

VACCINATION REQUIREMENTS AND MALARIA INFORMATION FOR TRAVELLERS

Pages with reference to book, From 206 To 208

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The International Health Regulations were adopted by the 22nd World Health Assembly in 1969¹ with the purpose to prevent the international spread of disease and in the context of international travel, to do so with the minimum of inconvenience to the passenger. This requires international collaboration in the detection, reduction or elimination of the sources from which infection spreads rather than attempt to prevent the introduction of disease by legalistic barriers which, over the years, have proved ineffective.

Based on epidemiological studies it was found that introduction of Cholera in any country cannot be prevented by Cholera Vaccine. The 26th World Health Assembly (WHA) in 1973 amended the regulations so that Cholera Vaccination certificate should not be required by any traveller.²

WHA declared on 8th May 1980, that Smallpox has been eradicated, therefore smallpox vaccination is no longer required; it may even be dangerous in some cases.³

YELLOW FEVER VACCINATION CERTIFICATE

A yellow fever vaccination certificate is now the only one that should be required in international travel. Yellow fever is endemic in Africa and South-America. For the traveller's own protection and the countries visited, travellers who enter areas where the yellow fever virus is endemic should be vaccinated.

The vaccination certificate is valid only if it conforms with the model recommended by International Health Regulation and the vaccine has been approved by WHO and administered at an approved Yellow Fever Vaccination Centre.⁴

The validity period of international certificate of vaccination against yellow fever is 10 years, beginning 10 days after vaccination. If a person is revaccinated before the end of the validity of certificate, the validity is extended for a further 10 years from the date of revaccination.

MALARIA

Malaria is a mosquito-borne disease closely associated with international travel and there is a high risk of acquiring the infection in endemic areas. Vaccination does not yet exist in a practicable form; individual travellers can and should protect themselves when visiting endemic countries.

In many countries where malaria is endemic, the main towns are often free of disease; While there is usually much less risk of malaria at altitudes greater than 1500 meters the disease can occur in certain climatic conditions as high as 3000 meters or above. Risk of infection may also vary with the season of the year.⁵

Protective measures should be taken by the travellers while visiting endemic areas i.e., sleeping in air-conditioned or properly screened rooms, using anti-fly spray to kill any mosquito in the screen, using mosquito nets around the bed at night, wearing sufficient clothing to protect whole body, arms and legs from mosquito bites, avoiding dark colours which attract mosquitos, smearing an insect repellent (diethyl-m-toluamide) on parts of the body not covered by clothing and drug prophylaxis. Travellers should be made aware that no drug can guarantee malaria suppression and medical advice should be obtained immediately if fever occurs while under, or after having treated, malaria prophylaxis.

It would be preferable to start drug prophylaxis one week before departure to assess the individual's tolerance to the drug, at the latest it should be given on the day of arrival in the malarious area.

Chemoprophylaxis should be continued for 6 weeks after leaving endemic area to control incubating

infections with falciparum malaria, but orale or vivax malaria may break through even after that period.

CHEMOPROPHYLAXIS FOR MALARIA⁵

Remarks

Drugs and Dosages

Where no resistance of P. quine exists falciparum to chloroWhere resistance of P. falciparum to chloroquine is not widespread and predominantly of low degree

If fever occurs, one or more treatment dose of 500 mg sulfodonin /25 mg pyrimithamine or 500 mg sulfaline/25 mg pyrimithamine should be taken Where highly chioroquine-resistant P. falciparum occurs.

(South—East Africa and Latin America)

Proguanil 200 mg (base) daily chloroquine 300 mg Dapsone/pyrimithamine (base) weekly+I tablet weekly

In no circumstances should the dose of depstone/pyrimithamine exceed 1 tablet weekly.

All dosages refer to 50 - 70 Kg. adults, for persons heavier than 70 Kg. doses may be increased. The recommendations given here are applicable only to non-immune travellers visiting endemic areas for not more than 6 months.

Side effects of chioroquine in prophylactic doses are rare and usually restricted to mild gastric discomfort, pruritus, longterm administration carries the risk of retinopathy. Sulfadoxin may cause drag fever, photo dermatitis, jaundice, toxic epidermic necrolysis, agranulocytosis and Steven—Johnson syndrome. Daprone/ Pyrimithamine may cause methaemoglobinaemia and agranulocytosis.

Pregnancy is not a contra-indication to the use of chioroquine or proguanil. In the recommended doses, any of these drugs can safely be taken at all stages of pregnancy. The real danger in pregnancy lies less in drug prophylaxis than in the malaria itself.

It is advisable not to give sulfadoxin, sulfone or daprone combinations to children below 1 year of age; similarly these drugs are not recommended during pregnancy.

RISK OF MALARIA EXIST IN FOLLOWING COUNTRIES

Afghanistan, Algeria, Angola, Bangladesh, Belize, Benin, Bhutan, Boliva, Brazil, Burkina Faso, Burma, Burundi, Cameroon, Central African Republic, Chad, China, Columbia, Congo, Cote D'Voire, Democratic Kampuchea, Democratic Yemen, Djibouti, Egypt, El Salvador, Equatorial Guinea, Ethiopia, Gabon, Gambia Ghana, Guatemala, Guinea, Guinea, Bissaea Guyana, Haiti, Honduras, India, Indonesia, Iran, Iraq, Kenya. LaosPeople's Democratic Republic, Liberia, Libyan Arab Jamahuriya, Madagascar, Malawi, Malaysia, Maldives, Mali, Mauritania, Mauritius, Mexico. Mozambique, Namibia Nepal, Netherland's Antilles, Nicaragua, Niger, Nigeria, Oman, Pakistan, Panama, Papua New Guinae, Paraguay, Peru, Phillipines, Rwanda, Sao Tome & Principe, Saudi Arabia, Senegal, Sierra Leone, Solomon Islands, Somalia, South Mrica, Sri Lanka, Sudan, Surinam, Swaziland, Syrian Arab Republic, Thailand, Togo, Uganda, United Arab Emirates. United Republic of Tanzania, Vietnam, Zaire, Zambia, Zimbabwe.

CHOLERA VACCINATION IS REQUIRED

IN FOLLOWING COUNTRIES

Albania, India, Lesotho, Madagascar, Malta, New Caledonia and Dependencies, Pakistan, Pitcairns, Somalia, Sn Lanka.

Following countries require no vaccination for any traveller:

Andorra, Argentina, Austria, Belgium, Bermuda, Botswana, British Virgin Islands, Bulgaria, Canada, Cayman Islands, Chile, Comoros, Cook Islands, Costa Rica, Cuba, Cyprus, Czechoslovakia, Democratic People's Republic of Korea, Denmark, Dominican Republic, Ecuador, Falkland Islands, Faroe Islands, Finland, France,

German Democratic Republic, Federal Republic of Germany, Gibraltar, Greenland, Guam, Hong Kong, Hungary, Iceland, Ireland, Israel, Italy, Japan, Jordan, Kuwait, Liechtenstein, Luxembourg, Macao,

Monaco, Mongolia, Morocco, Netherlands, New Zealand, Northern Mariana Islands, Norway, Pacific Islands—Trust territory of the U.S.A., Poland, Puerto Rico, Republic of Korea, Romania, Saint Helena, Saint Pierre anti Miquelon, San Marino, Seychelles, Spain, Sweden, Switzerland, Turkey, U.S.S.R., U.K., U.S.A., Uruguay, Vanuata, Venezuela, Virgin Islands, Wake Island, Yugoslavia.

REFERENCES

1. International Health Regulation (1969): Third annotated edition. Geneva, World Health Organization, 1983, pp. 79.
2. Resolution WHA 26.55.
3. Resolution WHA 34. 13.
4. Yellow fever vaccinating centres for international travel. Situation as on 1 January 1985. Geneva, W.H.O., 1985.
5. Vaccination certificate requirement and Health Advice for International Travel. WHO, 1987, pp.47.