Staying in TBE and LB endemic areas without using protective measures represent risk of getting the disease. The most effective measure to avoid TBE is vaccination, while the risk of tick bite can be reduced by using repellents, wearing protective clothes and practicing self-examination after returning from tick habitats. Our study shows, that effort to inform tourists about risks to get TBE or LB while staying in the endemic areas should be strengthened, especially for tourists coming from non endemic areas.

TRENDS IN ANTIMALARIAL PRESCRIPTIONS IN AUSTRALIA 2002-2005

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Objectives

The aim of this study was to investigate the trends in prescription of antimalarial drugs recommended for chemoprophylaxis in Australia from 2002-2005.

Methods

In 2007, data was extracted from the online Australian Statistics on Medicines reports published by the Pharmaceutical Benefits Advisory Committee, Drug Utilization Committee, on antimalarials used in Australia for the period 2002-2005.

Results

Doxycycline probably remains the malaria chemoprophylaxis of choice prescribed for Australians visiting multiple drug resistant malarious areas. Over the past 15 years, there has been marked drop in the prescription of less useful antifolate drugs, such as pyrimethamine-containing antimalarial drugs. There has also been a reduction in the number of prescriptions for chloroquine and proguanil, although the downward trend in prescriptions of mefloquine appears to have arrested and has trended upwards. The number of prescriptions for atovaquone and proguanil has been increasing dramatically, particularly since inclusion of this combination antimalarial in the prevailing Australian guidelines. Artemether plus lumefantrine combination is now available, but it is used in relatively small quantities.

Conclusions

The prescription of the antimalarials proguanil, chloroquine and the pyrimethamine containing compounds has been steadily reducing in number. Prescription of mefloquine trended upwards during 2002-2005, following a period of reducing prescriptions. The atovaquone plus proguanil combination has increased dramatically in use. Trends in antimalarial use may be influenced by a number of factors, including the availability of antimalarials, increasing resistance, the issuing of updated guidelines for malaria chemoprophylaxis, and continuing education.

KNOWLEDGE, ATTITUDES AND PRACTICES AMONG FOREIGN BACKPACKERS TOWARDS MALARIA RISK IN SOUTHEAST ASIA

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Objective

Malaria is still prevalent in Southeast Asia where large numbers of backpackers visited each year. This study aimed to assess the knowledge, attitude and practices among foreign backpackers towards malaria risk in Southeast Asia.

Method

Questionnaires were administered to foreign backpackers in Bangkok, Thailand. They were asked about their general background, their attitude to malaria risk and their preventive measure against malaria. Their knowledge about malaria was assessed by ten true-false questions in the questionnaires.

Result

In total, 434 questionnaires were evaluated. Fifty five percent of travellers were male and the median age was 28 years old. The main reason for travel was tourism (91%). Almost all travellers (94%) aware the risk of malaria. 22% of them would take antimalarial prophylaxis, 33% would use measure against mosquito bite, but nearly 40% had 'no prevention' at all. Mean knowledge score was only 5.52 of 10. Most backpackers (92%) knew that malaria is a serious disease and sometime fatal, 74% knew that some travellers could develop malaria after they return. However, up to 35% believed that taking dirty food could lead to malaria infection. And 49% believed that malaria could be 100% prevented by antimalarial medication. In backpackers who had travelled in the forest (n=65), only 54% use insect repellent regularly. Among those who had taken antimalarial prophylaxis, nearly 30% had stopped the medication prematurely.

Conclusion

Although most backpackers perceive the risk of malaria in Southeast Asia, they have some misunderstandings about malaria and tend to comply poorly with mosquito bite prevention and chemoprophylactic strategies.

THE ROYAL COLLEGE OF NURSING OF THE UNITED KINGDOM (RCN UK) TRAVEL HEALTH FORUM

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1 RCN Travel Health Forum

Travel Medicine in the United Kingdom is a nurse led specialty, with services provided mainly in Primary Care, but also in Occupational Health (Industry and the NHS), Armed Services, schools, universities, independent clinics and charitable organisations. The Royal College of Nursing (RCN) is a professional body for nurses, within which there are 75 Forums supporting the spectrum of specialist areas of practice. Currently membership of the Travel Health Forum (THF) is 5,309 with seven elected nurse members forming the Steering Committee They have a shared objective to support nurses in the field, to disseminate knowledge, promote education and best standards of practice and influence related National Policies. The poster describes some of the methods used to do this, including the 24 page Newsletter produced biannually, an informative website and well established annual conference. The THF was involved with the organisation and scientific programme for the Northern European Conference on Travel Medicine (NECTM) in Edinburgh in 2006 and similarly with the NECTM2 planned for Helsinki in 2008. The committee acts as a professional source of expert opinion to the RCN and advises on policy and accreditation matters when approached. At RCN Congress the forum gets involved in debates relevant to travel health and supports the RCN international agenda. The forum collaborates with the British Travel Health Association and other RCN forums where fields of practice cross. The Guidance for Practice Document produced in 2005 was the first of its kind available to describe minimum standards of practice for nurses working in the field. Competencies encompassing the skills and expertise required to manage and advise travellers, to promote best practice in patient centred care and to contribute to the health outcomes in UK travellers were developed and published in 2007. The Faculty of Travel Medicine (FTM) established in 2006 at the Royal College of Physicians and Surgeons of Glasgow (RCPSG) was the first Medical College to admit nurses.

AUSTRALASIAN FACULTY OF TRAVEL MEDICINE: ACTIVITIES OF A PROFESSIONAL ORGANISATION PROMOTING HEALTHY TRAVEL

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Background

The Australian Faculty of Travel Medicine (FTM), was established in 2000 by The Australasian College of Tropical Medicine (ACTM). It aims to provide professional representation for those working in travel medicine in Australasia.

Methods

The poster describes the major activities of the FTM which include: Faculty membership accreditation to Fellowship level; networking and scientific meetings of the Faculty; publications; development of policies in travel medicine; advocacy and public awareness; representation on external committees related to travel medicine; and a website.

Results

The FTM publishes a feature newsletter, the Travel Medicine Briefcase, twice per year, which is sent to all members of the FTM and the ACTM, as a supplement to the ACTM Bulletin. It has a secretariat supported by the ACTM based at the Australian Medical Association in Brisbane, Australia

(email. actm@tropmed.org). The FTM has developed a website: http://www.tropmed.org/travel/index.html, where information on the Faculty is provided, and it also hosts information for the New Zealand Society of Travel Medicine. Content and links to the website continue to be enhanced. Membership applications are accepted from doctors, nurses and other appropriate health professionals. The membership requirements for Fellowship are fairly stringent concerning the need for an applicant to be considered a reference person in travel health. There is some flexibility in the academic qualifications required; however a named postgraduate qualification in travel medicine is preferred. The FTM accepts the CTH designation of the International Society of Travel Medicine as an approved examination, as an option to an academic qualification required for Fellowship. The FTM publishes a textbook, now in its 3rd revised edition, through the ACTM, which is called the Primer of Travel Medicine. The FTM is also represented on the Australian Travel Health Advisory Group (URL. http://www.welltogo.com.au) and also contributes to scientific meetings, such as the Asia Pacific International Conference on Travel Medicine.

Conclusions

The FTM provides a useful platform and recognition for those professionals working in travel medicine in Australasia. The FTM is also making a useful contribution to the support of the field of travel medicine. Promotion of membership remains one of the FTM's major activities.

THE TASMANIAN EXPEDITION MEDICINE PROGRAM: TRAVEL MEDICINE TRAINING FOR TOMORROW'S GPS

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Registrars in the Australian General Practice Training system are encouraged to undertake Special Skills Posts in order to develop areas of special expertise. The Expedition Medicine Program was set up two years ago by General Practice Training Tasmania (Tasmania's Regional Training Provider that is responsible for the training of Registrars) to provide Registrars with an opportunity to develop skills in travel medicine and wilderness or expedition medicine. It is the first program in Australia to provide training in these fields. Registrars undertake a six month post based in a travel medicine clinic. Placements are currently available in Hobart and Canberra. The Registrars follows an on-line curriculum and workbook that is supported by regular tutorials from an experienced travel medicine specialist. In addition Registrars may choose other clinical activities and courses based on their interests and needs. This has included completing a Certificate in Travel Medicine, a diving medicine course, continuing mainstream general practice, up-skilling in emergency medicine, and teaching on Remote Area First Aid courses. All Registrars attend one or more short courses in Expedition Medicine that provides opportunities to develop practical skills in field medicine. This paper focuses on the practicalities of setting up and running a travel medicine post from the perspective of the travel physician, the Registrar, and the Regional Training Provider.

ABSENCE OF AVIAN INFLUENZA A (H5N1) INFECTION IN JAPANESE TRAVELLERS: AN EXPERIENCE AT THE LARGEST TRAVEL CLINIC IN TOKYO

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Objective

Avian influenza A (H5N1) has become endemic among birds throughout Asia and sporadic human cases have been occurring. Travellers may play a role to disseminate this infection to other areas in the world. The WHO suspected H5N1 case definition includes acute respiratory illness and a history of close contact with poultry in an area where H5N1 infection in birds has been reported. It remains uncertain that the definition is appropriate for travellers returning from H5N1-affected countries. We prospectively observed to elucidate the epidemiology of influenza in Japanese travellers.

Method

Febrile returning travellers with respiratory symptoms, who showed at the Travel Clinic, International Medical Center of Japan, Tokyo, from April 2007 until October 2007, received a rapid antigen test for influenza A and B (ESPLINE® INFLUENZA A&B-N, Fujirebio, Inc., Japan). In cases with positive influenza A by the rapid test and cases with pneumonia, if symptoms developed within 7 days after leaving the affected areas with confirmed cases of H5N1 avian influenza declared by WHO, nasal and throat swabs were sent to the Research Institute, International Medical Center of Japan for further investigation including influenza virus subtypes by RT-PCR and gene sequencing.

Results

There were 169 returning travellers seen at our clinic during the period. Fourteen (8%) patients had fever and respiratory symptoms simultaneously. Five (3%) patients (case-patients), who appeared from July until September, were positive for influenza A by the rapid antigen test and 1 patient returning from India had pneumonia. All the countries the case-patients visited were H5N1-affected: China (2), Vietnam (2), and Laos (1). Symptoms developed during travel in 1 case patient and within 2 days after leaving H5N1-affected countries in 4 case-patients. None of the case patients had exposure to poultry during travel. All the samples from the case-patients were negative for H5 and are receiving further analyses. One had a H3N2 isolate which was similar to human influenza A virus strain found outside Japan in 2007. In 3 case patients, influenza was considered to be transmitted to family members and close friends. There was no epidemic of influenza including H5N1 avian influenza in Tokyo during this period. None of the case-patients received influenza vaccination in the previous year.

Conclusion

Travellers are still at low risk of acquiring avian influenza A (H5N1) infection. However, human influenza is a common infectious disease in travellers returning from China and Southeast Asia from July until September. It is easily transmitted to close contacts and has a major impact on public health. Continuous surveillance for influenza in travellers returning from abroad is desperately needed and evaluation of patients with suspected H5N1 infection should be changed accordingly.

WHERE YOU WERE BORN MATTERS: THE PREVALENCE AND RISK FACTORS FOR SEXUALLY TRANSMITTED INFECTIONS/HIV FOR LOCAL, MIGRANT AND OVERSEAS FEMALE SEX WORKERS IN HONG KONG

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Objective

Sex workers have long been considered as reservoirs and vectors of sexually transmitted infections (STIs) in the community. In Hong Kong, a large proportion of female sex workers (FSWs) are new migrants or illegal overseas workers. This study aimed to find out the prevalence of STIs and HIV among the local, migrant and overseas of FSW and to identify the risk behaviours concerning sexual health

Methods

Community FSWs were recruited from the outreach team of an non-governmental organisation between 2005 to 2007. Details on their lifestyle and risky behaviour were recorded, together with the cervical smear and blood tests for various STIs and HIV were taken.

Results

503 FSWs were screened. 361 (71.8%) of them were new immigrants, 97 (19.3%) were local FSWs and 45 (8.9%) were overseas FSWs. The overall prevalence of hepatitis B surface antigen, syphilis, gonorrhoea, chlamydia, and HIV were 8.5%, 1.8%, 1.8%, 4.4%, and 0.2% respectively. Many more non-local FSWs worked on the street (91.1%), comparing with the other two groups (local: 4.1% and new immigrants: 2.8%). Syphilis (8.9%; Monte Carlo test $p = 0.01$) and gonorrhoea (6.7%; Monte Carlo test $p = 0.02$) were more prevalent among non-local FSWs than local and new migrant FSWs. Non-local FSW were also less likely to have had gynaecological examination and PAP smear tests, but more likely to always use condom when having oral sex with clients.

Conclusion

In the interest of public health it is important to identify different STI pattern among different groups of FSWs and, a coherent policy and target specific approach is required to effectively control the spread of STI/ HIV in the