.255.

- More on rabies at www.nathnac.org/ and http://tinyurl.com/cho33

T7 is here
Health advice for travellers, the booklet formerly known as the T6, has been updated and re-issued. The new T7 version covers the European Health Insurance Card (EHIC). See our winter 2004/2005 newsletter for changes to “E-Forms” and E111 information, which are available from post offices. They are also available any time from the DH Publications Orderline at dh@prolog.uk.com or on 08701 555 455. A textphone (minicom users) for the hard of hearing operates Monday-Friday, from 8am to 6pm on 08700 102 870. A summary of the information is constantly updated on CEEFAX (BBC 2) pages 460–464. Copies also are available on request in Braille, on audiocassette tape or disk and in large print. More at www.dh.gov.uk/travellers

The rough guide to safer travel
The Foreign and Commonwealth Office (FCO) “Know Before You Go” campaign has a new tool designed to help travellers prepare for the unexpected: The rough guide to safer travel is a neat little book full of useful information and it’s free. The FCO provides other information booklets to download in pdf format or hard copies are available on request. See www.fco.gov.uk/travel and www.roughguides.com

Passport to safer travel
The WorldWide video and the third edition of the booklet, Passport to safer travel, have been published. Aimed at gap-year and first time travellers, the new edition contains a section on the threat of terrorism and guidance for women travellers. Produced by the Suzy Lamplugh Trust, the video costs £7.50 plus £2.50 p&p, runs for 18 minutes and includes information and practical tips for reducing risks and avoiding danger. The guide costs £7.99 + p&p. See www.suzylamplugh.org

Raising awareness from tragedy
Caroline's Rainbow is a foundation set up in memory of backpacker Caroline Stuttle, who was tragically murdered in Australia in 2002 when a mugger pushed her over a bridge. The video, Time of your life, has been developed to promote some of the basic safety awareness do's and don'ts of travelling to teenagers. The video is targeted at sixth form schools, higher education and further education colleges, youth and other organisations, teachers, lecturers, youth workers and other group leaders, and is introduced by Neighbours star Blair McDonough. More at www.carolinesrainbowfoundation.org

Vaccination report
The HPA has published Protecting the health of England's children: the benefit of vaccines. The report sets out the work done by the Agency's Centre for Infections in surveillance and research, and is an important resource on vaccine preventable disease. Health protection in the 21st century – understanding the burden of disease; preparing for the future, another new document, is at www.hpa.org.uk/hpa/publications/publications.htm

Changes to BCG programme
Following advice from the Joint Committee on Vaccination and Immunisation (JCVI) the current universal BCG vaccination programme delivered through schools will be replaced with an improved programme of targeted vaccination for individuals who are at greatest risk. The new programme will identify and vaccinate babies and older people who are most likely to catch the disease, especially those living in areas with a high rate of TB or whose parents or...
grandparents were born in a country where TB is prevalent. Resources and information about the changes to the BCG programme are available at www.immunisation.nhs.uk and www.healthscotland.com/immunisation. Changes to the BCG vaccination programme are covered in the Chief Medical Officer’s letter at www.immunisation.nhs.uk/files/CMO060705.pdf. The new Green Book chapter on tuberculosis is at www.immunisation.nhs.uk

More online resources
- CMO Annual Report: On the state of the public health gives updates including the situation regarding West Nile Virus, E coli and HIV at http://tinyurl.com/coefk
- The Centers for Disease Control (CDC) “Yellow Book” for 2005/2006 is available at www.cdc.gov/travel/yb

Have fun with these sites ...
- on the altitude of just about every town on earth (you may have to sort through options in a large country where there are towns with the same name or variant local spellings) at www.fallingrain.com/world
- on global information at http://encarta.msn.com/encnet/features/MapCenter/Map.aspx

New packaging
In response to feedback regarding the similarity in packaging for REPEVAX® (TDaP IPV) and REVAXIS® (Td IPV), Sanofi Pasteur MSD has now redesigned the packaging for these IPV containing combination vaccines. This follows the introduction of new packaging for PEDIACEL® (DTaP IPV HiB) in August 2005. All changes were made after consultation with the Medicines and Health products Regulatory Agency (MHRA) and the Department of Health. For further information please visit VIS Online www.spmsd.co.uk

Hepatitis C
The Hepatitis C scandal, a report published in March, contained a call from the All-Party Parliamentary Group on Hepatology (APPG) for greater urgency in dealing with the coming “tidal wave” of hepatitis C in the UK. This blood-borne disease was formally identified in 1989 and is transmitted through direct blood-to-blood contact. In 2002 the Government published its Hepatitis C strategy for England and in July 2004 the Department of Health (DH) published the Hepatitis action plan for England. In December 2004 the campaign FaCe It was launched to raise awareness. Nurses carrying out a risk assessment for travellers are well placed to conduct health promotion in this important area and to identify those at risk. More at www.hepc.nhs.uk

New vaccine for hepatitis B
GlaxoSmithKline has developed a new hepatitis B vaccine (Fendrix®) licensed for use in those aged 15 years and over. Using recombinant DNA technology and an added adjuvant AS04, this vaccine is particularly useful in preventing hepatitis B infection in individuals with renal insufficiency and in specific high-risk groups such as pre-haemodialysis and haemodialysis patients.

Solomon, T; Marston, D; MacPherson, M et al. (2005) Paralytic rabies after a two week holiday in India, a clinical review, BMJ, 331, pp.501–503.

Hot off the presses!
The gap year handbook
Tim Beacon’s new book for gap year travellers has just been published (ISBN 0 7552 0201 5) and will be reviewed in our next edition. Subtitled “the essential guide to adventure travel”, it’s available in good bookshops or you can order from the Outdoor Experience, 43 Grovebury Court, Wootten, Bedfordshire MK43 9HZ (www.outdoorsex.co.uk) for £11.99 + £1.50 p&p. More about this book and gap year travel at the Telegraph Adventure Travel Show at Olympia London on 13–15 January – see www.adventureshow.co.uk
For those involved in advising business travellers and expatriates, Dr Andrew Dickson, an occupational health physician, explores the practical management of health for African programmes and shows how refocusing resources can cut budgets and improve health.

Many companies operating in Africa are uncertain about the quality of the health care they buy and have doubts about value for money. They are probably right. Audits – for quality and cost – are applied to all areas of industry, but rarely to health. Clinicians face huge problems and doctors struggle to meet even immediate expectations of patients, let alone manage preventive programmes. Yet immunisation programmes, ensuring safe water supplies and monitoring catering hygiene are more cost effective than clinic based care.

Stepping back from the clinical care frontline allows a more considered approach to the whole issue of health provision. “Curative” services can usually be rationalised with less time and expense going to self-limiting illness – sometimes up to 30 per cent of the health budget – and more resources focused on serious diseases: malaria, TB and HIV.

Medicine quality can be dramatically improved by defining critically important drugs and importing them from European charity outlets. Nurses welcome protocols, which rationalise prescribing and ensure diagnostic standards. Immunisation programmes can be piggybacked onto existing services with huge effects on childhood illness and mortality (vaccines can usually be obtained free from government health departments).

Health programmes beyond the confines of the clinic are usually more cost effective than even the most focused “curative” programmes. Water treatment programmes using sand filters and hypochlorite can be simple, sustainable and effective. Spraying programmes for mosquito control can dramatically reduce malaria prevalence and childhood deaths. Bed net programmes add greater benefit at little cost.

The legal position

Do UK companies have a duty of care in health provision overseas? Have UK nationals sued in the UK for ill health overseas? Do foreign nationals have rights in UK law as well as in their own countries? The answer to all three questions is “yes”.

Expatriates’ rights were clearly set out in the case of Connelley v. RTZ in 1997. The House of Lords found that Connelley could bring a case in the UK for the throat cancer he alleged he had developed as a result of exposure to uranium dust while working in Namibia. In 2001, 14 members of the armed forces sued the UK Ministry of Defence for allegedly not providing antimalarials in sufficient time ahead of their deployment abroad. As more cases go through the courts public awareness of duty of care overseas will increase.

The application of UK law to foreign nationals was unclear until another House of Lords decision in 2000. It was found that a group claim by a number of ex-employees of Cape Asbestos could be heard in the UK in spite of none of the appellants being UK domiciles and the company having ceased all operations in South Africa many years before.

Both of these precedents parallel similar legislation in the rest of the European Union. Unsurprisingly there are also parallels in US law giving rights to both US citizens and host country nations abroad. The Principle of Extraterritoriality seeks – usually successfully – to apply US law to all areas of the world where US nationals are employed. In the last few years the largely forgotten Alien Tort Law (1789) has also been resurrected to allow non-US citizens to bring cases against their employers.

Risk assessment

There is no reason why the conventional principles of risk assessment cannot be applied to corporate health in Africa in the same way as to any other company function. Issues include:

Emergency response. The absolute basics involve providing basic emergency equipment and ensuring that checklists are completed every week.

Local medical facilities. An assessment of the quality and cost of locally available medical care is central to any site health audit. The most important issues are evidence of needle/syringe reuse, sterilising procedures and the doctors’ knowledge.

Drug availability and quality. Many important medications are unavailable in some African countries. Substandard medicines are also a problem (up to 70 per cent in parts of West Africa). A cost-effective solution is to define a small number of essential drugs and import them. Charity outlets in the EU will sell quality assured generic drugs to companies in Africa. They can also provide new and reconditioned clinic equipment. Costs – including shipping – are often less than local suppliers.

Occupational health surveillance. Health surveillance is often sidelined by more immediate health concerns. In addition, employers are often concerned that surveillance may promote litigation. However, not carrying out surveillance is likely to be more costly in the long term. Up to 30 per cent of noise exposed employees in manufacturing industries may meet the criteria for noise induced hearing loss – clearly a huge potential liability. Many of these employees will have had substandard hearing from childhood. Pre-employment hearing assessments would detect this and avoid large numbers of claims. Assessments for the effects of noise, dust and chemical exposure are low cost and relatively easy to perform.
Falciparum malaria in travellers returning from the Gambia

On 9 December 2005 the Health Protection Agency (HPA) reported six cases of falciparum malaria in British tourists who returned from The Gambia and became ill in the last few weeks of November 2005. Two died and two were in intensive care. Five of the cases were on one to two week holidays at resorts within 20 kilometres of the Atlantic coast. The sixth had visited The Gambia several times in the last year on business and had travelled a little further inland. None of the cases had taken adequate anti-malarial prophylaxis.

The Gambia is a highly malarious area and a popular winter sun destination for British tourists, who account for half of all visitors there. The HPA informed the Federation of Tour Operators and the Association of British Travel Agents who are taking steps to inform their members of this issue and the need for intending travellers to be encouraged to seek medical advice before travel to malarious areas.

HPA issued a press release including sources of information for health care professionals and the public about the importance of taking anti-malarial medication when travelling to known malaria destinations. Health professionals who require specialist advice when advising travellers should contact the HPA Malaria Reference Laboratory on 020 7636 3924 or the National Travel Health Network and Centre (NaTHNaC) on 0845 602 6712. Clinicians should contact the doctor on call for tropical and infectious diseases at the Hospital for Tropical Diseases on 0845 155 5000.

Please ensure that you consider and investigate the possibility of the diagnosis of malaria in travellers returning from The Gambia who present with a fever or flu-like illness – whether or not they have taken any appropriate prophylaxis. It is important to take a full history of prophylaxis use.

The press release is available at http://tinyurl.com/dpcrg

© Dr Andrew Dickson is Medical Director of Medical Services Overseas Limited.

www.mso.cwc.net
A large part of any pre-travel consultation is the provision of health advice to the client, advice that is supposed to ensure a healthy and enjoyable trip, and a safe return with no health-related surprises afterwards.

Unfortunately, numerous studies conducted over the last few decades suggest that all is not well in terms of content, delivery, retention of or compliance with the advice given by well-meaning health professionals. Enough evidence exists indicating that people do not seek health advice, receive conflicting advice, or receive incorrect or outdated advice. Also, many do not remember the advice they get or do not plan to implement the advice either because they feel they are not at risk – or because it’s too bothersome or interferes with their plans.

To use travel health professionals’ time more efficiently, it is important to examine where potential pitfalls lie in travel health advice-giving. Three areas seem to be the main focus of concern: 
- the content of the advice
- the way the information is conveyed
- the effect it has on the recipient.

Health advice usually promotes a change in behaviour. A range of possible frameworks can be used individually or in combination to understand, analyse and modify areas of health behaviour changes. Two such areas are the models of human health behaviour to understand the components necessary to foster successful behaviour change, and theories of communication to understand the process of information giving.

### Models of human health behaviour in travel health

Nurses are generally very familiar with models of human health behaviour as they form the basis for patient education with the aim of fostering healthy behaviour.

There are four more commonly used models – Rosenstock’s Health Belief Model, Bandura’s Social-Learning Theory, Fishbein and Ajzen’s Theory of Reasoned Action, and Green and Kreuter’s PRECEDE Model. Each is useful in understanding why some travel health advice outcomes are more successful than others and all incorporate the underlying assumption that people need to understand that there is a potential threat to their health after having received a simple factual explanation. The advice given is then the strategy that may help keep this threat to a minimum.

### Communication theory as a guide for improving travel health advice

Lasswell’s five key components of communication – the sender, the message, the channel, the receiver and the effect – can also be used to examine the quality of health advice-giving as problems can be found in any of those components individually or in combination.

The sender (health professional) prepares and transmits the message based on knowledge (including geographical knowledge), qualification, experience, “people-knowledge” that allows some assessment of a client’s potential risk-taking behaviour and good interpersonal skills.

The travel health advice is the message released by the sender. Not only does the message have to be correct, consistent, complete, relevant and up-to-date, but also tailored to the unique needs of each traveller in terms of type, amount and delivery (the channel).

Travel health advice comes in a range of media: oral, printed, audio-visual, electronic and in any possible combination. Much has been written about the preparation of teaching materials and details can be found in patient education handbooks. However, two aspects pertain to any medium: one is that the medium complements, but doesn’t replace the personalised advice; the other is that the material should consider a person’s perception of health and risks.

The principles of adult learning apply to the receivers of travel health advice – that is, the presence of previous knowledge and experience, physiological changes throughout the lifespan, their assessment of risk and their motivation play a major role in accepting advice given.

The effect (or outcome) of travel health advice should be the adoption of a suggested behaviour. However, it has been demonstrated that, once they are at the destination, many know very little or seem unconcerned about advice they were given. Travel health nurses should
Royal College of Nursing

New card complaints

As reported in the Daily Telegraph (August 2005), the Department of Health has had thousands of complaints and queries following the launch of the new European health insurance card. The card replaces the "E-forms", particularly the E111 used by European citizens to prove entitlement to free or reduced cost emergency medical treatment during temporary stays in other EU countries. The card is produced by computer-scanning application forms, but the computers have been unable to read applicants handwriting and have printed inaccurate details. The DH has now produced easier to scan forms and say that if the computer continues to have difficulty reading the information then a human would deal with it! It may be simpler to apply by telephone, Internet or email. Proposals for a new National NHS smart card in England will be developed as part of the EU Health Insurance card and the DH will consult further on these proposals in due course. See www.dh.gov.uk/PublicationsAndStatistics

New airport technology

Major US airports have installed new security technology whereby passengers will no longer need to be body searched, but will pass through a machine which analyses the air for traces of explosives. A computerised voice will tell passengers when to proceed.

More checks but ...

... passengers travelling to the USA face increased delays due to immigration authorities requiring further information. Airlines are required to pass on information not available on passports, such as country of residence and an address for first night stay in the US. Passing on passport details to American officials as part of the Advance Passenger Information System (APIS) is instantaneous when passports are scanned at check-in. Airlines are encouraging passengers to provide the information in advance via their websites to reduce queues at airports.

....don't desert us!

American tourism officials are urging British travellers to continue to travel to areas devastated by hurricanes. Tour operators have stopped offering stays in New Orleans meantime and will reopen when safety is assured. Many British companies are continuing tours with amended itineraries.

Hurricane Katrina ...

... wreaked havoc in several states in the USA, but despite predictions health issues were few. CDC information and guidance is at www.cdc.gov/travel/other/hurricane/guidance_hp_travelers.htm and www.bt.cdc.gov/disasters/hurricanes/infectiousdisease.asp

Visa waiver extended

The US Department of Homeland Security has announced a one year extension of its visa waiver programme (VWP) to October 2006. The UK and other VWP countries are required to have a biometric passport issuing system in place by then to continue as programme members and benefit from visa-free travel to the USA after that date. They also announced that all new passports issued on or after October 2005 must contain a digital photo image to enable the holder to travel to the USA without a visa. More at www.usembassy.org.uk

Ships ahoy

New rules from the US Supreme Court will ensure that foreign cruise ships
sailing into US waters can now be sued if they discriminate against disabled passengers. The ruling followed a judgement that three disabled passengers were unfairly charged extra for cabins with disabled access and denied use of some facilities. The court ruled that the Americans with Disabilities Act of 1990 also applies to foreign-flagged vessels.

**Piracy and cruising**

Cruise passengers at North American ports are being treated with hostility rather than hospitality according to a new guide on cruising and cruise ships. The fear of terrorism has led authorities to treat all passengers as a potential threat. The recent case of piracy off the coast of Somalia has heightened fears of attacks on cruise ships. The Berlitz complete guide to cruising and cruise ships is at www.berlitzpublishing.com

**Terrorism: you’re on your own!**

The British Insurance Broker’s Association (BIBA) says more travel insurance companies to include cover against terrorism. As research by the US State Department showed a steady increase in the number of terrorist attacks worldwide, holidaymakers are advised to ensure their policies include protection against terrorism. If not and if tourists are caught up in an attack, they may have to pay their own medical bills and flights home.

**Insuring adventurous pensioners**

BIBA also says there has been a marked increase in the number of people aged over 65 taking adventurous holidays and struggling to find insurers to cover them. Some have to pay inflated prices while others travel without insurance rather than cancel their holiday.

**Too much sun**

Much attention is given to terrorism and security for travellers, but according to a study of attitudes towards skin cancer, little is done to warn tourists of what Professors Ken and Sue Peattie of Cardiff University, authors of the study, call “one of the biggest killers of our time”. The study published in Tourism Management magazine criticises tour companies for featuring suntanned, scantily dressed families in their brochures: travel companies must take more responsibility for warning about the dangers of sun damage. A spokesman for the Association of British Travel Agents (ABTA) said there is no legal requirement for travel agents to provide advice on sun exposure, but the industry is providing information leaflets to holidaymakers.

**Not enough sun**

The re-emergence of rickets in some parts of the UK has prompted agencies to recommend vitamin D supplement. The Committee on Medical Aspects of Food and Nutrition Policy and the Scientific Advisory Committee on Nutrition recommend dietary vitamin D for pregnant and nursing mothers, children under five and the elderly to reduce the risk of fractures. South Asian and African-Caribbean women and children, as well as those who cover up for cultural or religious reasons are more at risk through limited exposure of their skin to sunlight.

**African boom**

Following the Live8 Summit in Scotland and concerts throughout the world, a growing number of British tourists want to visit Africa. A series of television programmes featuring Bob Geldof in Africa fired interest in the continent. Tour companies reported a 20 per cent rise on the same period last year, but say that debt cancellation can only go so far and they are aware that support needs to reach African people directly.

**Chavellers v travellers?**

Research published at the World Travel Market trade fair in London shows that graduates saddled with debt and the urge to get on the career ladder are delaying “gap-year” travel until their 30s. The middleclass gap year traveller is keen to avoid so-called “Chavellers” who head for mass tourism destinations like Australia, India and Thailand. Instead South and Central America, and East Africa are providing new frontiers not yet colonised by outwardly mobile chavs.

**It’s those grown-up gappers again**

Gap Year for Grown-Ups says that the Kenya Orphan Outreach programme is the most popular destination for grown-up gappers. The programme runs for four-to-12 weeks and helps people affected by HIV/AIDS. Opportunities for life changing experiences are available in many countries at www.gapyearforgrownups.co.uk

**Scientists urged to lead a revolution**

Some of the world’s most inventive scientists have been awarded grants totalling £245 million to turn their ideas into practical solutions to help combat the greatest health problems of today. Among the proposals for funding are:

- vaccines which don’t require refrigeration
- genetically engineered mosquitoes that die before they mature and pass on dengue fever
- no-needle vaccinations for children
Growing vitamin enriched crops for poor children. Exploring ways of stimulating the immune system to develop vaccines for HIV, tuberculosis and malaria.

The Bill and Melinda Gates Foundation launched the initiative and made it clear that scientists should do more to tackle the diseases of the poor. Read more at www.gatesfoundation.org and www.childrensvaccines.org

World’s most neglected diseases
Scientists at Dundee University’s School of Life Sciences were awarded £8.1 million by the Wellcome Trust to develop new drugs to treat some of the third world’s neglected diseases. The funding, over a five year period, will allow scientists to translate basic research discoveries into candidate drugs ready for clinical trials to treat diseases such as leishmaniasis and Chagas disease.

UK increases fund
The Department for International Development pledged £100 million in each of the next two years to the Global Fund to fight AIDS, tuberculosis and malaria. The Fund, established in 2002, is underwriting projects in 127 countries. The increase will mean that Britain accounts for 20 per cent of the total global financial support for the battle against AIDS.

Rise in hantavirus
Eurosurveillance Bulletin in July described a very marked increased incidence in reported hantavirus in France, Belgium and Germany. Information was distributed via camping sites, tourist accommodation and tourist information centres.

See www.eurosurveillance.org/ew/2005/050721.asp#4

Drugs and Dubai
For those travelling to Dubai information is available regarding carrying “acceptable drugs” through airports and ports. The Ministry of Health website contains information and advice. A full list of acceptable drugs is available in the “drug formulary” at www.moh.govae/moh_site/phar_med/moh_p_m.htm. In the FAQ area it states: “Individuals may bring medicines into the country for personal use. Up to three months’ supply of prescription items by visitors and up to 12 months’ for residents if they can produce a doctor’s letter or a copy of the original prescription.”

Safe sex, nice hair and ... sticking plasters?
A study commissioned by the DH which included 1,000 single men and women aged 18–30 found that a perfect hairstyle on holiday was more important to young women than safe sex. Almost half of the women hoped to have one or more sexual partners on holiday, but only 18 per cent packed condoms while 33 per cent packed hair straighteners. Almost two-thirds of the men anticipated sleeping with one-to-three partners, but were more likely to take sticking plasters than condoms – 28 per cent packed condoms while 48 per cent packed plasters. Two-fifths of the men and women expecting to have sex believed they had a low risk of catching a sexually transmitted infection even if they were unprotected. The DH-backed research said there is still a lack of education about safe sex. See www.playingsafely.co.uk and www.mariestopes.org.uk/pdf/travelguide.pdf

Tale of the tiger
British tourists who pay handsomely to visit India to “tiger watch” will be disappointed to learn that their contribution is not helping to save the species. A report commissioned for the Indian Government to investigate the dwindling tiger population has shown that the substantial revenue from the tourist trade is not being re-invested in the parks and the people. Many “elite” eco-lodge hotels charge hundreds of pounds a night for tourists to live in luxury as they watch Indian tigers while the local population lives in poverty. The hotels contest the report, saying they act responsibly and employ local people, and the poverty issue is a political matter which they can’t comment on. It is thought that the number of tigers left in India has been grossly inflated after it emerged that poachers had emptied a reserve of the animals.

London attacks
Following the terrorist attacks in London in July, medical teams have been reviewing their response and are looking at how they can meet future challenges through lessons learned. Several related articles make interesting reading in New England Journal of Medicine at http://content.nejm.org/content/vol353/issue6/index.shtml

Vaccine alert from the US
The Food and Drug Administration and Centers for Disease Control (CDC) issued an alert on Menactra Meningococcal Vaccine and Guillain Barre Syndrome (GBS). The five cases of GBS reported following administration of Menactra occurred in individuals aged 17 or 18 years who developed weakness or abnormal sensations in the arms or legs, two-to-four weeks after vaccination. All individuals are recovering or have recovered. CDC conducted a rapid study using available health care organisation databases and found that no cases of GBS have been reported to date among 110,000 Menactra recipients. Information was circulated by GeoSentinal, the global surveillance network of the International Society of Travel Medicine (ISTM) to alert members. See www.istm.org/geosentinel/main.html
If you are thinking about opening and running a private travel clinic, there are lots of issues to consider. HILARY BAKER and DAWN COLEY operate a private nurse-led travel clinic and here they outline some of the legal requirements and other aspects involved in running an independent clinic as an entirely private concern in England.

So you’re thinking of running a private travel health clinic?

The first thing to say is that it won’t happen overnight. In advance of any other research or activity, it is important to put your ideas on paper. A business plan is essential and it helps clarify initial ideas, focusing on financial and personal commitments, and other requirements for running a business.

If the clinic is independent and situated in a non-NHS building, you are required to register with the Healthcare Commission (HCC), which in April 2004 assumed responsibility from the National Care Standards Commission (NCSC) for regulating and inspecting the independent (private and voluntary) health care sector.

Registration includes meeting the criteria specific to a private clinic. Once this is achieved and the ability to function as an independent clinic agreed, the clinic is inspected annually to see if it continues to meet the Commission’s standards. When applying to the HCC, it’s vital to ensure that all the standards are met. There are many areas to address so a considerable amount of preparation is involved, but work through it step by step – and don’t panic!

Registration costs £648 for small establishments with an annual fee of £1,944. (2005/2006). Details at www.healthcarecommission.org.uk

In addition to registering with the HCC, you must register with Data Protection as the clinic will hold personal information on others. The annual cost is £35. There are many bogus companies so beware! More at www.informationcommissioner.gov.uk

The building in which your clinic is situated, its location and accessibility are fundamental to your success. The type of property and rental agreement will have implications regarding your responsibilities for maintenance and overheads. To make sure there are no hidden costs, seek legal advice before signing any agreement. The building should meet health & safety and fire regulations, offer access to disabled people and be suitable for a medical business. The local planning office will advise on buildings holding appropriate status.

Initial set up costs are likely to exceed expectations!

A glance around your current workplace will give you an idea of what is needed. Polish up your negotiating skills and be prepared to broker a deal. Discounts may be available, but are often not advertised.

Each clinic will be organised differently and the set up will depend on the personnel involved in the business. Every organisation should demonstrate appropriate mechanisms for ordering, prescribing, and dispensing medicines and vaccines. Patient Group Directions (PGDs) are a legal requirement within the private sector and unlicensed vaccines cannot be given under a PGD. There’s guidance at www.rcn.org.uk/members/downloads/pgd.pdf and www.nelm.nhs.uk/PGD/default.aspx

If you are based in England or Wales and plan on offering yellow fever vaccine, you must register with the National Travel Health Network and Centre (NaTHNac) and become a Registered Yellow Fever Vaccinating Centre (YFVC). Information at www.nathnac.org

A business bank account is necessary and do research the products on offer. Bank services differ so consider incentives like free banking and low interest charges as this can be beneficial, especially in the early years of trading.

Nowadays customers will expect you to offer a debit and credit card facility, and there is a considerable cost element to this. Providers vary so make sure you ask for a breakdown of the services and charges before committing to a service.

It is essential to keep accurate records and accounts. Various accounting packages are available so choose one that is user friendly and meets your needs. You will need to engage an accountant and have the support of professional advice. If you’re setting up a limited company, you need to complete an annual tax return and log it with Companies House (www.companieshouse.gov.uk).

Marketing and advertising are important too. Letting a wide audience know about your clinic and the services you provide is essential but expensive. Carrying out your own research will be vital in tailoring your advertising to reach your target audience with minimum expense. Consider having a website and email
Visit Hiliary and Dawn's website at www.bmcmedical.co.uk

Recommended reading:

To Register as a YFVC outside England:
Scotland: Health Department of the Scottish Executive: Tel 0131 244 2278.
Wales: The National Travel Health Network and Centre (NaTHNaC)
Northern Ireland: The Health Protection Branch of the Department of Health and Social Services. Tel 028 90522 333.

facility. Access to the Internet is an essential tool for travel health consultations, but costs vary widely so shop around.

It's a bit of a cliché, but if you are planning to open a clinic you will need to have good friends! Running your own business will totally engulf you, and you will need the support of family and friends at all times.

And finally, commitment is 150 per cent, but remember to include time for your own travel arrangements in your business plan. A holiday will be very important ... and you can always call it research!

Update on travel-related deep venous thrombosis
John Smith MP, the aviation health campaigner, joined victims in welcoming the passing in Parliament of the Civil Aviation Bill which offers protection for the health of air passengers. The wait for the change in the law was a long and anxious one for the members of VARDA (Victims of Air Related DVT Association), who held a meeting in Parliament to coincide with the passing of the Bill.

Coming into line?
DVT awareness aviation health campaigner John Smith MP vows to redouble efforts following Law Lords ruling against the judicial case of DVT victims which sought to obtain the right to claim compensation from airlines. Following the ruling John Smith said: “I along with DVT victims are clearly disappointed but not surprised with the Law Lords’ ruling. We believe they missed an opportunity to apply some common sense by bringing airlines in line with other passenger carriers. We will redouble our efforts to achieve justice for the thousands of flight-related DVT victims in Britain.”

Cheaper calls
The Foreign Office (FCO) has set up a cheaper method of seeking travel advice by telephone following Government recommendations to give callers better value for money. From March 2006, members of the public should call 0845 850 2829.

On the piste
FCO research has found that 36 per cent of people involved in alcohol-related accidents on the ski slopes had insured themselves. The study found that 31 per cent of Britons don’t take out adequate insurance. Two-thirds were fined for causing damage and over half were asked to leave the resort. The FCO said that almost 45 per cent of young people are unaware of the effects of alcohol and altitude. In the United States a zero tolerance policy is in place, and fines and arrests are a possibility for out of control skiers. Austria and Italy have introduced “Ski Marshalls” who can breathalyse and fine skiers thought to be drunk or acting dangerously.

FCO consultation on Brits abroad
The Foreign Secretary Jack Straw has launched a consultation on the FCO’s Comprehensive guide to support for British nationals abroad. The guide includes information on what the FCO can and can’t do for British nationals in difficulty. Over the last year cases dealt with included 4,200 British nationals hospitalised overseas, 3,900 deaths, around 150 cases of child abduction and 250 forced marriages. A copy of the draft guide is available from katey.ma@fco.gov.uk or call 020 7008 1213.

Sustainable tourism
The FCO held a meeting with the heads of major UK travel companies and the UK charity Travel Foundation to promote sustainable tourism. Under discussion were the ways in which tourism can make a positive contribution to holiday destinations. More from www.thetravelfoundation.org.uk

Trial audits in India
The Indian Government is to set up a registry to audit some clinical trials following controversies over illegal and unethical trials. The Indian Council of Medical Research will establish the registry and drug regulators will scrutinise trials to ensure compliance with ethical guidelines and good clinical practice.
ANNIE BRADLEY reports on this year’s RCN Travel Health Forum Conference in London.

Travel on a Thursday

Closures and delays on London transport did not deter the 175 delegates who experienced the challenges of Travel on a Thursday and they were rewarded with excellent speakers at our 12th annual conference.

Today’s world increasingly involves manmade or natural disasters. Dr Richard Dawood specialises in advising news industry professionals who may be deployed to disaster zones at short notice. He showed a graphic newsreel demonstrating situations journalists and photographers frequently face. Personnel are often ill prepared, and he identified the key issues and challenges of last minute, high-risk travel.

The physical, mental and emotional support needed for disaster response workers was highlighted by nurse Sally Greenwood who related her personal experience with a medical team in post-tsunami Sri Lanka. Indeed, both sessions explored from different viewpoints the challenges for health professionals advising travellers going to disaster areas.

Dr Paul Giangrande, a consultant haematologist, clarified the association between long distance travel and venous thromboembolism, including the ongoing issues surrounding traveller’s thrombosis.

Charlie McGrath entertained us with an excellent presentation on gap year travel preparations, using the acronym READE = Recognise, Evaluate, Avoid, Defuse and Extract!

Jenny Percival has personal experience as a nurse on passenger liners and she offered an interesting look at the nurse’s role in cruise ship travel.

Vaccinations are a key factor in promoting good health for travellers. Professor David Hill, Director of the National Travel Health Network and Centre (NaTHNaC), gave an excellent overview of the benefits and risks of providing pre-travel immunisations.

Professor Pat Troop, Chief Executive of the Health Protection Agency, gave us an update on Avian flu – a topic on everyone’s mind.

Using stories from history and art, Professor Peter Chiodini treated us to a graphic pictorial review of worms (helminths), which are responsible for considerable morbidity – especially in the tropics. The “Three Graces” will never look the same again!

Forum Chair Jane Chiodini completed the day with an update on travel health issues and new developments over the past year. A comprehensive handout in the form of a CD-ROM contained current information and new resources. Jane emphasised the importance of keeping up to date with developments in our field.

Thanks go to the RCN Events team, the exhibitors, the Primary Health Care Journal and our sponsors GlaxoSmithKline and Sanofi Pasteur MSD for a successful conference.

The prize draw saw one lucky delegate win a place at the Northern European Conference on Travel Medicine in Edinburgh, 7–10 June 2006 (see page two).

Richard, Jane and Sally join in the tsunami debate

Jane chats with Isabella Stevens and Ursula Shine, founder members of the forum

Sandra Grieve