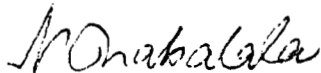


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INTERNATIONAL HEALTH REGULATIONS ACT, 1974 (ACT NO. 28 OF 1974)**PUBLICATION OF TEXT OF "INTERNATIONAL TRAVEL AND HEALTH: VACCINE REQUIREMENTS AND HEALTH ADVICE" (WORLD HEALTH ORGANIZATION)**

I, Mantombazana Edmie Tshabalala-Msimang, Minister of Health, hereby publish for purposes of the Supplementary Regulation under the International Health Regulations Act, 1974 (Act No. 28 of 1974), Chapters 5, 6 and the Country List: Vaccination Requirements of the World Health Organization titled "International Travel and Health: Vaccination Requirements and Health Advice" in the Schedule.

SCHEDULE

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MINISTER OF HEALTH

CHAPTER 5

Infectious diseases of potential risk for travellers

Depending on the travel destination, travellers may be exposed to a number of infectious diseases; exposure depends on the presence of infectious agents in the area to be visited. The risk of becoming infected will vary according to the purpose of the trip and the itinerary within the area, the standards of accommodation, hygiene and sanitation, as well as the behaviour of the traveller. In some instances, disease can be prevented by vaccination, but there are some infectious diseases, including some of the most important and most dangerous, for which no vaccines exist.

General precautions can greatly reduce the risk of exposure to infectious agents and should always be taken for visits to any destination where there is a significant risk of exposure. These precautions should be taken regardless of whether any vaccinations or medication have been administered.

Modes of transmission and general precautions

The modes of transmission for different infectious diseases and the corresponding general precautions are outlined in the following paragraphs.

Foodborne and waterborne diseases

Food- and waterborne diseases are transmitted by consumption of contaminated food and drink. The risk of infection is reduced by taking hygienic precautions with all food, drink and drinking-water consumed when travelling and by avoiding direct contact with polluted recreational waters (see Chapter 3). Examples of diseases transmitted by food and water are hepatitis A, typhoid fever and cholera.

Vector-borne diseases

A number of particularly serious infections are transmitted by insects and other vectors such as ticks. The risk of infection can be reduced by taking precautions

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to avoid insect bites and contact with other vectors in places where infection is likely to be present (see Chapter 3). Examples of vector-borne diseases are malaria, yellow fever, dengue and tick-borne encephalitis.

Zoonoses (diseases transmitted from animals)

Zoonoses include many infections that can be transmitted to humans through animal bites or contact with contaminated body fluids or faeces from animals, or by consumption of foods of animal origin, particularly meat and milk products. The risk of infection can be reduced by avoiding close contact with any animals—including wild, captive and domestic animals—in places where infection is likely to be present. Particular care should be taken to prevent children from approaching and handling animals. Examples of zoonoses are rabies, brucellosis, leptospirosis and certain viral haemorrhagic fevers.

Sexually transmitted diseases

Sexually transmitted diseases are passed from person to person through unsafe sexual practices. The risk of infection can be reduced by avoiding casual and unprotected sexual intercourse, and by use of condoms. Examples of sexually transmitted diseases are hepatitis B, HIV/AIDS and syphilis.

Bloodborne diseases

Bloodborne diseases are transmitted by direct contact with infected blood or other body fluids. The risk of infection can be reduced by avoiding direct contact with blood and body fluids, by avoiding the use of potentially contaminated needles and syringes for injection or any other medical or cosmetic procedure that penetrates the skin (including acupuncture, piercing and tattooing), and by avoiding transfusion of unsafe blood (see Chapter 8). Examples of bloodborne diseases are hepatitis B and C, HIV/AIDS and malaria.

Airborne diseases

Airborne diseases are transmitted from person to person by aerosol and droplets from the nose and mouth. The risk of infection can be reduced by avoiding close contact with people in crowded and enclosed places. Examples of airborne diseases are influenza, meningococcal disease and tuberculosis.

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Diseases transmitted from soil

Soil-transmitted diseases include those caused by dormant forms (spores) of infectious agents, which can cause infection by contact with broken skin (minor cuts, scratches, etc.). The risk of infection can be reduced by protecting the skin from direct contact with soil in places where soil-transmitted infections are likely to be present. Examples of bacterial diseases transmitted from soil are anthrax and tetanus. Certain intestinal parasitic infections, such as ascariasis and trichuriasis, are transmitted via soil and infection may result from consumption of soil-contaminated vegetables.

Specific infectious diseases involving potential health risks for travellers

The main infectious diseases to which travellers may be exposed, and precautions for each, are detailed on pages 47–70. Information on malaria, the most important infectious disease threat for travellers, is provided in Chapter 7. Other infectious diseases that affect travellers only rarely are not described in this book. The infectious diseases described in this chapter have been selected on the basis of the following criteria:

- diseases that have a sufficiently high global or regional prevalence to constitute a significant risk for travellers;
- diseases that are severe and life-threatening, even though the risk of exposure may be low for most travellers;
- diseases for which the perceived risk may be much greater than the real risk, and which may therefore cause anxiety to travellers;
- diseases that involve a public health risk due to transmission of infection to others by the infected traveller.

Information about available vaccines and indications for their use by travellers is provided in Chapter 6. Advice concerning the diseases for which vaccination is routinely administered in childhood, i.e. diphtheria, measles, mumps and rubella, pertussis, poliomyelitis and tetanus, and the use of the corresponding vaccines later in life and for travel, is also given in Chapter 6. These diseases are not included in this chapter.

The most common infectious illness to affect travellers, namely travellers' diarrhoea, is covered in Chapter 3. Because travellers' diarrhoea can be caused by many different foodborne and waterborne infectious agents, for which treatment and precautions are essentially the same, the illness is not included with the specific infectious diseases.

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Some of the diseases included in this chapter, such as brucellosis, HIV/AIDS, leishmaniasis and tuberculosis, have prolonged and variable incubation periods. Clinical manifestations of these diseases may appear long after the return from travel, so that the link with the travel destination where the infection was acquired may not be readily apparent.

ANTHRAX

Cause	<i>Bacillus anthracis</i> bacteria.
Transmission	Cutaneous infection, the most frequent clinical form of anthrax, occurs through contact with contaminated products from infected animals (mainly cattle, goats, sheep), such as leather or woollen goods, or through contact with soil containing anthrax spores.
Nature of the disease	A disease of herbivorous animals that occasionally causes acute infection in humans, usually involving the skin, as a result of contact with contaminated tissues or products from infected animals, or with anthrax spores in soil. Untreated infections may spread to regional lymph nodes and to the bloodstream, and may be fatal.
Geographical distribution	Sporadic cases occur in animals worldwide; there are occasional outbreaks in central Asia.
Risk for travellers	Very low for most travellers.
Prophylaxis	None. (A vaccine is available for people at high risk because of occupational exposure to <i>B. anthracis</i> ; it is not commercially available in most countries.)
Precautions	Avoid direct contact with soil and with products of animal origin, such as souvenirs made from animal skins.

BRUCELLOSIS

Cause	Several species of <i>Brucella</i> bacteria.
Transmission	Brucellosis is primarily a disease of animals. Infection occurs from cattle (<i>Brucella abortus</i>), dogs (<i>B. canis</i>), pigs (<i>B. suis</i>), or sheep and goats (<i>B. melitensis</i>), usually by direct contact with infected animals or by consumption of unpasteurized (raw) milk or cheese.
Nature of the disease	A generalized infection with insidious onset, causing continuous or intermittent fever and malaise, which may last for months if not treated adequately. Relapse is common after treatment.
Geographical distribution	Worldwide, in animals. It is most common in developing countries and the Mediterranean region.
Risk for travellers	Low for most travellers. Those visiting rural and agricultural areas may be at greater risk. There is also a risk in places where unpasteurized milk products are sold near tourist centres.
Prophylaxis	None.

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Precautions	Avoid consumption of unpasteurized milk and milk products and direct contact with animals, particularly cattle, goats and sheep.
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CHOLERA

Cause	<i>Vibrio cholerae</i> bacteria, serogroups O1 and O139.
Transmission	Infection occurs through ingestion of food or water contaminated directly or indirectly by faeces or vomitus of infected persons. Cholera affects only humans; there is no insect vector or animal reservoir host.
Nature of the disease	An acute enteric disease varying in severity. Most infections are asymptomatic (i.e. do not cause any illness). In mild cases, diarrhoea occurs without other symptoms. In severe cases, there is sudden onset of profuse watery diarrhoea with nausea and vomiting and rapid development of dehydration. In severe untreated cases, death may occur within a few hours due to dehydration leading to circulatory collapse.
Geographical distribution	Cholera occurs mainly in poor countries with inadequate sanitation and lack of clean drinking-water and in war-torn countries where the infrastructure may have broken down. Many developing countries are affected, particularly those in Africa and Asia, and to a lesser extent those in central and south America (see map, page 73).
Risk for travellers	Very low for most travellers, even in countries where cholera epidemics occur. Humanitarian relief workers in disaster areas and refugee camps are at risk.
Prophylaxis	Oral cholera vaccines for use by travellers and those in occupational risk groups are available in some countries (see Chapter 6).
Precautions	As for other diarrhoeal diseases. All precautions should be taken to avoid consumption of potentially contaminated food, drink and drinking-water. Oral rehydration salts should be carried to combat dehydration in case of severe diarrhoea (see Chapter 3).

DENGUE

Cause	The dengue virus—a flavivirus of which there are four serotypes.
Transmission	Dengue is transmitted by the <i>Aedes aegypti</i> mosquito, which bites during daylight hours. There is no direct person-to-person transmission. Monkeys act as a reservoir host in south-east Asia and west Africa.
Nature of the disease	Dengue occurs in three main clinical forms: <ul style="list-style-type: none"> ■ Dengue fever is an acute febrile illness with sudden onset of fever, followed by development of generalized symptoms and sometimes a macular skin rash. It is known as “breakbone fever” because of severe muscular pains. The fever may be biphasic (i.e. two separate episodes or waves of fever). Most patients recover after a few days. ■ Dengue haemorrhagic fever has an acute onset of fever followed by other symptoms resulting from thrombocytopenia, increased vascular permeability and haemorrhagic manifestations.

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	<p>■ Dengue shock syndrome supervenes in a small proportion of cases. Severe hypotension develops, requiring urgent medical treatment to correct hypovolaemia. Without appropriate treatment, 40–50% of cases are fatal; with timely therapy, the mortality rate is 1% or less.</p>
Geographical distribution	Dengue is widespread in tropical and subtropical regions of central and south America and south and south-east Asia and also occurs in Africa (see map, page 74); in these regions, dengue is limited to altitudes below 600 metres (2000 feet).
Risk for travellers	There is a significant risk for travellers in areas where dengue is endemic and in areas affected by epidemics of dengue.
Prophylaxis	None.
Precautions	Travellers should take precautions to avoid mosquito bites both during the day and at night in areas where dengue occurs.

FILARIASIS

Cause	The parasitic diseases covered by the term filariasis are caused by nematodes (roundworms) of the family Filarioidea. Diseases in this group include lymphatic filariasis and onchocerciasis (river blindness).
Transmission	Lymphatic filariasis is transmitted through the bite of infected mosquitoes, which inject larval forms of the nematode during a blood meal. Onchocerciasis is transmitted through the bite of infected blackflies.
Nature of the disease	<p>■ Lymphatic filariasis is a chronic parasitic disease in which adult filaria inhabit the lymphatic vessels, discharging microfilaria into the blood stream. Typical manifestations in symptomatic cases include filarial fever, lymphadenitis and retrograde lymphangitis.</p> <p>■ Onchocerciasis is a chronic parasitic disease occurring mainly in sub-Saharan west Africa in which adult worms are found in fibrous nodules under the skin. They discharge microfilaria, which migrate through the skin causing dermatitis, and reach the eye causing damage that results in blindness.</p>
Geographical distribution	Lymphatic filariasis occurs throughout sub-Saharan Africa and in much of south-east Asia. Onchocerciasis occurs mainly in western and central Africa, also in central and south America.
Risk for travellers	Generally low, unless travel involves extensive exposure to the vectors in endemic areas.
Prophylaxis	None.
Precautions	Avoid exposure to the bites of mosquitoes and/or blackflies in endemic areas.

GIARDIASIS

Cause	The protozoan parasite <i>Giardia lamblia</i> .
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Transmission	Infection usually occurs through ingestion of <i>Giardia</i> cysts in water (including both unfiltered drinking-water and recreational waters) contaminated by the faeces of infected humans or animals.
Nature of the disease	Many infections are asymptomatic. When symptoms occur, they are mainly intestinal, characterized by anorexia, chronic diarrhoea, abdominal cramps, bloating, frequent loose greasy stools, fatigue and weight loss.
Geographical distribution	Worldwide.
Risk for travellers	Significant risk for travellers in contact with recreational waters used by wildlife or with unfiltered water in swimming pools.
Prophylaxis	None.
Precautions	Avoid ingesting any potentially contaminated (i.e. unfiltered) drinking-water or recreational water.

HAEMOPHILUS MENINGITIS

Cause	<i>Haemophilus influenzae</i> type b (Hib) bacteria.
Transmission	Direct contact with an infected person (usually children).
Nature of the disease	Hib causes meningitis in infants and young children; it may also cause epiglottitis, osteomyelitis, pneumonia, sepsis and septic arthritis.
Geographical distribution	Worldwide. Hib disease is most common in countries where vaccination against Hib is not practised. It has almost disappeared in countries where routine childhood vaccination is carried out.
Risk for travellers	A risk for unvaccinated children visiting countries where Hib vaccination is not practised and where infection is therefore likely to be more common.
Prophylaxis	Vaccination of children (see Chapter 6).
Precautions	None.

HAEMORRHAGIC FEVERS

Haemorrhagic fevers are viral infections; important examples are Crimean–Congo haemorrhagic fever (CCHF), dengue, Ebola and Marburg haemorrhagic fevers, Lassa fever, Rift Valley fever (RVF) and yellow fever.

Dengue and yellow fever are described separately.

Cause	Viruses belonging to several families. Most haemorrhagic fevers, including dengue and yellow fever, are caused by flaviviruses; Ebola and Marburg are caused by filoviruses, CCHF by a bunyavirus, Lassa fever by an arenavirus, and RVF by a phlebovirus.
Transmission	Most viruses that cause haemorrhagic fevers are transmitted by mosquitoes. However, no insect vector has so far been identified for Ebola or Marburg viruses: these viruses are acquired by direct contact with the body fluids or secretions of infected patients. CCHF is transmitted by ticks. Lassa fever virus is carried by rodents and transmitted by excreta, either as aerosol

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	or by direct contact. RVF can be acquired either by mosquito bite or by direct contact with blood or tissues of infected animals (mainly sheep), including consumption of unpasteurized milk.
Nature of the diseases	The haemorrhagic fevers are severe acute viral infections, usually with sudden onset of fever, malaise, headache and myalgia followed by pharyngitis, vomiting, diarrhoea, skin rash and haemorrhagic manifestations. The outcome is fatal in a high proportion of cases (over 50%).
Geographical distribution	Diseases in this group occur widely in tropical and subtropical regions. Ebola and Marburg haemorrhagic fevers and Lassa fever occur in sub-Saharan Africa. CCHF occurs in the steppe regions of central Asia and in central Europe, as well as in tropical and southern Africa. RVF occurs in Africa and has recently spread to Saudi Arabia. Other viral haemorrhagic fevers occur in central and south America.
Risk for travellers	Very low for most travellers. However, travellers visiting rural or forest areas may be exposed to infection.
Prophylaxis	None (except for yellow fever).
Precautions	Avoid exposure to mosquitoes and ticks and contact with rodents.

HANTAVIRUS DISEASES

Hantavirus diseases are viral infections; important examples are haemorrhagic fever with renal syndrome (HFRS) and hantavirus pulmonary syndrome (HPS).

Cause	Hantaviruses, which belong to the family of bunyaviruses.
Transmission	Hantaviruses are carried by various species of rodents. Infection occurs through direct contact with the faeces, saliva or urine of infected rodents or by inhalation of the virus by aerosol transmission from rodent excreta.
Nature of the diseases	Acute viral diseases in which vascular endothelium is damaged, leading to increased vascular permeability, hypotension, haemorrhagic manifestations and shock. Impaired renal function with oliguria is characteristic of HFRS. Respiratory distress due to pulmonary oedema occurs in HPS. The outcome is fatal in up to 15% of HFRS cases and up to 50% of HPS cases.
Geographical distribution	Worldwide, in rodents.
Risk for travellers	Very low for most travellers. However, travellers may be at risk in any environment where rodents are present in large numbers and contact may occur.
Prophylaxis	None.
Precautions	Avoid exposure to rodents and their excreta. Adventure travellers, backpackers, campers and travellers with occupational exposure to rodents in areas endemic for hantaviruses should take precautions to exclude rodents from tents or other accommodation and to protect all food from contamination by rodents.

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HEPATITIS A

Cause	Hepatitis A virus, a member of the picornavirus family.
Transmission	The virus is acquired directly from infected persons by the faecal-oral route or by close contact, or by consumption of contaminated food or drinking-water. There is no insect vector or animal reservoir (although some non-human primates are sometimes infected).
Nature of the disease	An acute viral hepatitis with abrupt onset of fever, malaise, nausea and abdominal discomfort, followed by the development of jaundice a few days later. Infection in very young children is usually mild or asymptomatic; older children are at risk of symptomatic disease. The disease is more severe in adults, with illness lasting several weeks and recovery taking several months; case-fatality is greater than 2% for those over 40 years of age and 4% for those over 60.
Geographical distribution	Worldwide, but most common where sanitary conditions are poor and the safety of drinking-water is not well controlled (see map, page 75).
Risk for travellers	Non-immune travellers to developing countries are at significant risk of infection. The risk is particularly high for travellers exposed to poor conditions of hygiene, sanitation and drinking-water control.
Prophylaxis	Vaccination (see Chapter 6).
Precautions	Travellers who are non-immune to hepatitis A (i.e. have never had the disease and have not been vaccinated) should take particular care to avoid potentially contaminated food and water.

HEPATITIS B

Cause	Hepatitis B virus (HBV), belonging to the Hepadnaviridae.
Transmission	Infection is transmitted from person to person by contact with infected body fluids. Sexual contact is an important mode of transmission, but infection is also transmitted by transfusion of contaminated blood or blood products, or by use of contaminated needles or syringes for injections. There is also a potential risk of transmission through other skin-penetrating procedures including acupuncture, piercing and tattooing. Perinatal transmission may occur from mother to baby. There is no insect vector or animal reservoir.
Nature of the disease	Many HBV infections are asymptomatic or cause mild symptoms, which are often unrecognized in adults. When clinical hepatitis results from infection, it has a gradual onset, with anorexia, abdominal discomfort, nausea, vomiting, arthralgia and rash, followed by the development of jaundice in some cases. In adults, about 1% of cases are fatal. Chronic HBV infection persists in a proportion of adults, some of whom later develop cirrhosis and/or liver cancer.
Geographical distribution	Worldwide, but with differing levels of endemicity. In north America, Australia, northern and western Europe and New Zealand, prevalence of chronic HBV infection is relatively low (less than 2% of the general population) (see map, page 76).

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Risk for travellers	Negligible for those vaccinated against hepatitis B. Unvaccinated travellers are at risk if they have unprotected sex or use contaminated needles or syringes for injection, acupuncture, piercing or tattooing. An accident or medical emergency requiring blood transfusion may result in infection if the blood has not been screened for HBV. Travellers engaged in humanitarian relief activities may be exposed to infected blood or other body fluids in health care settings (see box, page 56).
Prophylaxis	Vaccination (see Chapter 6).
Precautions	Adopt safe sexual practices and avoid the use of any potentially contaminated instruments for injection or other skin-piercing activity.

HEPATITIS C

Cause	Hepatitis C virus (HCV), which is a flavivirus.
Transmission	The virus is acquired through person-to-person transmission by parenteral routes. Before screening for HCV became available, infection was mainly transmitted by transfusion of contaminated blood or blood products. Nowadays transmission frequently occurs through use of contaminated needles, syringes and other instruments used for injections and other skin-piercing procedures. Sexual transmission of hepatitis C occurs rarely. There is no insect vector or animal reservoir for HCV.
Nature of the disease	Most HCV infections are asymptomatic. In cases where infection leads to clinical hepatitis, the onset of symptoms is usually gradual, with anorexia, abdominal discomfort, nausea and vomiting, followed by the development of jaundice in some cases (less commonly than in hepatitis B). Most clinically affected patients will develop a long-lasting chronic infection, which may lead to cirrhosis and/or liver cancer.
Geographical distribution	Worldwide, with regional differences in levels of prevalence, as shown on the map (page 77).
Risk for travellers	Travellers are at risk if they practise unsafe behaviour involving the use of contaminated needles or syringes for injection, acupuncture, piercing or tattooing. An accident or medical emergency requiring blood transfusion (see box, page 56) may result in infection if the blood has not been screened for HCV. Travellers engaged in humanitarian relief activities may be exposed to infected blood or other body fluids in health care settings.
Prophylaxis	None.
Precautions	Adopt safe sexual practices and avoid the use of any potentially contaminated instruments for injection or other skin-piercing activity.

HEPATITIS E

Cause	Hepatitis E virus, which has not yet been definitively classified but probably belongs to the Caliciviridae.
Transmission	Hepatitis E is a waterborne disease usually acquired from contaminated drinking-water. Direct faecal-oral transmission from person to person is

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	also possible. There is no insect vector. It is suspected, but not proved, that hepatitis E may have a domestic animal reservoir host, such as pigs.
Nature of the disease	The clinical features and course of the disease are generally similar to those of hepatitis A. As with hepatitis A, there is no chronic phase. Young adults are most commonly affected. In pregnant women there is an important difference between hepatitis E and hepatitis A: during the third trimester of pregnancy, hepatitis E takes a much more severe form with a case-fatality rate reaching 20%.
Geographical distribution	Worldwide. Most cases, both sporadic and epidemic, occur in countries with poor standards of hygiene and sanitation.
Risk for travellers	Travellers to developing countries may be at risk when exposed to poor conditions of sanitation and drinking-water control.
Prophylaxis	None.
Precautions	Travellers should follow the general conditions for avoiding potentially contaminated food and drinking-water (see Chapter 3).

HIV/AIDS AND OTHER SEXUALLY TRANSMITTED INFECTIONS

The most important sexually transmitted diseases and infectious agents are:

HIV/AIDS	human immunodeficiency virus
hepatitis B	hepatitis B virus
syphilis	<i>Treponema pallidum</i>
gonorrhoea	<i>Neisseria gonorrhoeae</i>
chlamydial infections	<i>Chlamydia trachomatis</i>
trichomoniasis	<i>Trichomonas vaginalis</i>
chancroid	<i>Haemophilus ducreyi</i>
genital herpes	herpes simplex virus (human (alpha) herpesvirus 1)
genital warts	human papillomavirus

Travel restrictions

Some countries have adopted entry and visa restrictions for people with HIV/AIDS. Travellers who are infected with HIV should consult their personal physician for a detailed assessment and advice before travel. WHO has taken the position that there is no public health justification for entry restrictions that discriminate solely on the basis of a person's HIV status.

Transmission	Infection occurs during unprotected sexual intercourse. Hepatitis B, HIV and syphilis may also be transmitted in contaminated blood and blood products, by contaminated syringes and needles used for injection, and potentially by unsterilized instruments used for acupuncture, piercing and tattooing.
Nature of the diseases	Most of the clinical manifestations are included in the following syndromes: genital ulcer, pelvic inflammatory disease, urethral discharge and vaginal discharge. However, many infections are asymptomatic. Sexually transmitted infections are a major cause of acute illness, infertility, long-term disability and death, with severe medical and psychological consequences for millions of men, women and children.

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Apart from being serious diseases in their own right, sexually transmitted infections increase the risk of HIV infection. The presence of an untreated disease (ulcerative or non-ulcerative) can increase by a factor of up to 10 the risk of becoming infected with HIV and transmitting the infection. On the other hand, early diagnosis and improved management of other sexually transmitted infections can reduce the incidence of HIV infection by up to 40%. Prevention and treatment of all sexually transmitted infections are therefore important for the prevention of HIV infection.

Geographical distribution	Worldwide (see map, page 78). The regional differences in the prevalence of HIV infection are shown on the map (page 78). Sexually transmitted infections have been known since ancient times; they remain a major public health problem, which was compounded by the appearance of HIV/AIDS around 1980. An estimated 340 million episodes of curable sexually transmitted infections (chlamydial infections, gonorrhoea, syphilis, trichomoniasis) occur throughout the world every year. Viral infections, which are more difficult to treat, are also very common in many populations. Genital herpes is becoming a major cause of genital ulcer, and subtypes of the human papillomavirus are associated with cervical cancer.
Risk for travellers	<p>For some travellers there may be an increased risk of infection. Lack of information about risk and preventive measures and the fact that travel and tourism enhance the probability of having sex with casual partners increase the risk of exposure to sexually transmitted infections. In some developed countries, a large proportion of sexually transmitted infections now occur as a result of unprotected sexual intercourse during international travel.</p> <p>In addition to transmission through sexual intercourse (both heterosexual and homosexual—anal, vaginal or oral), most of these infections can be passed on from an infected mother to her unborn or newborn baby. Hepatitis B, HIV and syphilis are also transmitted through transfusion of contaminated blood or blood products and the use of contaminated needles (see box, page 56).</p> <p>There is no risk of acquiring any sexually transmitted infection from casual day-to-day contact at home, at work or socially. People run no risk of infection when sharing any means of communal transport (e.g. aircraft, boat, bus, car, train) with infected individuals. There is no evidence that HIV or other sexually transmitted infections can be acquired from insect bites.</p>
Prophylaxis	Vaccination against hepatitis B (see Chapter 6). No prophylaxis is available for any of the other sexually transmitted diseases.
Precautions	Male or female condoms, when properly used, have proved to be effective in preventing the transmission of HIV and other sexually transmitted infections, and for reducing the risk of unwanted pregnancy. Latex rubber condoms are relatively inexpensive, are highly reliable and have virtually no side-effects. The transmission of HIV and other infections during sexual intercourse can be effectively prevented when high-quality condoms are used correctly and consistently. Studies on serodiscordant couples (only one of whom is HIV-positive) have shown that, with regular sexual intercourse over a period of two years, partners who consistently use condoms have a near-zero risk of HIV infection.

Accidental exposure to blood or other body fluids

Accidental exposure to blood or other body fluids may occur in health care settings, during natural or manmade disasters, or as a result of accidents or acts of violence. This may lead to infection by bloodborne pathogens, particularly hepatitis B and C viruses and HIV. The average risk of seroconversion to HIV after a single percutaneous exposure to HIV-infected blood is 0.3%; the risk for hepatitis C is 3% and for hepatitis B it is 10–30%.

Accidental exposure to potentially infected blood or other body fluids is a medical emergency. The following measures should be taken without delay.

Percutaneous exposure

In the case of injury with equipment contaminated with blood or contact of broken skin with blood or other body fluids, allow the wound to bleed freely; wash the wound and surrounding skin immediately with soap and water and rinse. Disinfect the wound and surrounding skin with a suitable disinfectant such as:

- povidone iodine 2.5% for 5 minutes, or
- alcohol 70% for 3 minutes.

Exposure of the eyes or mucous membranes

Rinse the exposed area immediately with an isotonic saline solution for 10 minutes. In the case of contamination of mucosa of the eye, disinfect with chlorhexidine-cetrimide 0.05%, 3 drops given twice at an interval of 10 minutes. If neither saline nor disinfectant is available, use clean water.

In all cases, a physician should be contacted immediately.

Under certain conditions, the use of a combination of antiretroviral drugs is the recommended prophylactic intervention to prevent transmission of HIV after accidental exposure to infected blood or other body fluids. The decision to provide this treatment depends on a number of factors, including the HIV status of the source individual, the nature of the body fluid involved, the severity of exposure and the period between the exposure and the beginning of treatment (which should never be more than 48 hours). Repatriation should be carried out as soon as possible.

If HIV and hepatitis B and C testing has been done, subsequent tests will be necessary 6 weeks following exposure and 6 months following exposure. People who test positive at these stages should be offered psychological support.

After accidental exposure, the exposed individual should not have unprotected sexual intercourse until the 6-months post-exposure tests confirm that he/she is not seropositive. Women should avoid becoming pregnant during this period.

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A man should always use a condom during sexual intercourse, each time, from start to finish, and a woman should make sure that her partner uses one. A woman can also protect herself from sexually transmitted infections by using a female condom—essentially, a vaginal pouch—which is now commercially available in some countries.

It is essential to avoid injecting drugs for non-medical purposes, and particularly to avoid any type of needle-sharing to reduce the risk of acquiring hepatitis, HIV, syphilis and other infections from contaminated needles and blood.

Medical injections using unsterilized equipment are also a possible source of infection. If an injection is essential, the traveller should try to ensure that the needles and syringes come from a sterile package or have been sterilized properly by steam or boiling water for 20 minutes.

Patients under medical care who require frequent injections, e.g. diabetics, should carry sufficient sterile needles and syringes for the duration of their trip and a doctor's authorization for their use.

Unsterile dental and surgical instruments, needles used in acupuncture and tattooing, ear-piercing devices, and other skin-piercing instruments can likewise transmit infection and should be avoided.

Treatment

Travellers with signs or symptoms of a sexually transmitted disease should cease all sexual activity and seek medical care immediately. The absence of symptoms does not guarantee absence of infection, and travellers exposed to unprotected sex should be tested for infection on returning home. HIV testing should always be voluntary and with counselling.

The sexually transmitted infections caused by bacteria, e.g. chancroid, chlamydia, gonorrhoea and syphilis, can be treated successfully, but there is no single antimicrobial that is effective against more than one or two of them. Moreover, throughout the world, many of these bacteria are showing increased resistance to penicillin and other antimicrobials.

Treatment for sexually transmitted viral infections, e.g. hepatitis B, genital herpes and genital warts, is unsatisfactory due to lack of specific medication, and cure is difficult to achieve. The same is true of HIV infection, which in its late stage causes AIDS and is thought to be invariably fatal. Antiretroviral drugs cannot completely eradicate the HIV virus; treatment is expensive and complex and most countries have only a few centres that are able to provide it.

INFLUENZA**Cause**

Influenza viruses of types A, B and C; type A occurs in two subtypes (H1N1 and H3N2). Type A viruses cause most of the widespread influenza epidemics; type B viruses generally cause regional outbreaks, and type C are of minor significance for humans.

Influenza viruses evolve rapidly, changing their antigenic characteristics, so that vaccines need to be modified each year to be effective against currently circulating influenza strains.

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	Other types and subtypes of influenza viruses occur in animals and birds; transmission and reassortment between species may give rise to new subtypes able to infect humans.
Transmission	Airborne transmission of influenza viruses occurs particularly in crowded enclosed spaces. Transmission also occurs by direct contact with droplets disseminated by unprotected coughs and sneezes and contamination of the hands.
Nature of the disease	An acute respiratory infection of varying severity, ranging from asymptomatic infection to fatal disease. Initial symptoms include fever with rapid onset, sore throat, cough and chills, often accompanied by headache, coryza, myalgia and prostration. Influenza may be complicated by viral or more often bacterial pneumonia. Illness tends to be most severe in the elderly and in young children. Death resulting from influenza occurs mainly in the elderly and in individuals with pre-existing chronic diseases.
Geographical distribution	Worldwide. In temperate regions, influenza is a seasonal disease occurring in winter: it affects the northern hemisphere from November to March and the southern hemisphere from April to September. In tropical areas there is no clear seasonal pattern, and influenza may occur at any time of the year.
Risk for travellers	Travellers, like local residents, are at risk in any country during the influenza season. Travellers visiting countries in the opposite hemisphere during the influenza season are at special risk, particularly if they have not built up some degree of immunity through regular vaccination. The elderly, people with pre-existing chronic diseases and young children are most susceptible.
Prophylaxis	Vaccination before the start of the influenza season. However, vaccine for visitors to the opposite hemisphere is unlikely to be obtainable before arrival at the travel destination (see Chapter 6). For travellers in the highest risk groups for severe and complicated influenza who have not been or cannot be vaccinated, the prophylactic use of antiviral drugs such as zanamivir and oseltamivir is indicated in countries where they are available. Amantidine and rimantidine may also be considered.
Precautions	Whenever possible, avoid crowded enclosed spaces and close contact with people suffering from acute respiratory infections.

JAPANESE ENCEPHALITIS

Cause	Japanese encephalitis (JE) virus, which is a flavivirus.
Transmission	The virus is transmitted by various mosquitoes of the genus <i>Culex</i> . It infects pigs and various wild birds as well as humans. Mosquitoes become infective after feeding on viraemic pigs or birds.
Nature of the disease	Most infections are asymptomatic. In symptomatic cases, severity varies; mild infections are characterized by febrile headache or aseptic meningitis. Severe cases have a rapid onset and progression, with headache, high fever and meningeal signs. There may be neurological sequelae after recovery. Approximately 50% of severe clinical cases have a fatal outcome.

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Geographical distribution	JE occurs in a number of countries in Asia (see map, page 79) and occasionally in northern Queensland, Australia.
Risk for travellers	Low for most travellers. Visitors to rural and agricultural areas in endemic countries may be at risk, particularly during epidemics of JE.
Prophylaxis	Vaccination, if justified by likelihood of exposure (see Chapter 6).
Precautions	Avoid mosquito bites (see Chapter 3).

LEGIONELLOSIS

Cause	Various species of <i>Legionella</i> bacteria, frequently <i>Legionella pneumophila</i> , serogroup I.
Transmission	Infection results from inhalation of contaminated water sprays or mists. The bacteria live in water and colonize hot-water systems at temperatures of 20–50 °C (optimal 35–46 °C). They contaminate air-conditioning cooling towers, hot-water systems, humidifiers, whirlpool spas and other water-containing devices. There is no direct person-to-person transmission.
Nature of the disease	Legionellosis occurs in two distinct clinical forms: <ul style="list-style-type: none"> ■ Legionnaires disease is an acute bacterial pneumonia with rapid onset of anorexia, malaise, myalgia, headache and rapidly rising fever, progressing to pneumonia, which may lead to respiratory failure and death. ■ Pontiac fever is an influenza-like illness with spontaneous recovery after 2–5 days. <p>Susceptibility to legionellosis increases with age, especially among smokers and people with pre-existing chronic lung disease or other immunocompromising conditions.</p>
Geographical distribution	Worldwide.
Risk for travellers	Generally low. Outbreaks occasionally occur through dissemination of infection by contaminated water or air-conditioning systems in hotels and other facilities used by visitors.
Prophylaxis	None. Prevention of infection depends on regular cleaning and disinfection of possible sources.
Precautions	None.

LEISHMANIASIS (including espundia or oriental sore, and kala-azar)

Cause	Several species of the protozoan parasite <i>Leishmania</i> .
Transmission	Infection is transmitted by the bite of female phlebotomine sandflies. Dogs, rodents and other mammals are reservoir hosts for leishmaniasis. Sandflies acquire the parasites by biting infected humans or animals. Transmission from person to person by injected blood or contaminated syringes and needles is also possible.

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Nature of the disease	Leishmaniasis occurs in two main forms: <ul style="list-style-type: none"> ■ Cutaneous and mucosal leishmaniasis (espundia) cause skin sores and chronic ulcers of the mucosae. Cutaneous leishmaniasis is a chronic, progressive, disabling and often mutilating disease. ■ Visceral leishmaniasis (kala-azar) affects the bone marrow, liver, spleen, lymph nodes and other internal organs. It is usually fatal if untreated.
Geographical distribution	Many countries in tropical and subtropical regions, including Africa, parts of central and south America, Asia, southern Europe and the eastern Mediterranean. Over 90% of all cases of visceral leishmaniasis occur in Bangladesh, Brazil, India, Nepal and Sudan. More than 90% of all cases of cutaneous leishmaniasis occur in Afghanistan, Algeria, Brazil, the Islamic Republic of Iran, Saudi Arabia and the Syrian Arab Republic.
Risk for travellers	Generally low. Visitors to rural and forested areas in endemic countries are at risk.
Prophylaxis	None.
Precautions	Avoid sandfly bites, particularly after sunset, by using repellents and insecticide-impregnated bednets. The bite leaves a non-swollen red ring, which can alert the traveller to its origin.

LEPTOSPIROSIS (including Weil disease)

Cause	Various spirochaetes of the genus <i>Leptospira</i> .
Transmission	Infection occurs through contact between the skin (particularly skin abrasions) or mucous membranes and water, wet soil or vegetation contaminated by the urine of infected animals, notably rats. Occasionally infection may result from direct contact with urine or tissues of infected animals, or from consumption of food contaminated by the urine of infected rats.
Nature of the disease	Leptospiral infections take many different clinical forms, usually with sudden onset of fever, headache, myalgia, chills, conjunctival suffusion and skin rash. The disease may progress to meningitis, haemolytic anaemia, jaundice, haemorrhagic manifestations and other complications, including hepatorenal failure.
Geographical distribution	Worldwide. Most common in tropical countries.
Risk for travellers	Low for most travellers. There is occupational risk for farmers in paddy rice and sugar cane production. Visitors to rural areas and in contact with water in canals, lakes and rivers may be exposed to infection. There is increased risk after recent floods. The risk may be greater for those who practise canoeing, kayaking or other activities in water.
Prophylaxis	None. Vaccine against local strains is available for workers where the disease is an occupational hazard but is not commercially available in most countries.
Precautions	Avoid swimming or wading in potentially contaminated waters including canals, ponds, rivers, streams and swamps. Avoid all direct or indirect contact with rodents.

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LISTERIOSIS

Cause	The bacterium <i>Listeria monocytogenes</i> .
Transmission	Listeriosis affects a variety of animals. Foodborne infection in humans occurs through the consumption of contaminated foods, particularly unpasteurized milk, soft cheeses, vegetables and prepared meat products such as pâté. Listeriosis multiplies readily in refrigerated foods that have been contaminated, unlike most foodborne pathogens. Transmission can also occur from mother to fetus or from mother to child during birth.
Nature of the disease	Listeriosis causes meningoencephalitis and/or septicaemia in adults and newborn infants. In pregnant women, it causes fever and abortion. Newborn infants, pregnant women, the elderly and immunocompromised individuals are particularly susceptible to listeriosis. In others, the disease may be limited to a mild acute febrile episode. In pregnant women, transmission of infection to the fetus may lead to stillbirth, septicaemia at birth or neonatal meningitis.
Geographical distribution	Worldwide, with sporadic incidence.
Risk for travellers	Generally low. Risk is increased by consumption of unpasteurized milk and milk products and prepared meat products.
Prophylaxis	None.
Precautions	Avoid consumption of unpasteurized milk and milk products. Pregnant women and immunocompromised individuals should take stringent precautions to avoid infection by listeriosis and other foodborne pathogens (see Chapter 3).

LYME BORRELIOSIS (Lyme disease)

Cause	The spirochaete <i>Borrelia burgdorferi</i> , of which there are several different serotypes.
Transmission	Infection occurs through the bite of infected ticks, both adults and nymphs, of the genus <i>Ixodes</i> . Most human infections result from bites by nymphs. Many species of mammals can be infected, and deer act as an important reservoir.
Nature of the disease	The disease usually has its onset in summer. Early skin lesions have an expanding ring form, often with a central clear zone. Fever, chills, myalgia and headache are common. Meningeal involvement may follow. Central nervous system and other complications may occur weeks or months after the onset of illness. Arthritis may develop up to 2 years after onset.
Geographical distribution	There are endemic foci of Lyme borreliosis in forested areas of Asia, north-western, central and eastern Europe, and the USA.
Risk for travellers	Generally low. Visitors to rural areas in endemic regions, particularly campers and hikers, are at risk.
Prophylaxis	A vaccine available in the USA provides protection against the specific serotype endemic in the USA (see Chapter 6).

MALARIA

See Chapter 7 and map, page 80.

MENINGOCOCCAL DISEASE

Cause	The bacterium <i>Neisseria meningitidis</i> , of which 12 serotypes are known. Most cases of meningococcal disease are caused by serogroups A, B and C; less commonly, infection is caused by serogroups Y and W-135. Epidemics in Africa are usually caused by <i>N. meningitidis</i> type A.
Transmission	Transmission occurs by direct person-to-person contact, including aerosol transmission and respiratory droplets from the nose and pharynx of infected persons, patients or asymptomatic carriers. There is no animal reservoir or insect vector.
Nature of the disease	Most infections do not cause clinical disease. Many infected people become asymptomatic carriers of the bacteria and serve as a reservoir and source of infection for others. In general, susceptibility to meningococcal disease decreases with age, although there is a small increase in risk in adolescents and young adults. Meningococcal meningitis has a sudden onset of intense headache, fever, nausea, vomiting, photophobia and stiff neck, plus various neurological signs. The disease is fatal in 5–10% of cases even with prompt antimicrobial treatment in good health care facilities; among individuals who survive, up to 20% have permanent neurological sequelae. Meningococcal septicaemia, in which there is rapid dissemination of bacteria in the bloodstream, is a less common form of meningococcal disease, characterized by circulatory collapse, haemorrhagic skin rash and high fatality rate.
Geographical distribution	Sporadic cases are found worldwide. In temperate zones, most cases occur in the winter months. Localized outbreaks occur in enclosed crowded spaces (e.g. dormitories, military barracks). In sub-Saharan Africa, in a zone stretching across the continent from Senegal to Ethiopia (the African "meningitis belt"), large outbreaks and epidemics take place during the dry season (November–June).
Risk for travellers	Generally low. However, the risk is considerable if travellers are in crowded conditions or take part in large population movements such as pilgrimages in the Sahel meningitis belt. Localized outbreaks occasionally occur among travellers (usually young adults) in camps or dormitories. See also Chapter 6 for specific risks for travellers.
Prophylaxis	Vaccination is available for <i>N. meningitidis</i> types A, C, Y and W-135 (see Chapter 6).
Precautions	Avoid overcrowding in confined spaces. Following close contact with a person suffering from meningococcal disease, medical advice should be sought regarding chemoprophylaxis.

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PLAGUE

Cause	The plague bacillus, <i>Yersinia pestis</i> .
Transmission	Plague is a zoonotic disease affecting rodents and transmitted by fleas from rats to other animals and to humans. Direct person-to-person transmission does not occur except in the case of pneumonic plague, when respiratory droplets may transfer the infection from the patient to others in close contact.
Nature of the disease	<p>Plague occurs in three main clinical forms:</p> <ul style="list-style-type: none"> ■ Bubonic plague is the form that usually results from the bite of infected fleas. Lymphadenitis develops in the drainage lymph nodes, with the regional lymph nodes most commonly affected. Swelling, pain and suppuration of the lymph nodes produces the characteristic plague buboes. ■ Septicaemic plague may develop from bubonic plague or occur in the absence of lymphadenitis. Dissemination of the infection in the bloodstream results in meningitis, endotoxic shock and disseminated intravascular coagulation. ■ Pneumonic plague may result from secondary infection of the lungs following dissemination of plague bacilli from other body sites. It produces severe pneumonia. Direct infection of others may result from transfer of infection by respiratory droplets, causing primary pulmonary plague in the recipients. <p>Without prompt and effective treatment, 50–60% of cases of bubonic plague are fatal, while untreated septicaemic and pneumonic plague are invariably fatal.</p>
Geographical distribution	There are natural foci of plague infection of rats in many parts of the world. Wild rodent plague is present in central, eastern and southern Africa, south America, the western part of north America and in large areas of Asia. In some areas, contact between wild and domestic rats is common, resulting in sporadic cases of human plague and occasional outbreaks.
Risk for travellers	Generally low. However, travellers in rural areas of plague-endemic regions may be at risk, particularly if camping or hunting or if contact with rodents takes place.
Prophylaxis	A vaccine effective against bubonic plague is available exclusively for persons with a high occupational exposure to plague; it is not commercially available in most countries.
Precautions	Avoid any contact with live or dead rodents.

RABIES

Cause	The rabies virus, a rhabdovirus of the genus <i>Lyssavirus</i> .
Transmission	Rabies is a zoonotic disease affecting a wide range of domestic and wild animals, including bats. Infection of humans usually occurs through the bite of an infected animal. The virus is present in the saliva. Any other contact involving penetration of the skin occurring in an area where rabies is present should be treated with caution. In developing countries

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Rabies post-exposure treatment

In a rabies-endemic area, the circumstances of an animal bite, other contact with the animal, and the animal's behaviour and appearance may suggest that it is rabid. In such situations, medical advice should be obtained immediately.

Post-exposure treatment to prevent the establishment of rabies infection involves first-aid treatment of the wound followed by administration of rabies vaccine and antirabies immunoglobulin in the case of class 3 exposure. The administration of vaccine, and immunoglobulin if required, must be carried out, or directly supervised, by a physician.

Post-exposure treatment depends on the type of contact with the confirmed or suspect rabid animal, as follows:

Type of contact (class of exposure)	Recommended treatment
1. Touching or feeding animals Licks on the skin	None
2. Nibbling unbroken skin Minor scratches without bleeding Licks on broken skin	Administer vaccine immediately
3. Single or multiple bites or scratches with skin penetration Contamination of mucous membrane by saliva from licking	Administer antirabies immunoglobulin and vaccine immediately

First-aid treatment

Since elimination of the rabies virus at the site of infection by chemical or physical means is the most effective mechanism of protection, immediate vigorous washing and flushing with soap or detergent and water, or water alone, is imperative. Following washing, apply either ethanol (70%) or tincture or aqueous solution of iodine or povidone iodine.

Specific treatment

Antirabies immunoglobulin (RIG) is applied by instillation into the depth of the wound and by infiltration of the surrounding tissues. As much as possible of the total RIG volume required should be instilled into the wound. Vaccine² is applied by intradermal or intramuscular injection in schedules requiring several doses (4 or 5 doses by intramuscular injection, depending on the vaccine used), with the first dose being administered as soon as possible after exposure and the last dose within 28 days for intramuscular or 90 days for intradermal vaccination.

Patients who have been vaccinated prophylactically against rabies with a full course of cell-culture or duck-embryo vaccine can be given a shorter course of post-exposure treatment with fewer doses; they do not require RIG. Urgent post-exposure treatment remains essential whether or not patients have been previously vaccinated.

¹ Treatment can be stopped if the suspect animal is shown by appropriate laboratory examination to be free of rabies or, in the case of domestic dogs and cats, if the animal remains healthy throughout a 10-day observation period.

² Modern rabies vaccines, made from cell-culture or duck-embryo-derived rabies virus which is then purified and inactivated, are replacing the older vaccines produced in brain tissue.

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	transmission is usually from dogs. Person-to-person transmission has not been documented.
Nature of the disease	An acute viral encephalomyelitis, which is almost invariably fatal. The initial signs include a sense of apprehension, headache, fever, malaise and sensory changes around the site of the animal bite. Excitability, hallucinations and aerophobia are common, followed in some cases by fear of water (hydrophobia) due to spasms of the swallowing muscles, progressing to delirium, convulsions and death a few days after onset. A less common form, paralytic rabies, is characterized by loss of sensation, weakness, pain and paralysis.
Geographical distribution	Rabies is present in animals in many countries worldwide (see map, page 82). Most cases of human infection occur in developing countries.
Risk for travellers	In rabies-endemic areas, travellers may be at risk if there is contact with both wild and domestic animals, including dogs and cats.
Prophylaxis	Vaccination for travellers with a foreseeable significant risk of exposure to rabies or travelling to a hyperendemic area where modern rabies vaccine may not be available (see Chapter 6).
Precautions	Avoid contact with wild animals and stray domestic animals, particularly dogs and cats, in rabies-endemic areas. If bitten by an animal that is potentially infected with rabies, or after other suspect contact, immediately clean the wound thoroughly with disinfectant or with soap or detergent and water. Medical assistance should be sought immediately (see box, page 64). The vaccination status of the animal involved should not be a criterion for withholding post-exposure treatment, unless the vaccination has been thoroughly documented and vaccine of known potency has been used. In the case of domestic animals, the suspect animal should be kept under observation for a period of 10 days.

SCHISTOSOMIASIS (bilharziasis)

Cause	Several species of parasitic blood flukes (trematodes), of which the most important are <i>Schistosoma mansoni</i> , <i>S. japonicum</i> and <i>S. haematobium</i> .
Transmission	Infection occurs in fresh water containing larval forms (cercariae) of schistosomes, which develop in snails. The free-swimming larvae penetrate the skin of individuals swimming or wading in water. Snails become infected as a result of excretion of eggs in human urine or faeces.
Nature of the disease	Chronic conditions in which adult flukes live for many years in the veins (mesenteric or vesical) of the host where they produce eggs, which cause damage to the organs in which they are deposited. The symptoms depend on the main target organs affected by the different species, with <i>S. mansoni</i> and <i>S. japonicum</i> causing hepatic and intestinal signs and <i>S. haematobium</i> causing urinary dysfunction. The larvae of some schistosomes of birds and other animals may penetrate human skin and cause a self-limiting dermatitis, "swimmers itch". These larvae are unable to develop in humans.

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Geographical distribution	<i>S. mansoni</i> occurs in many countries of sub-Saharan Africa, in the Arabian peninsula, and in Brazil, Suriname and Venezuela. <i>S. japonicum</i> is found in China, in parts of Indonesia, and in the Philippines (but no longer in Japan). <i>S. haematobium</i> is present in sub-Saharan Africa and in eastern Mediterranean areas.
Risk for travellers	In endemic areas, travellers are at risk while swimming or wading in fresh water.
Prophylaxis	None.
Precautions	Avoid direct contact (swimming or wading) with potentially contaminated fresh water in endemic areas. In case of accidental exposure, dry the skin vigorously to reduce penetration by cercariae. Avoid drinking, washing, or washing clothing in water that may contain cercariae. Water can be treated to remove or inactivate cercariae by paper filtering or use of iodine or chlorine.

TICK-BORNE ENCEPHALITIS (spring-summer encephalitis)

Cause	The tick-borne encephalitis (TBE) virus, which is a flavivirus. Other closely related viruses cause similar diseases.
Transmission	Infection is transmitted by the bite of infected ticks. There is no direct person-to-person transmission. Some related viruses, also tick-borne, infect animals such as birds, deer (louping-ill), rodents and sheep.
Nature of the disease	Infection may induce an influenza-like illness, with a second phase of fever occurring in 10% of cases. Encephalitis develops during the second phase and may result in paralysis, permanent sequelae or death. Severity of illness increases with age.
Geographical distribution	Present in large parts of Europe, particularly Austria, the Baltic States (Estonia, Latvia, Lithuania), the Czech Republic, Hungary and the Russian Federation. The disease is seasonal, occurring mainly during the summer months in rural and forest areas at altitudes up to 1000 metres.
Risk for travellers	In endemic areas during the summer months, travellers are at risk when hiking or camping in rural or forest areas.
Prophylaxis	A vaccine against TBE is available (see Chapter 6).
Precautions	Avoid bites by ticks by wearing long trousers and closed footwear when hiking or camping in endemic areas. If a bite occurs, the tick should be removed as soon as possible.

TRYPANOSOMIASIS**1. African trypanosomiasis (sleeping sickness)**

Cause	Protozoan parasites <i>Trypanosoma brucei gambiense</i> and <i>T. b. rhodesiense</i> .
Transmission	Infection occurs through the bite of infected tsetse flies. Humans are the main reservoir host for <i>T. b. gambiense</i> . Domestic cattle and wild animals, including antelopes, are the main animal reservoir of <i>T. b. rhodesiense</i> .

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Nature of the disease	<i>T. b. gambiense</i> causes a chronic illness with onset of symptoms after a prolonged incubation period of weeks or months. <i>T. b. rhodesiense</i> causes a more acute illness, with onset a few days or weeks after the infected bite; often, there is a striking inoculation chancre. Initial clinical signs include severe headache, insomnia, enlarged lymph nodes, anaemia and rash. In the late stage of the disease, there is progressive loss of weight and involvement of the central nervous system. Without treatment, the disease is invariably fatal.
Geographical distribution	<i>T. b. gambiense</i> is present in foci in the tropical countries of western and central Africa. <i>T. b. rhodesiense</i> occurs in east Africa, extending south as far as Botswana.
Risk for travellers	Travellers are at risk in endemic regions if they visit rural areas for hunting, fishing, safari trips, sailing or other activities in remote areas.
Prophylaxis	None.
Precautions	Travellers should be aware of the risk in endemic areas and as far as possible avoid any contact with tsetse flies. However, bites are difficult to avoid because tsetse flies can bite through clothing. Travellers should be warned that tsetse flies bite during the day and are not repelled by available insect-repellent products. The bite is painful, which helps to identify its origin, and travellers should seek medical attention promptly if symptoms develop subsequently.
2. American trypanosomiasis (Chagas disease)	
Cause	Protozoan parasite <i>Trypanosoma cruzi</i> .
Transmission	Infection is transmitted by blood-sucking triatomine bugs ("kissing bugs"). During feeding, infected bugs excrete trypanosomes, which can then contaminate the conjunctiva, mucous membranes, abrasions and skin wounds including the bite wound. Transmission also occurs by blood transfusion when blood has been obtained from an infected donor. Congenital infection is possible; due to parasites crossing the placenta during pregnancy. <i>T. cruzi</i> infects many species of wild and domestic animals as well as humans.
Nature of the disease	In adults, <i>T. cruzi</i> causes a chronic illness with progressive myocardial damage leading to cardiac arrhythmias and cardiac dilatation, and gastrointestinal involvement leading to mega-oesophagus and megacolon. <i>T. cruzi</i> causes acute illness in children, which is followed by chronic manifestations later in life.
Geographical distribution	American trypanosomiasis occurs in Mexico and in central and south America (as far south as central Argentina and Chile). The vector is found mainly in rural areas where it lives in the walls of poorly-constructed housing.
Risk for travellers	In endemic areas, travellers are at risk when trekking, camping or using poor-quality housing.
Precautions	Avoid exposure to blood-sucking bugs. Residual insecticides can be used to treat housing. Exposure can be reduced by the use of bednets in houses and camps.

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TUBERCULOSIS

Cause	<i>Mycobacterium tuberculosis</i> , the tubercle bacillus. Humans can also become infected by bovine tuberculosis, caused by <i>M. bovis</i> .
Transmission	Infection is usually by direct airborne transmission from person to person.
Nature of the disease	Exposure to <i>Mycobacterium tuberculosis</i> may lead to infection, but most infections do not lead to disease. The risk of developing disease following infection is generally 5–10% during the lifetime, but may be increased by various factors, notably immunosuppression (e.g. advanced HIV infection). Multidrug resistance refers to strains of <i>M. tuberculosis</i> that are resistant to at least isoniazid and rifampicin. The resistant strains do not differ from other strains in infectiousness, likelihood of causing disease, or general clinical effects; however, if they do cause disease, treatment is more difficult and the risk of death will be higher.
Geographical distribution	Worldwide. The risk of infection differs between countries, as shown on the map of estimated TB incidence (page 83).
Risk for travellers	Low for most travellers. Long-term travellers (over 3 months) to a country with a higher incidence of tuberculosis than their own may have a risk of infection comparable to that for local residents. As well as the duration of the visit, living conditions are important in determining the risk of infection: high-risk settings include health facilities, shelters for the homeless, and prisons.
Prophylaxis	BCG vaccine is of limited use for travellers but may be advised for infants and young children in some situations (see Chapter 6).
Precautions	Travellers should avoid close contact with known tuberculosis patients. For travellers from low-incidence countries who may be exposed to infection in relatively high-incidence countries (e.g. health professionals, humanitarian relief workers, missionaries), a baseline tuberculin skin test is advisable in order to compare with retesting after return. If the skin reaction to tuberculin suggests recent infection, the traveller should receive, or be referred for, treatment for latent infection. Patients under treatment for tuberculosis should not travel until the treating physician has documented, by laboratory examination of sputum, that the patient is not infectious and therefore of no risk to others. The importance of completing the prescribed course of treatment should be stressed.

TYPHOID FEVER

Cause	<i>Salmonella typhi</i> , the typhus bacillus, which infects only humans. Similar paratyphoid and enteric fevers are caused by other species of <i>Salmonella</i> , which infect domestic animals as well as humans.
Transmission	Infection is transmitted by consumption of contaminated food or water. Occasionally direct faecal–oral transmission may occur. Shellfish taken from sewage-polluted beds are an important source of infection. Infection occurs through eating fruit and vegetables fertilized by night soil and eaten raw, and milk and milk products that have been contaminated by those in contact with them. Flies may transfer infection to foods, resulting in contamination

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	that may be sufficient to cause human infection. Pollution of water sources may produce epidemics of typhoid fever, when large numbers of people use the same source of drinking-water.
Nature of the disease	A systemic disease of varying severity. Severe cases are characterized by gradual onset of fever, headache, malaise, anorexia and insomnia. Constipation is more common than diarrhoea in adults and older children. Without treatment, the disease progresses with sustained fever, bradycardia, hepatosplenomegaly, abdominal symptoms and, in some cases, pneumonia. In white-skinned patients, pink spots (papules), which fade on pressure, appear on the skin of the trunk in up to 50% of cases. In the third week, untreated cases develop additional gastrointestinal and other complications, which may prove fatal. Around 2–5% of those who contract typhoid fever become chronic carriers, as bacteria persist in the biliary tract after symptoms have resolved.
Geographical distribution	Worldwide. The disease occurs most commonly in association with poor standards of hygiene in food preparation and handling and where sanitary disposal of sewage is lacking.
Risk for travellers	Generally low risk for travellers, except in parts of north and west Africa, in south Asia and in Peru. Elsewhere, travellers are usually at risk only when exposed to low standards of hygiene with respect to food handling, control of drinking-water quality, and sewage disposal.
Prophylaxis	Vaccination (see Chapter 6).
Precautions	Observe all precautions against exposure to foodborne and waterborne infections (see Chapter 3).

TYPHUS FEVER (epidemic louse-borne typhus)

Cause	<i>Rickettsia prowazekii</i> .
Transmission	The disease is transmitted by the human body louse, which becomes infected by feeding on the blood of patients with acute typhus fever. Infected lice excrete rickettsia onto the skin while feeding on a second host, who becomes infected by rubbing louse faecal matter or crushed lice into the bite wound. There is no animal reservoir.
Nature of the disease	The onset is variable but often sudden, with headache, chills, high fever, prostration, coughing and severe muscular pain. After 5–6 days, a macular skin eruption (dark spots) develops first on the upper trunk and spreads to the rest of the body but usually not to the face, palms of the hands or soles of the feet. The case-fatality rate is up to 40% in the absence of specific treatment. Louse-borne typhus fever is the only rickettsial disease that can cause explosive epidemics.
Geographical distribution	Typhus fever occurs in colder (i.e. mountainous) regions of central and east Africa, central and south America and Asia. In recent years, most outbreaks have taken place in Burundi, Ethiopia and Rwanda. Typhus fever occurs in conditions of overcrowding and poor hygiene, such as prisons and refugee camps.

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Risk for travellers	Very low for most travellers. Humanitarian relief workers may be exposed in refugee camps and other settings characterized by crowding and poor hygiene.
Prophylaxis	None.
Precautions	Cleanliness is important in preventing infestation by body lice. Insecticidal powders are available for body-lice control and treatment of clothing for those at high risk of exposure.

YELLOW FEVER

Cause	The yellow fever virus, an arbovirus of the <i>Flavivirus</i> genus.
Transmission	<p>Yellow fever in urban and some rural areas is transmitted by the bite of infective <i>Aedes aegypti</i> mosquitoes and by other mosquitoes in the forests of south America. The mosquitoes bite during daylight hours. Transmission occurs at altitudes up to 2500 metres. Yellow fever virus infects humans and monkeys.</p> <p>In jungle and forest areas, monkeys are the main reservoir of infection, with transmission from monkey to monkey carried out by mosquitoes. The infective mosquitoes may bite humans who enter the forest area, usually causing sporadic cases or small outbreaks.</p> <p>In urban areas, monkeys are not involved and infection is transmitted among humans by mosquitoes. Introduction of infection into densely populated urban areas can lead to large epidemics of yellow fever.</p> <p>In Africa, an intermediate pattern of transmission is common in humid savannah regions. Mosquitoes infect both monkeys and humans, causing localized outbreaks.</p>
Nature of the disease	Although some infections are asymptomatic, most lead to an acute illness characterized by two phases. Initially, there is fever, muscular pain, headache, chills, anorexia, nausea and/or vomiting, often with bradycardia. About 15% of patients progress to a second phase after a few days, with resurgence of fever, development of jaundice, abdominal pain, vomiting and haemorrhagic manifestations; half of these patients die 10–14 days after onset of illness.
Geographical distribution	The yellow fever virus is endemic in some tropical areas of Africa and central and south America (see map, page 84). The number of epidemics has increased since the early 1980s. Other countries are considered to be at risk of introduction of yellow fever due to the presence of the vector and suitable primate hosts (including Asia, where yellow fever has never been reported).
Risk for travellers	Travellers are at risk in all areas where yellow fever is endemic. The risk is greatest for visitors who enter forest and jungle areas.
Prophylaxis	Vaccination (see Chapter 6). In some countries, yellow fever vaccination is mandatory for visitors (see country list).
Precautions	Avoid mosquito bites during the day as well as at night (see Chapter 3).

CHAPTER 5. INFECTIOUS DISEASES OF POTENTIAL RISK FOR TRAVELLERS

Further reading

Disease outbreak news: <http://www.who.int/disease-outbreak-news/index.html>

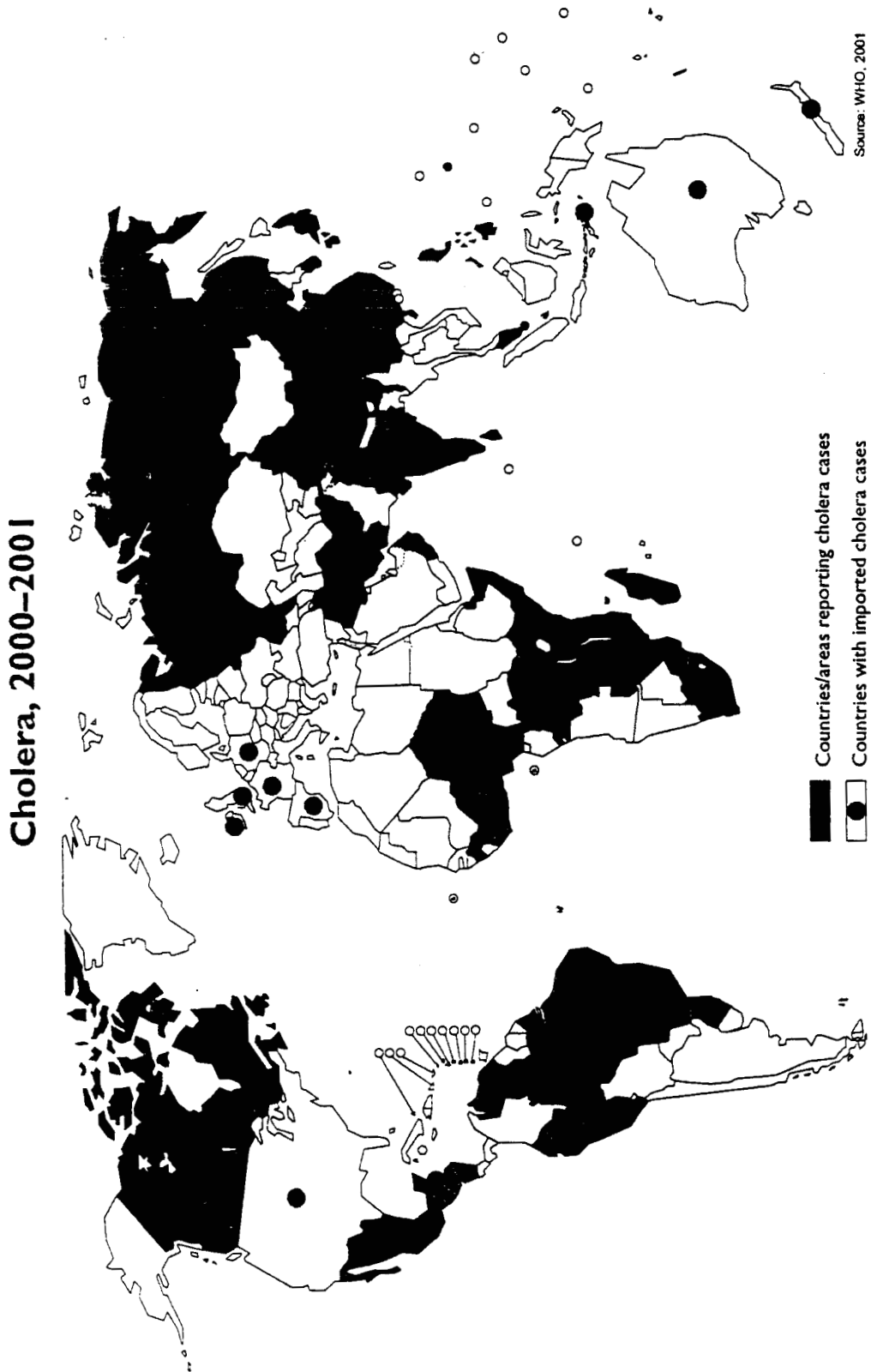
Weekly epidemiological record: <http://www.who.int/wer/>

Chin J, ed. *Control of communicable diseases manual*, 17th ed. Washington, DC, American Public Health Association, 2000.

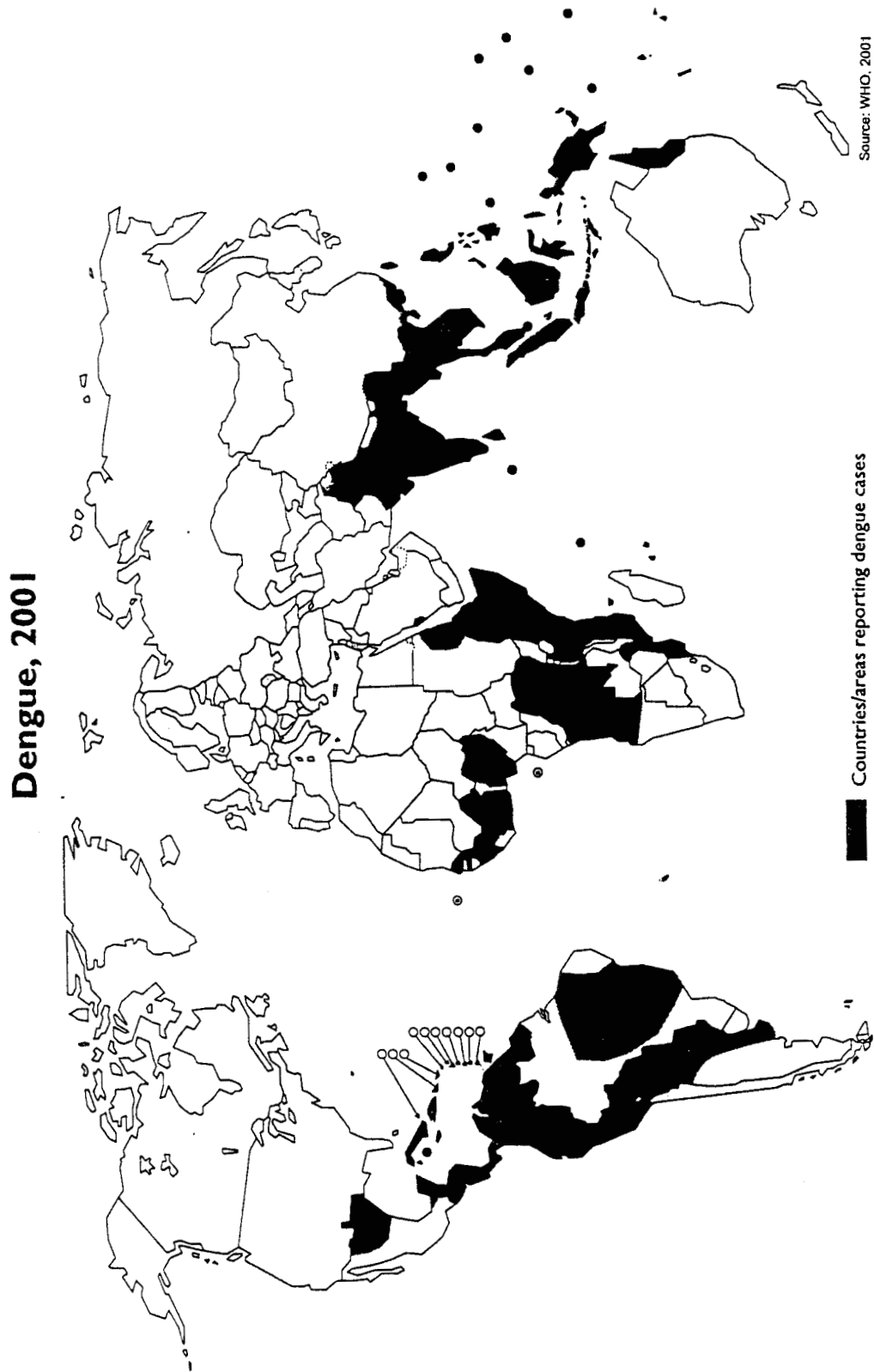
Cholera: basic facts for travellers: <http://www.who.int/emc/diseases/cholera/factstravellers.html>

WHO information on infectious diseases: <http://www.who.int/emc/diseases/index.html>;
<http://www.who.int/infectious-disease-news>

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Hepatitis A, 2001



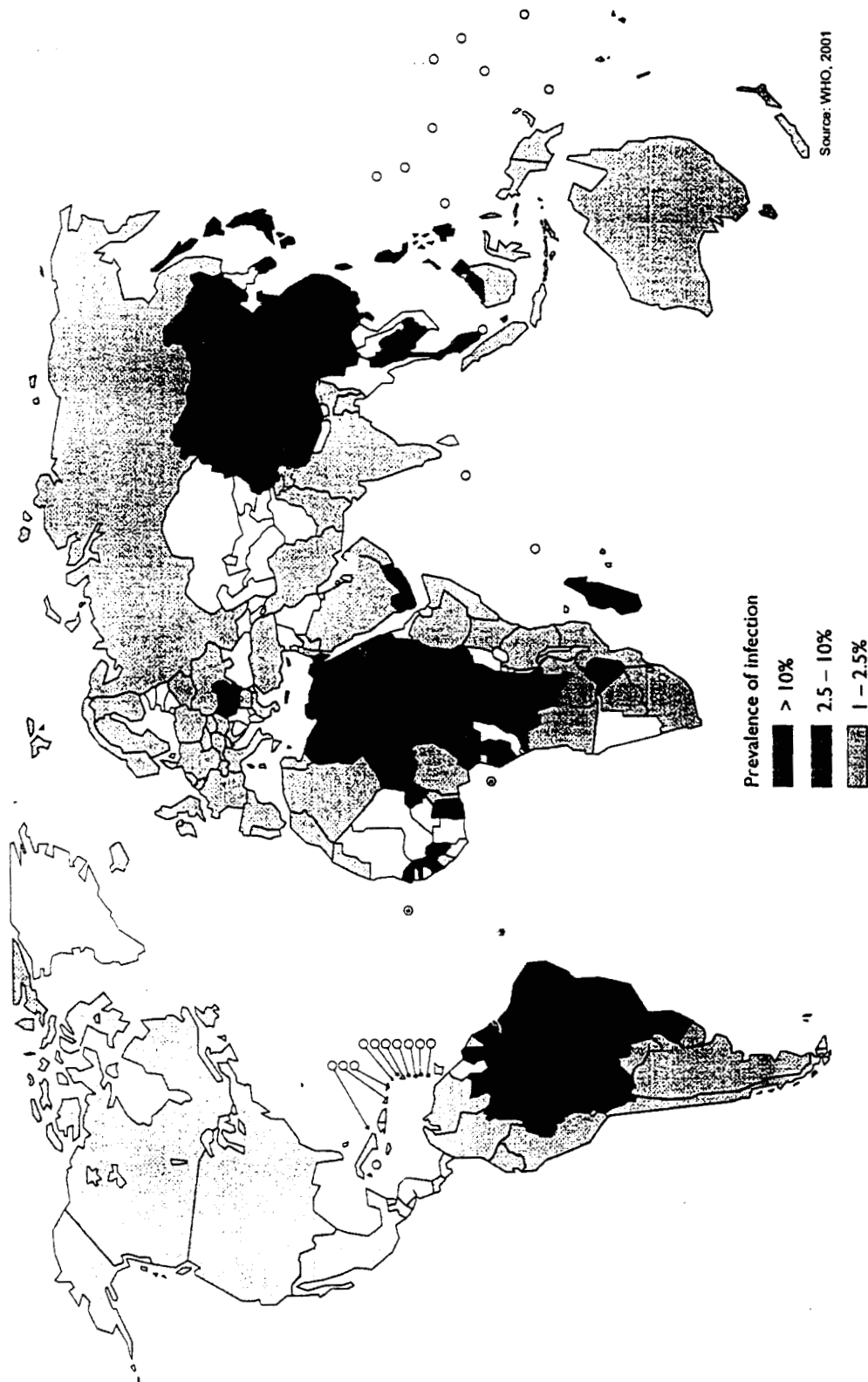
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Hepatitis B, 2001



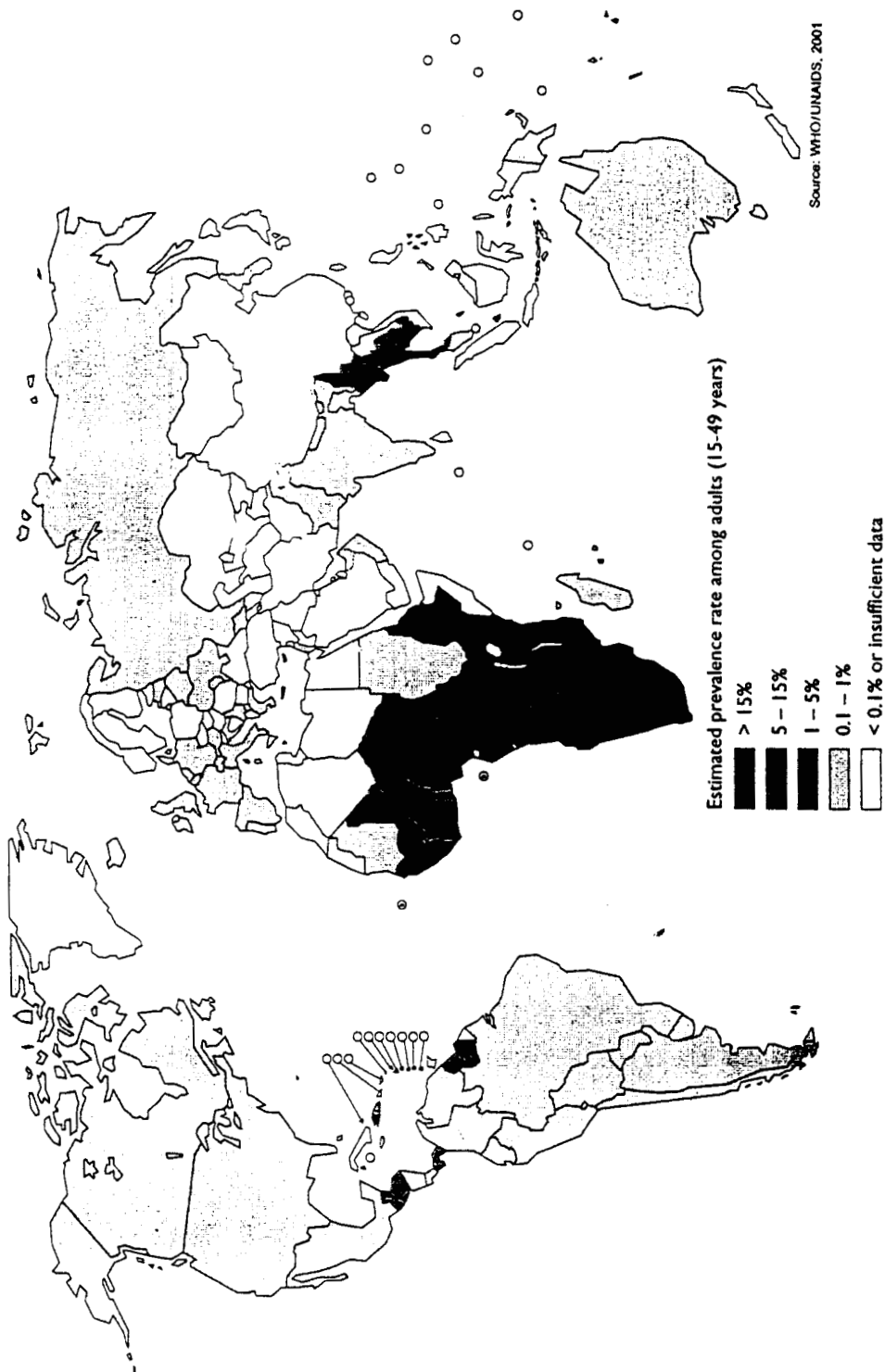
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Hepatitis C, 2001



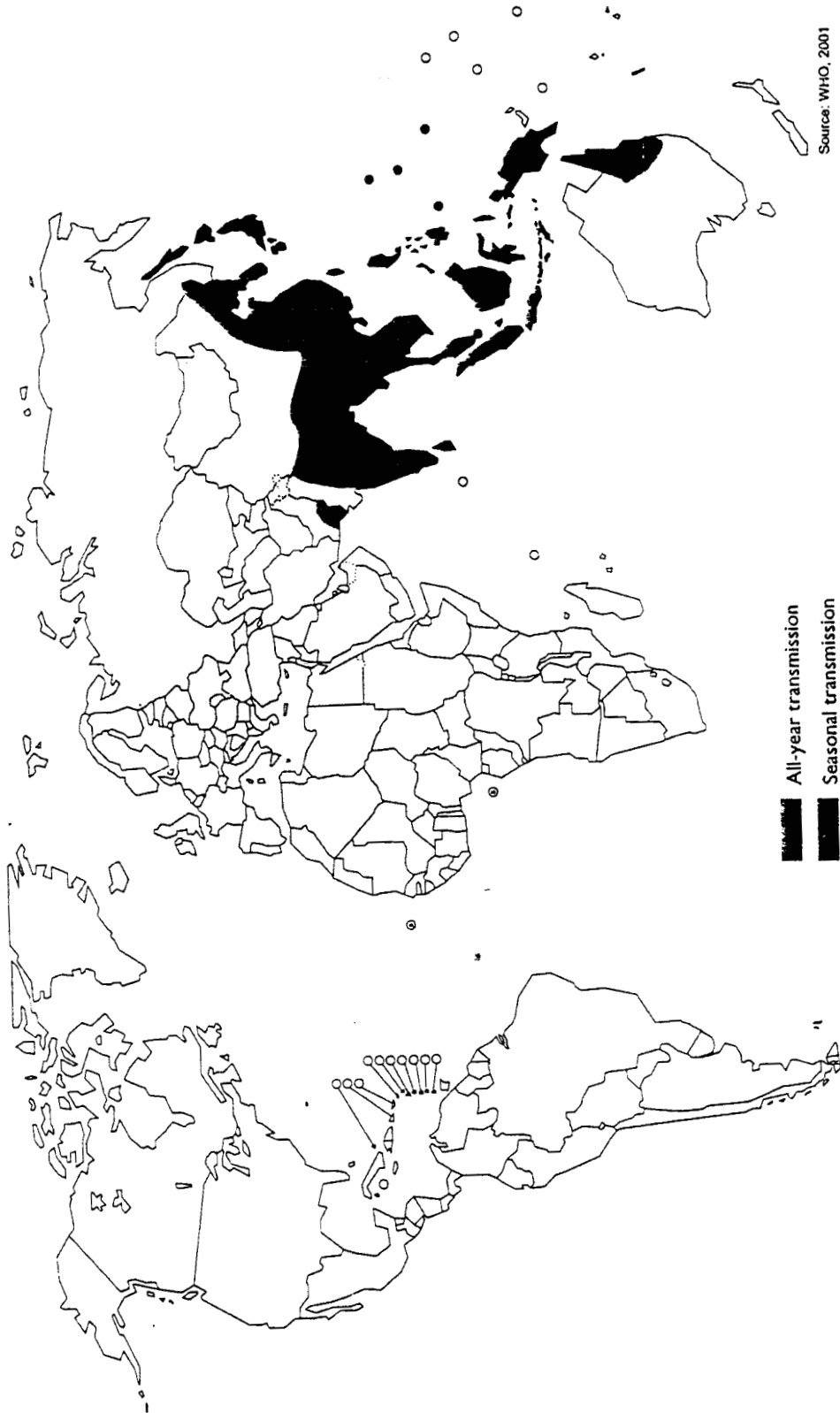
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HIV infection, end 1999

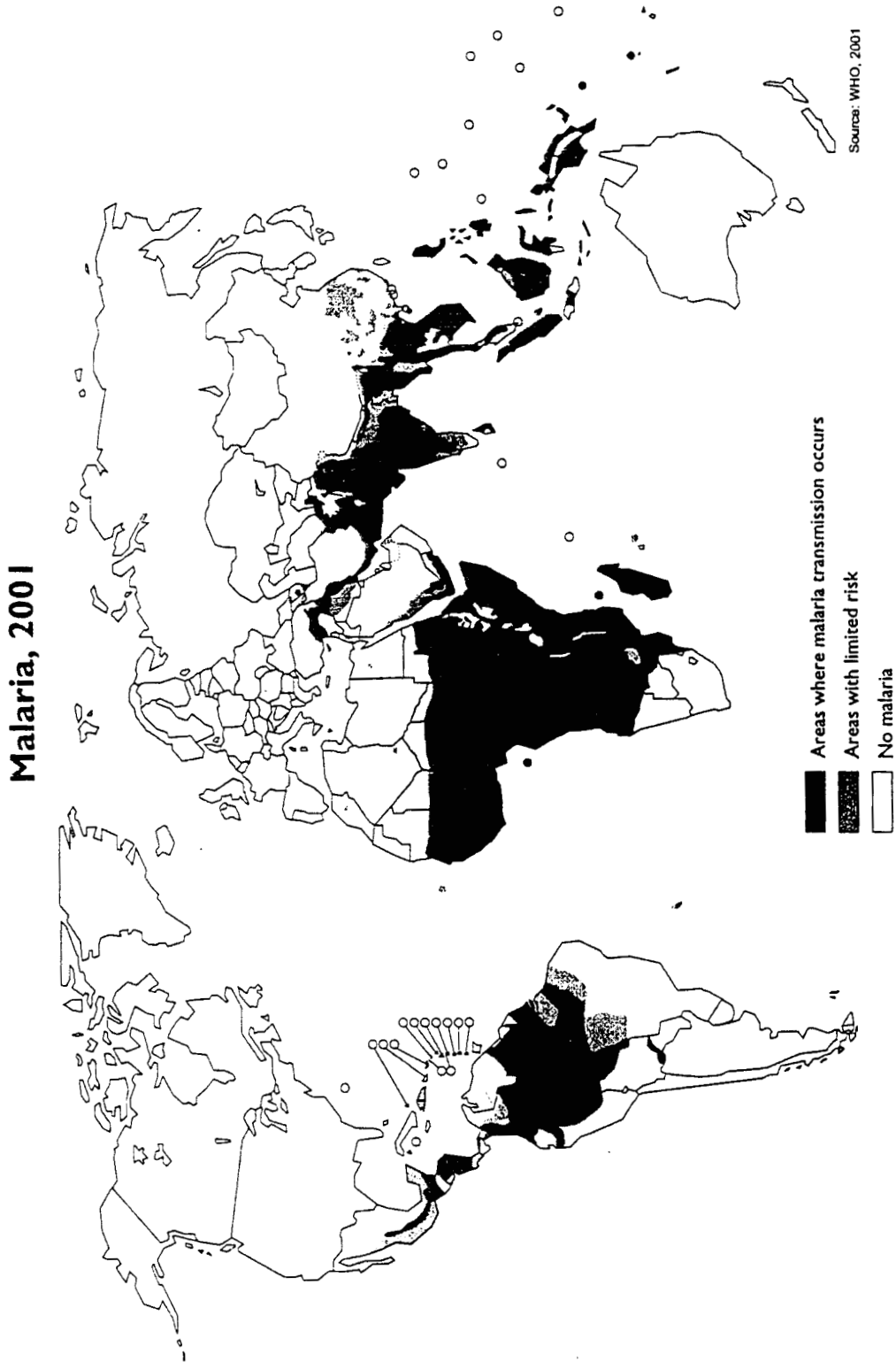


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Japanese encephalitis, 2001

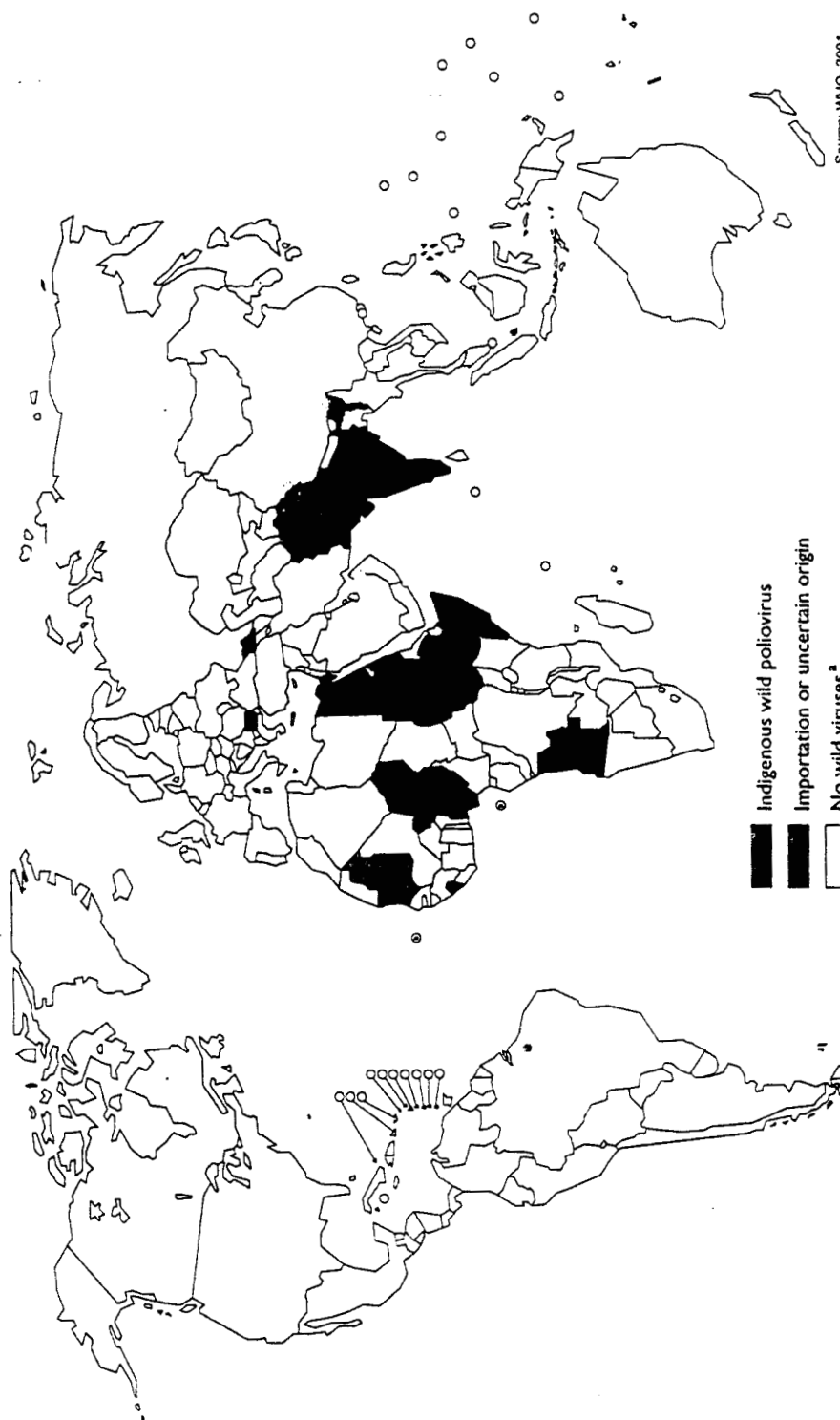


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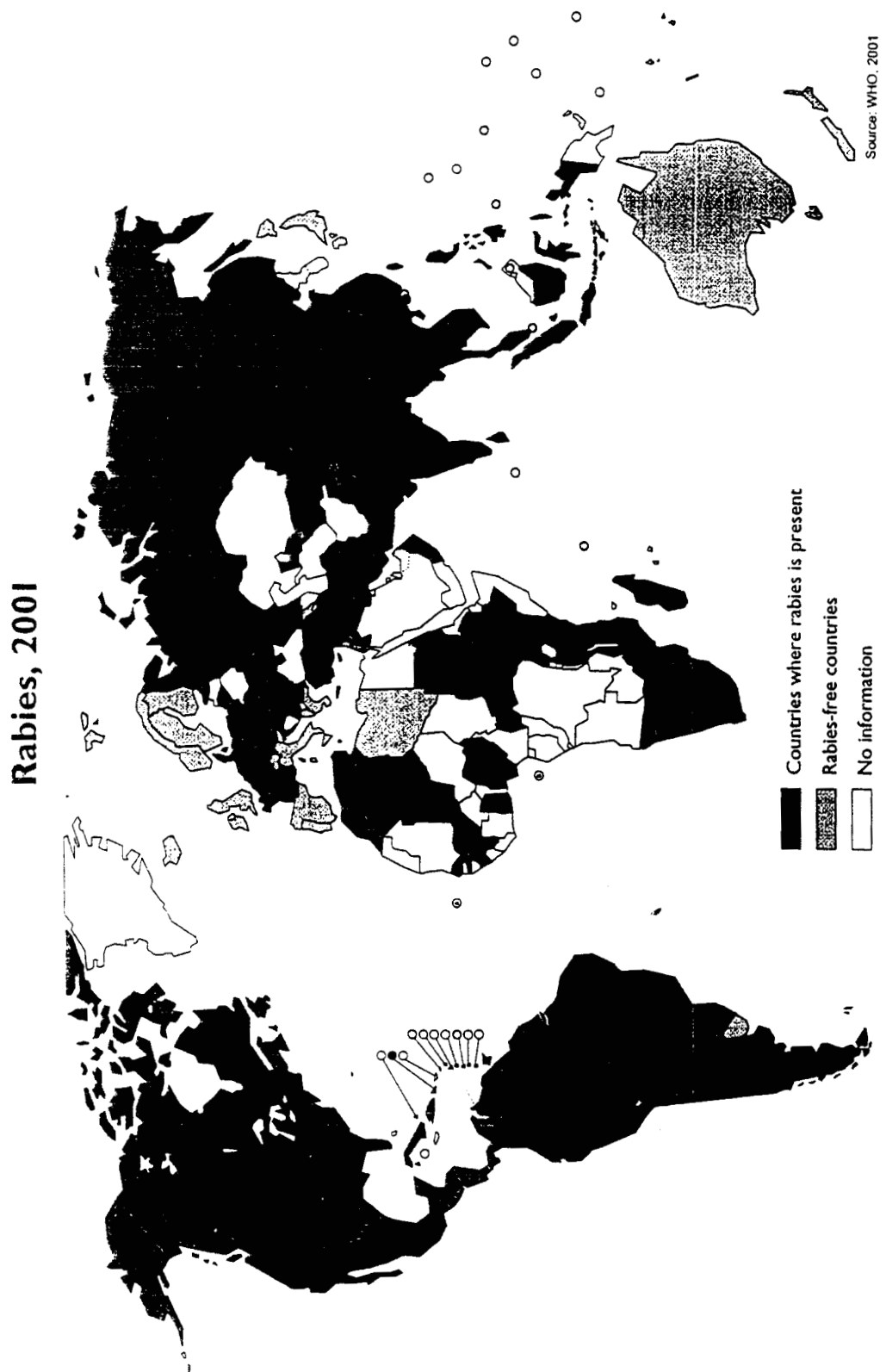
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Poliomyelitis, 2001

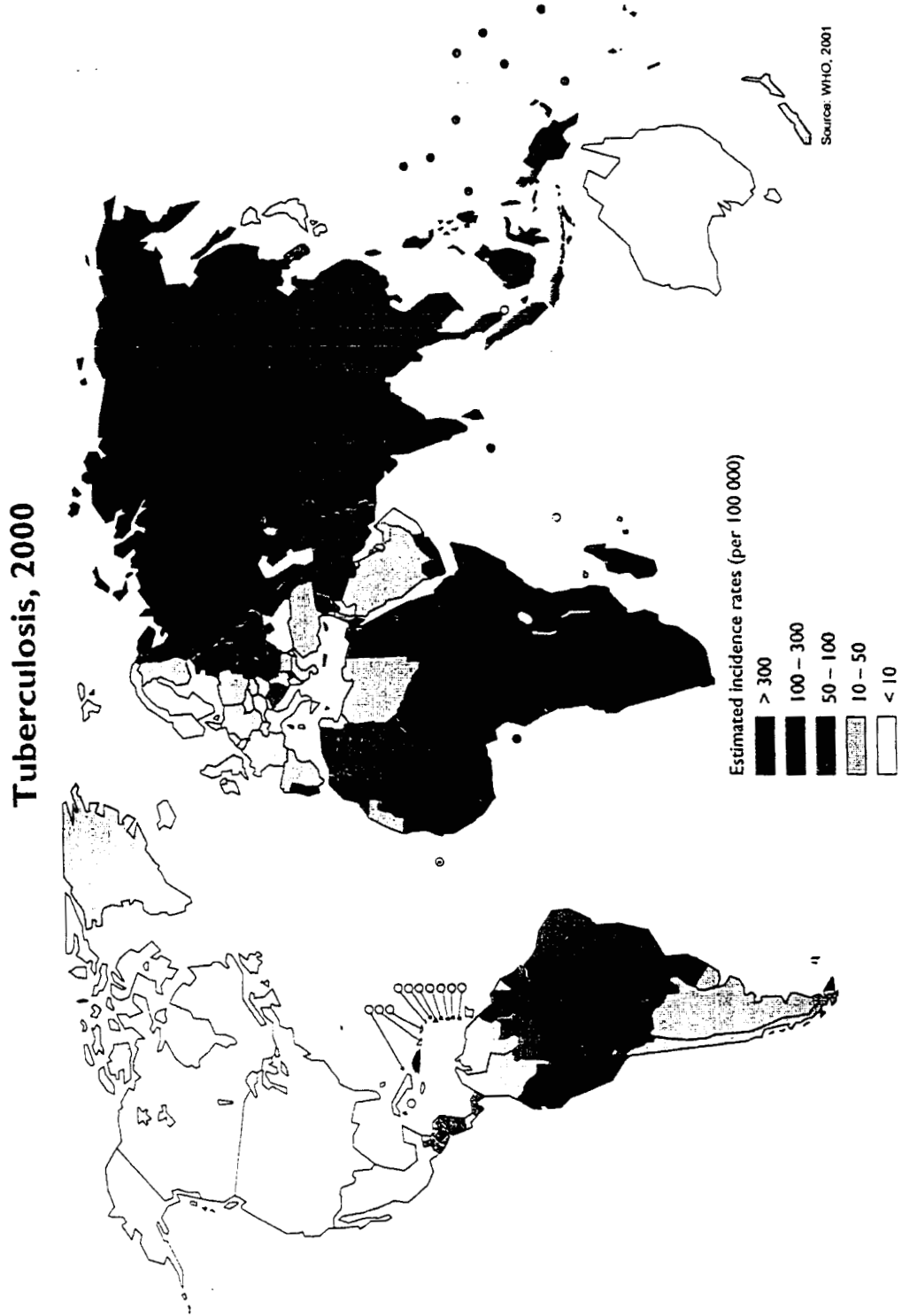


^a Countries bordering on areas where wild poliovirus transmission occurs should be considered to pose a risk for travellers. The Democratic Republic of the Congo should be considered as continuing to pose a risk, although no virus has been detected in that country for over a year.

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