Schweizerische Fachgesellschaft für Tropen- und Reisemedizin FMH
Société Suisse de Médecine Tropicale et de Médecine des voyages FMH
Società Svizzera di Medecina Tropicale e dei Viaggi FMH
Swiss Society of Tropical and Travel Medicine FMH

Expertenkomitee für Reisemedizin
Comité d'experts pour la médecine des voyages
Comitato di esperti per la medicina di viaggio
Expert committee for travel medicine

Healthy**Travel** Pro

TRAVEL HEALTH ADVICE FOR HEALTH CARE PROFESSIONALS

BY THE SWISS EXPERT COMMITTEE FOR TRAVEL MEDICINE

A quick user guide

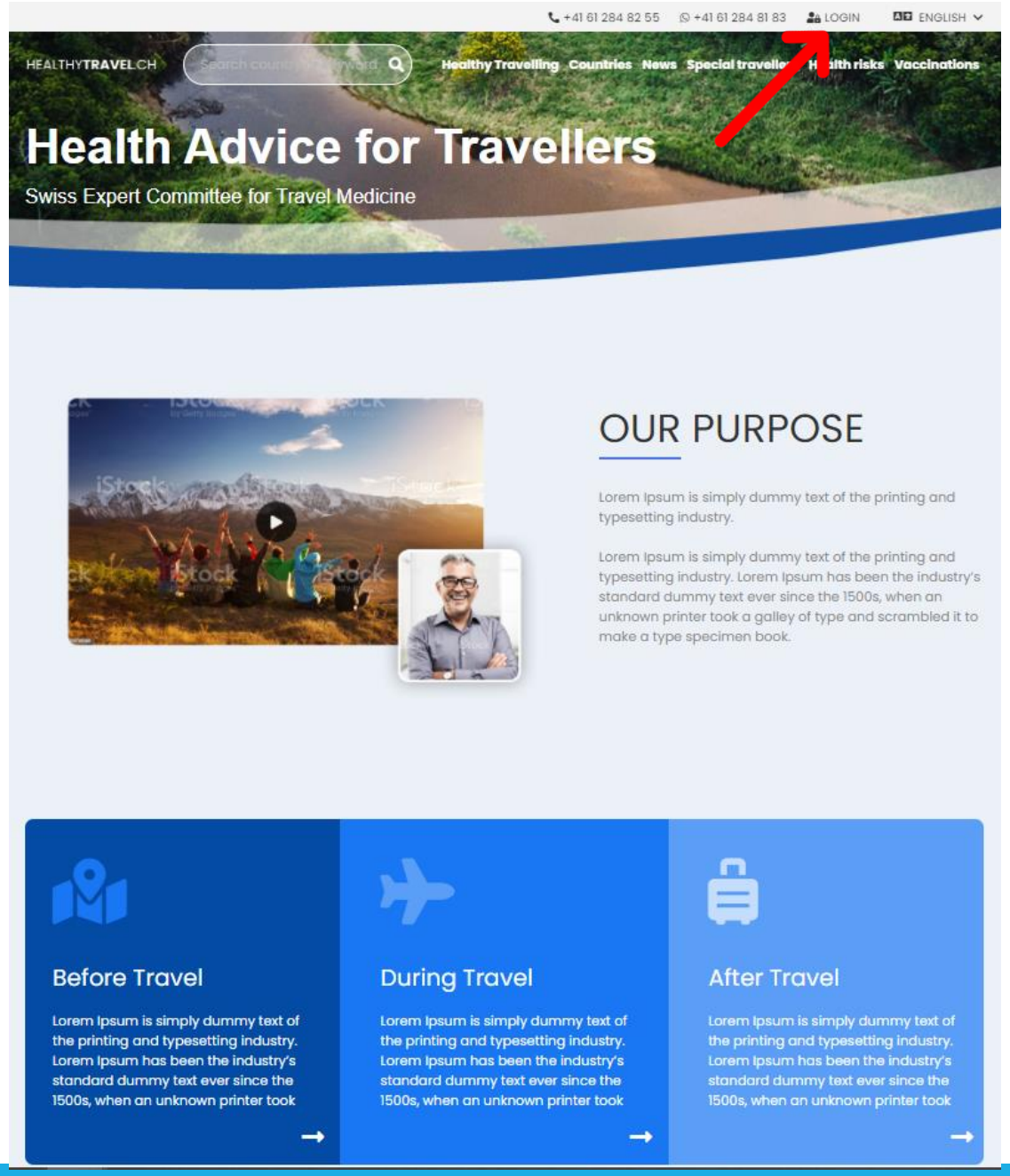
We are happy to introduce our website with travel health advice and information for health professionals.

We are at your assistance, whether with information for optimal travel preparation, vaccination recommendations, maps, definition of risk areas and much more! We invite you to browse through the various websites, where you can compile all the information individually and create a printable report.

This is a short user guide to quickly find your way around the website.

Landing page - public

SECTION 1



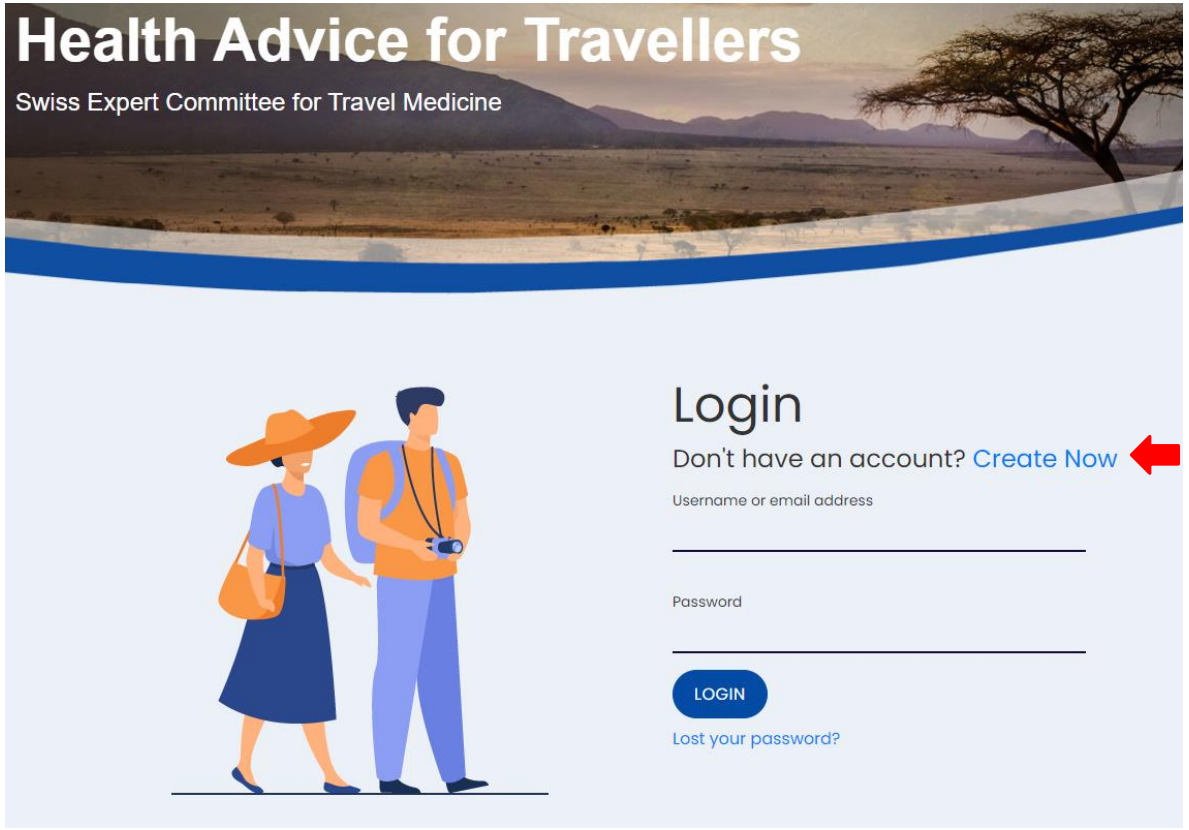
LANDING PAGE

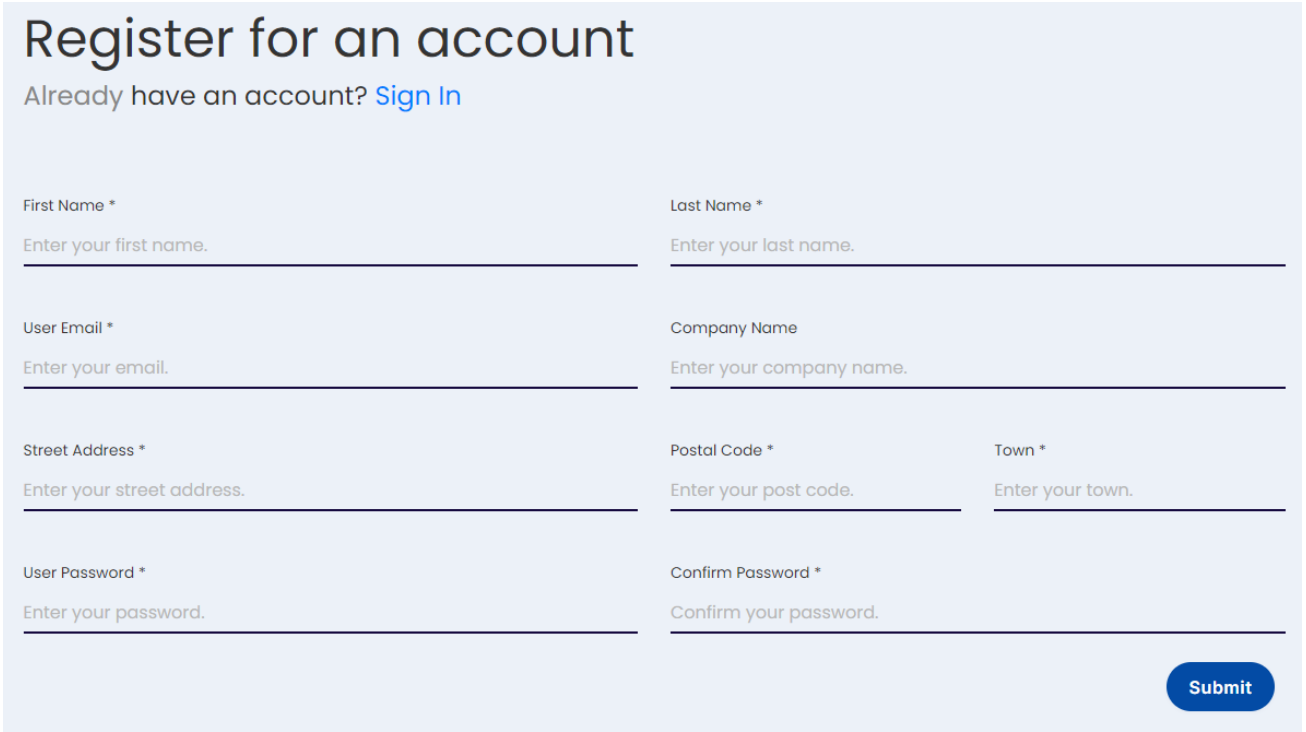
www. healthytravel.ch

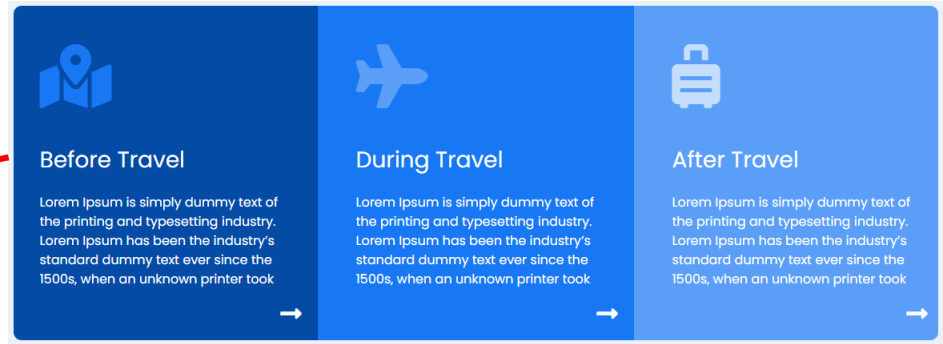
Landing Page - professional

SECTION 2

Login for health professionals







Before travel

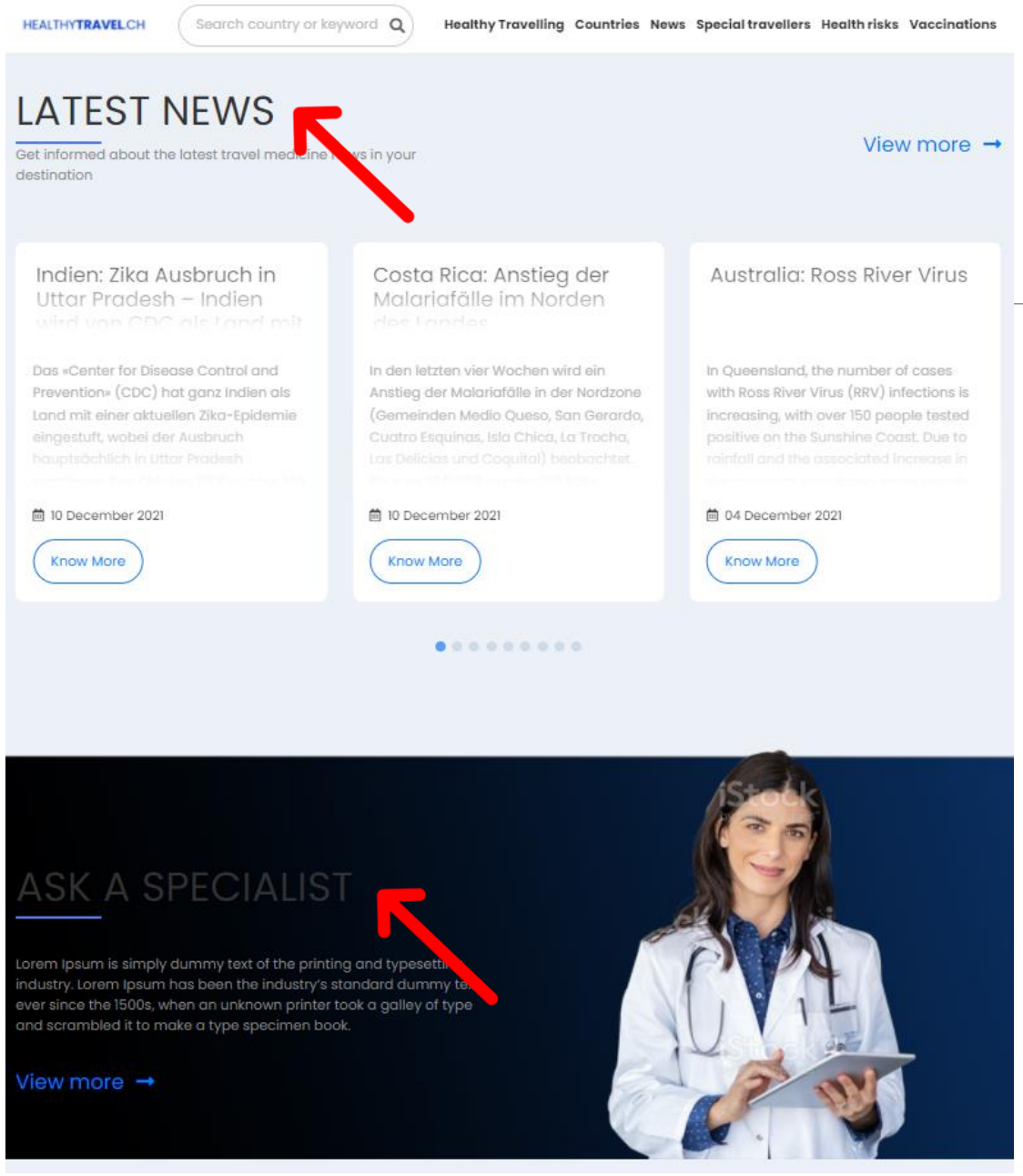
- Travel planning - Checklist
- Visiting friends and family
- Vaccinations - general information
- Mosquito and tick bite prevention measures
- Insurances
- Travel pharmacy
- Air Travel
- Cruiseship travel
- Buiseness travel

During travel

- Useful tips
- Mosquito and tick bite prevention measures
- Sick during | after the trip
- Travel safety
- Travel and Accidents
- Animals
- Food and drink
- Diarrhea
- Sun exposure

After travel

- Checklist
- Sick after travel?



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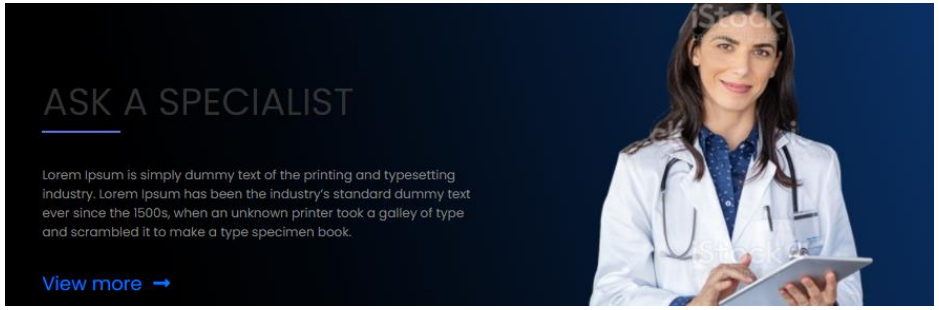
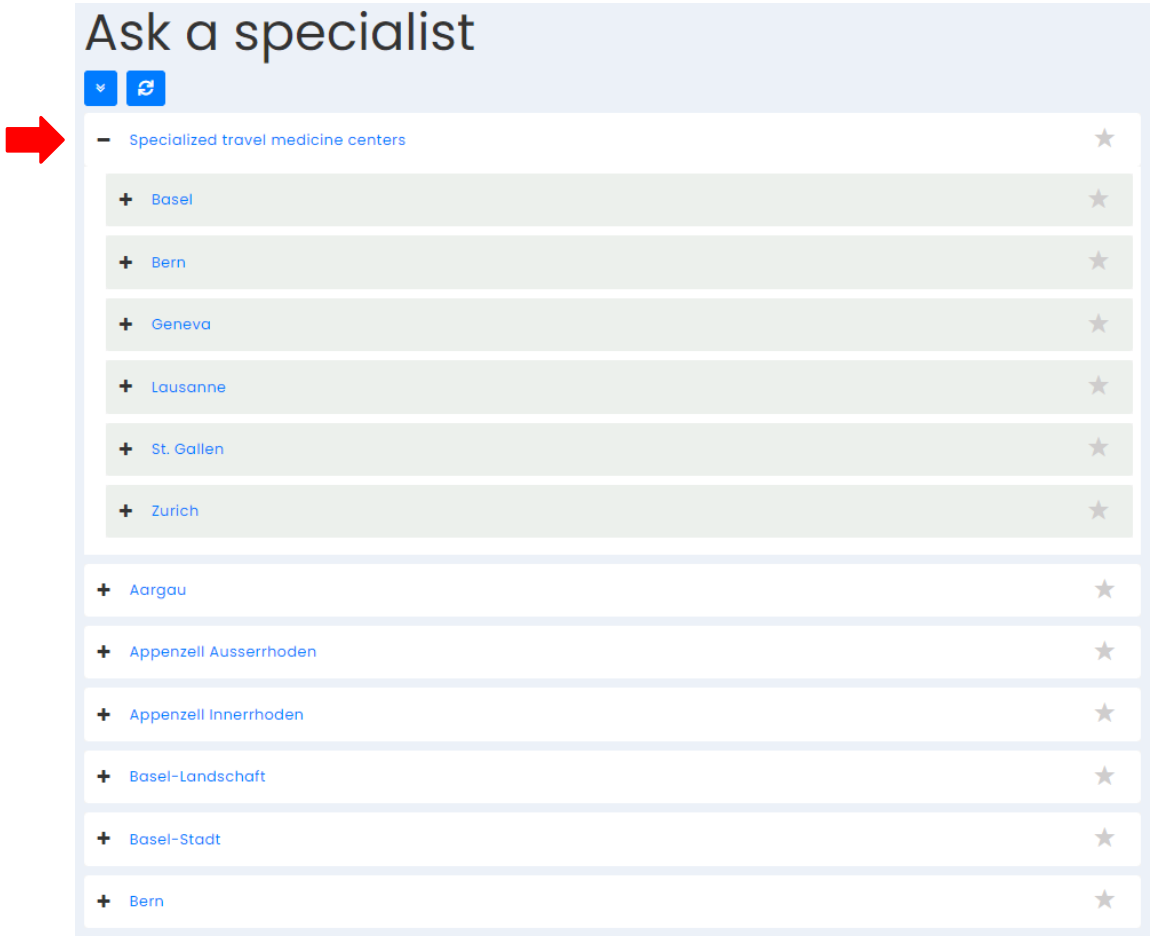
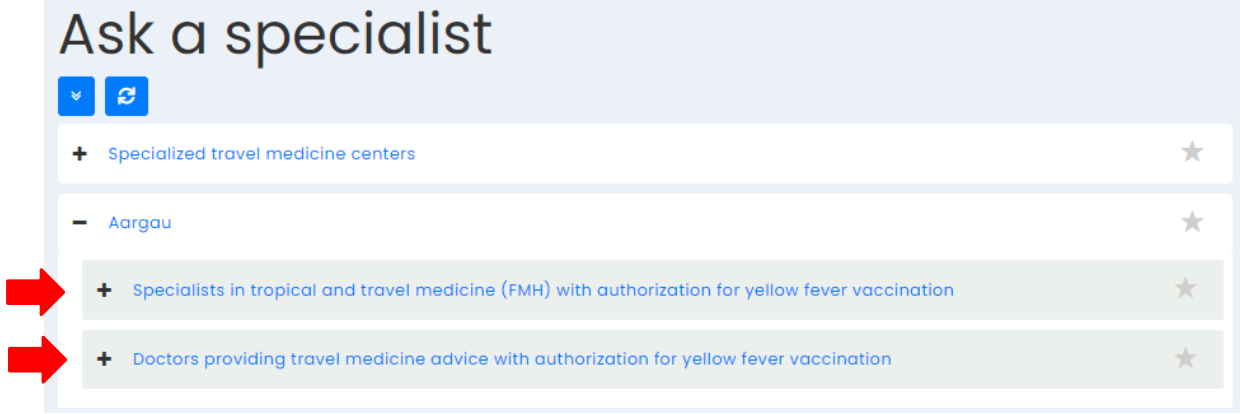
4. Latest travel medicine news per country or region

5. Ask a specialist: List of specialists with experience in travel and tropical medicine

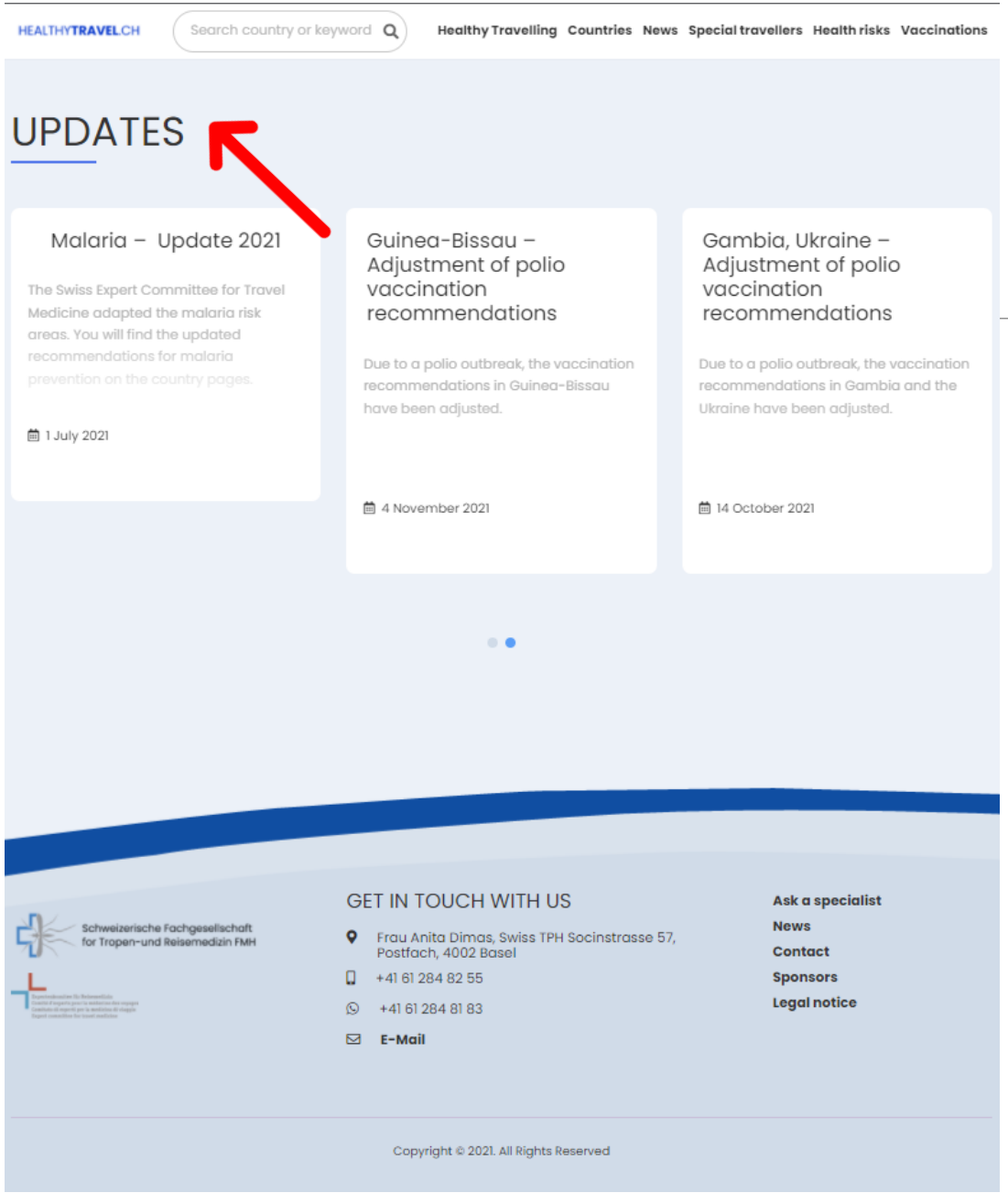






Ask a specialist: Find a specialist in travel medecine in your area:

- ECTM specialized travel medecine centers
- Specialists in tropical and travel medicine
- Doctors with travel medicine advice and authorization for yellow fever vaccination



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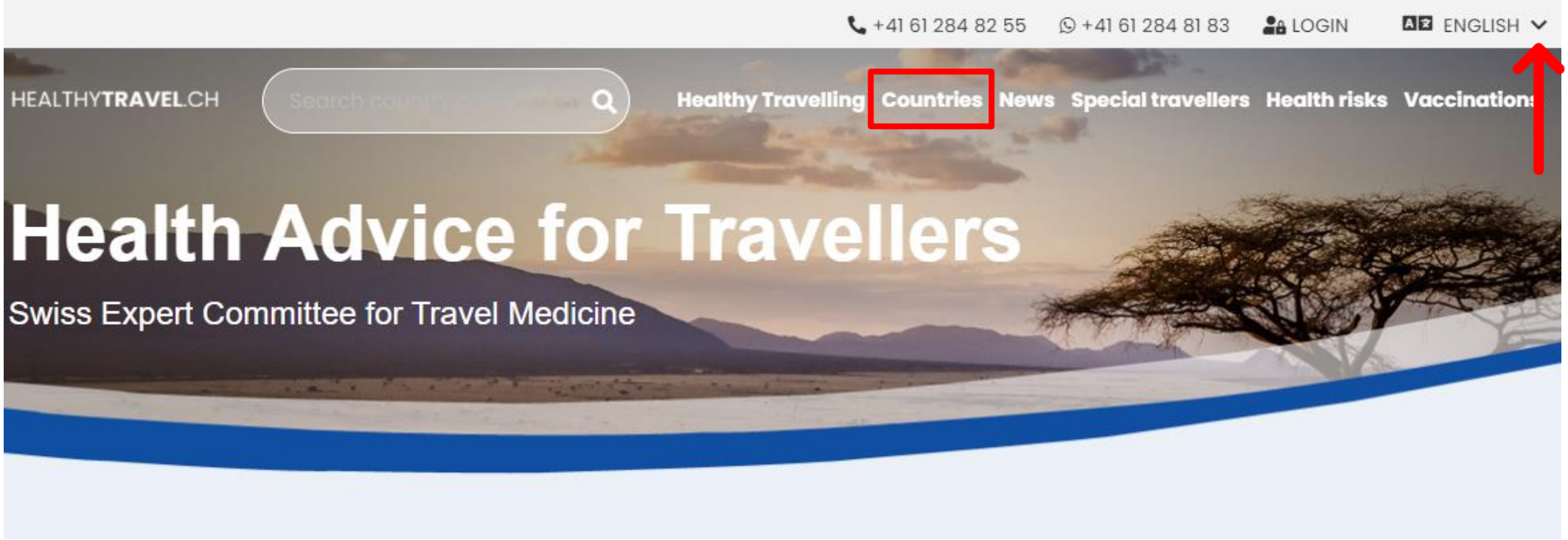
6. Stay informed on the latest **content** updates that will be done on the website

Country Pages

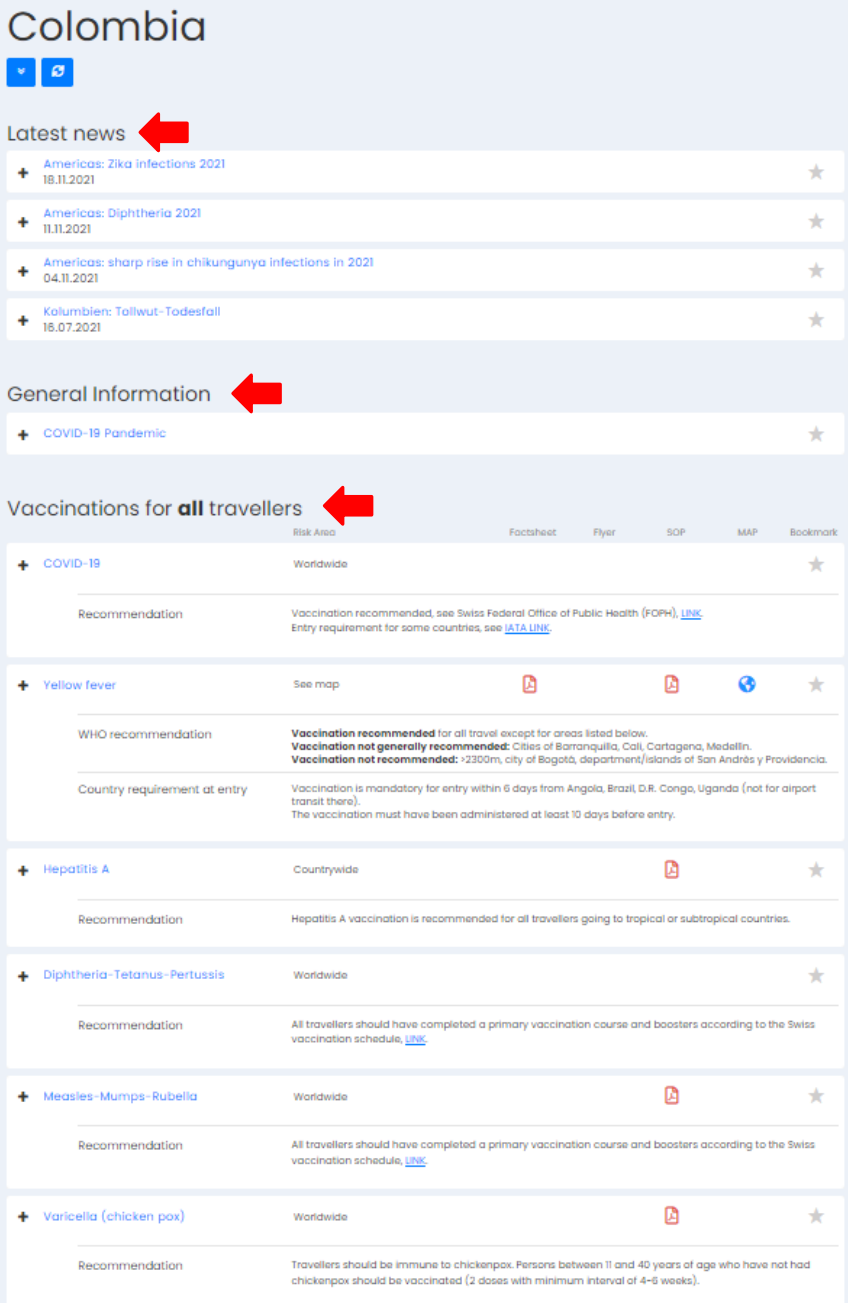
SECTION 3

Choose your language and find out the important health risks and vaccination recommendations per country:



Every country page is divided into the following categories:

- Latest travel medicine news
- General information
- Vaccinations recommended for all travellers
- Vaccinations recommended for some travellers
- Malaria
- Important health risks



Vaccinations for **all** travellers

	Risk Area	Factsheet	Flyer	SOP	MAP	Bookmark
+ COVID-19	Worldwide					★
Recommendation	Vaccination recommended, see Swiss Federal Office of Public Health (FOPH), LINK. Entry requirement for some countries, see IATA LINK.					
+ Yellow fever	See map					★
WHO recommendation	**Vaccination recommended** for all travel except for areas listed below. **Vaccination not generally recommended:** Cities of Barranquilla, Cali, Cartagena, Medellín. **Vaccination not recommended:** >2300m, city of Bogotá, department/islands of San Andrès y Providencia.					
Country requirement at entry	Vaccination is mandatory for entry within 6 days from Angola, Brazil, D.R. Congo, Uganda (not for airport transit there). The vaccination must have been administered at least 10 days before entry.					

Find vaccination recommendations, entry requirements and the definition of the risk areas on a glance.

Vaccinations for **all** travellers

	Risk Area	Factsheet	Flyer	SOP	MAP	Bookmark
+ COVID-19	Worldwide					★
Recommendation	Vaccination recommended, see Swiss Federal Office of Public Health (FOPH), LINK. Entry requirement for some countries, see IATA LINK.					
+ Yellow fever	See map					★
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Country requirement at entry	Vaccination is mandatory for entry within 6 days from Angola, Brazil, D.R. Congo, Uganda (not for airport transit there). The vaccination must have been administered at least 10 days before entry.					

Find additional information per disease:

- Factsheet: General Information on the disease for laypersons
- Flyer: General Information on the disease + its medication or treatment. Can be used and given to the client during consultation.
- SOP: Standard Operating Procedure for the use of vaccinations

Factsheet, Flyer, Infosheet, SOP

SECTION 4

FACTSHEET

Provides information in layperson language.

Accessible for

- Public **and**
- Health care professionals

FACTSHEET CHIKUNGUNYA

Expertenkomitee für Reisemedizin
Comité d'experts pour la médecine des voyages
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Expert committee for travel medicine

Key aspects briefly summarized

- Chikungunya is a viral disease transmitted by Aedes mosquitoes.
- Chikungunya can be prevented by protection against mosquito bites.
- It typically presents with severe joint pain of the hands and feet. In a few patients, these may persist for weeks or months.

Disease

Chikungunya is caused by the chikungunya virus, which was first described in 1952 in Tanzania. The name is believed to come from a local African language, meaning 'to become bent over', and refers to the posture of affected persons who lean on walking sticks due to severe joint pain.

Occurrence / Risk areas

Indian subcontinent, South-East Asia and Pacific islands, Central and South America, Caribbean islands, Sub-Sahara Africa, Arabian peninsula. In Europe, cases are mainly imported from endemic countries. However, local transmission has occurred in 2007, in 2014, and in 2017 (Italy and France).

Transmission

The chikungunya virus is transmitted through the bite of Aedes mosquitoes, which predominantly bite humans during daytime.

Symptoms

A 19-year-old Indian lady with chikungunya, South India. Her finger and foot joints were swollen and very painful (photo by C. Staehelin).

The infection may present with some or all of the following symptoms: sudden onset of high-grade fever, chills, headache, redness of eyes, muscle and joint pain, and rash. The rash usually occurs after the onset of fever and typically involves the trunk and extremities, but can also include the palms, soles of the feet, and the face.

Often fever occurs in two phases of up to one week duration, with an interval of one to two fever-free days in between. The second phase may present with much more intense muscle and joint pain, which can be severe and debilitating. These symptoms are typically bilateral and symmetric and mainly involve hands and feet, but may also involve the larger joints, such as the knees or shoulders.

About 5-10% of infected people continue to experience severe joint pain even after the fever has subsided, in some cases lasting up to several months or, albeit rare, even years.

Diagnosis

Diagnosis can be confirmed by blood tests: PCR in the first week of symptoms or serology (antibody measurement) from the second week of illness.

Treatment

There is no treatment against the virus itself, only symptomatic treatment for the joint pain (anti-inflammatory drugs).

Prevention

Mosquito bite prevention during the daytime (when Aedes mosquitoes are active): repellants on uncovered skin; wearing long clothes; treating clothes with insecticide. A further very important protective factor is the so called 'environmental hygiene', meaning preventing the occurrence of breeding sites for mosquitoes within close proximity of human housing by eliminating all forms of recipients containing water.

Further Information / References

FOPH CH: https://www.bag.admin.ch/bag/de/home/krankheiten/krankheiten-im-ueberblick/chikungunya.html
WHO - Chikungunya factsheet: https://www.who.int/news-room/fact-sheets/detail/chikungunya
Center for Disease Control and Prevention (CDC): https://www.cdc.gov/chikungunya/index.html

FLYER

Provides medical instructions for clients.

Accessible **only** for

- Health care professionals

Delivery to clients during consultation or electronically

MALARIA
PREVENTION / PROPHYLAXIS

Expertenkomitee für Reisemedizin
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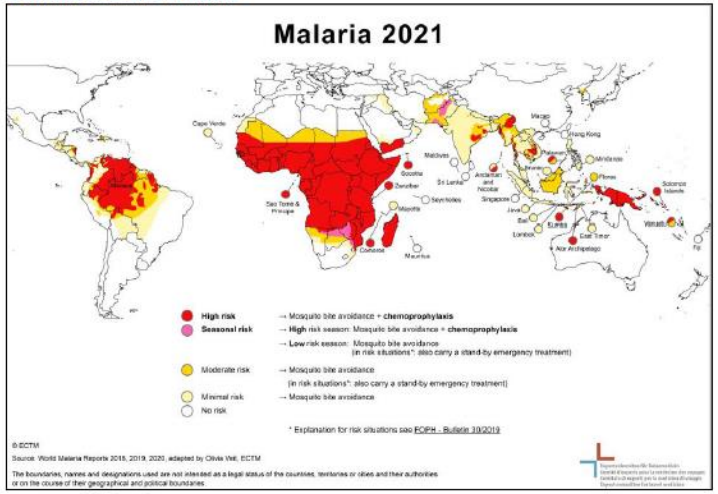
Key Points

- Malaria is a life-threatening infection, which is transmitted by mosquitoes that bite **from dusk to dawn.**
- Great care should be given to preventive **mosquito protection** in **all malaria risk areas.**
- In **high-risk areas**, it is recommended to take chemoprophylaxis which is medication to prevent malaria.
- For stays in **low risk areas**: discuss with a travel health advisor about the possible need for medication for emergency self-treatment.
- If you belong to a **special risk group** (pregnant women, small children, senior citizens, persons with pre-existing conditions and/or with immune deficiency): seek expert medical advice before the trip as malaria can quickly become very severe.
- **If you have a fever** >37.5°C on axillary or tympanic measurement (a functioning thermometer is indispensable!) during or after the trip, see a doctor / hospital immediately and have a blood test done for malaria! This applies regardless of whether you have used chemoprophylactic medication or not!

Worldwide occurrence of malaria



How can I protect myself?

Malaria prevention requires a combination of measures:

1. **Diligent mosquito-bite protection** (see LINK) is recommended in all areas with malaria, even in regions with minimal risk of malaria transmission.
2. **Chemoprophylaxis** is recommended additionally for travel in all high-risk regions.
3. **Carrying a standby emergency treatment** (**SBET**, drugs used to self-treat malaria) with you is recommended for special risk situations when traveling to low-risk regions.

MALARIA
PREVENTION / PROPHYLAXIS

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Mosquito protection at night

1. **Clothing:** Wear light-colored, long-sleeved clothes and long trousers. For additional protection, impregnate the clothes beforehand with insecticides containing the active ingredient permethrin (e.g. *Nobite*® Textile, *MükoRex*®)
2. **Mosquito repellents**: Apply a mosquito repellent to uncovered skin.(e.g., Anti Brumm Forte® or other repellents, see factsheet mosquito and tick bite protection, LINK).
3. **Sleeping room:** Sleep in rooms with running air conditioning or under an **impregnated** mosquito net. Other means, such as insecticides, can be used additionally.

Chemoprophylaxis (= preventive medication in areas with high malaria risk that needs to be taken regularly)

Atovaquone/Proguanil (*Malarone*®, *Atovaquon Plus Spirig HC*®)	**Mefloquin** (*Mephaquin*®)	**Doxycyclin** (z.B. *Supracyclin*®) (Not for children ages less than 8 years or for pregnant women)
1 Tab. daily	**1 Tab. (250 mg) per week**	**1 Tab. (100 mg) daily**
Start: 1-2 days before travel End: 7 days after travel	Start: 1-2 weeks before travel End: 4 weeks after travel	Start: 1-2 days before travel End: 4 weeks after travel6

- Antimalarial drugs are available on **prescription** only. Tablets should be taken **with or after food.**
- The above dosages apply to adults. Please discuss the correct dosage for children with your doctor. As malaria poses a higher risk to mother and the unborn child during pregnancy, specific guidelines apply to malaria prophylaxis or therapy in pregnant women.
- In case of adverse drug reactions, especially skin rashes, dizziness, depression, or anxiety reactions (see package leaflet): Stop taking the medication and consult a doctor.

Important:
- **Malaria may occur from 7 days on after entering a malaria endemic area.**
- **Malaria infection must always be considered in case of fever in the second week of stay in a malaria area until months after return** despite correct prophylactic measures (mosquito repellent/medication)!

In case of **fever > 37.5° C (use a thermometer!):** if the fever persists for more than 24 hours or recurs: it is essential to have a **blood test as soon as possible (within 24 hours)** to rule out malaria, regardless of what prophylactic measures you have taken. To do so, consult a doctor or a clinic. If the result is negative or uncertain, the examination should be repeated.

Emergency Self-Treatment

If you have been prescribed stand-by emergency self-treatment (SBET) for malaria, please proceed as follows: If you have a **fever >37.5°C that persists for more than 24h or recurs: please seek immediate medical advice** from a doctor/hospital and get a malaria blood test. However, if this is not possible, reduce the fever (paracetamol, physical), take fluids and please start taking the SBET medication as prescribed:

Artemether/Lumefantrin (*Riamet*®)	**Atovaquone/Proguanil** (*Malarone*®/*Atovaquon Plus Spirig HC*®)
24 Tablets in 6 doses over 3 days:	**12 Tablets in 3 doses over 3 days:**
▸ **Immediately:** 4 tablets; 4 tablets 8 hours later	▸ **Immediately:** 4 Tablets (take all at once)
▸ **Day 2. + 3.**: 4 tablets each in the morning and evening	▸ **Day 2. + 3.**: 4 tablets each (take all at once)

- The tablets should be taken **with** or **after food that** contains some fat
- The above dosages are for adults. Please discuss children's dosages with a specialist.

Important: Even after taking an emergency self-treatment, always seek out medical attention or a hospital as soon as possible. Why? It is possible that the malaria infection has not yet been eliminated or that another cause of fever must be ruled out.

This leaflet was handed out by this specialist department:

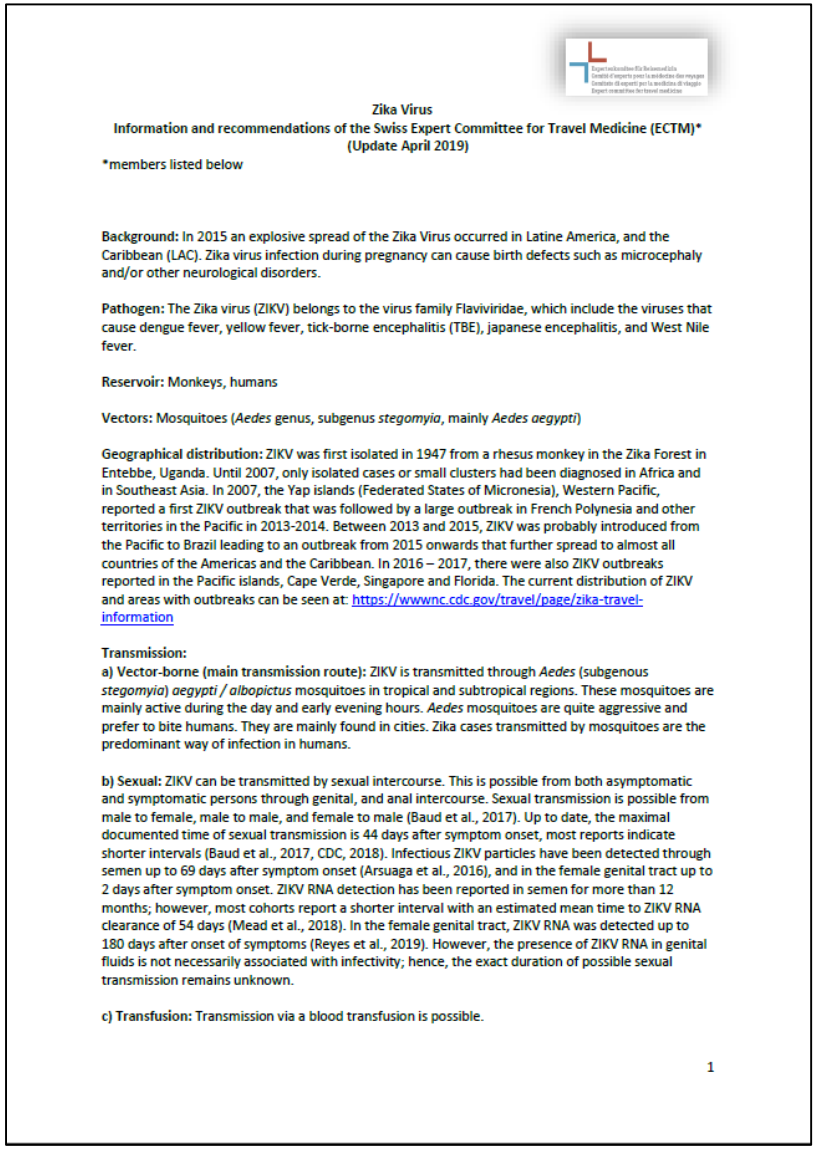
No guarantee can be given for the accuracy and completeness of the medical information, nor can any liability be accepted for any damage that may occur.
This information cannot be forwarded without the permission of the Swiss Expert Committee for Travel Medicine (ECTM).

INFOSHEET

Provides detailed information for health care providers

Accessible **only** for

- Health care professionals



Zika Virus
Information and recommendations of the Swiss Expert Committee for Travel Medicine (ECTM)* (Update April 2019)

*members listed below

Background: In 2015 an explosive spread of the Zika Virus occurred in Latine America, and the Caribbean (LAC). Zika virus infection during pregnancy can cause birth defects such as microcephaly and/or other neurological disorders.

Pathogen: The Zika virus (ZIKV) belongs to the virus family Flaviviridae, which include the viruses that cause dengue fever, yellow fever, tick-borne encephalitis (TBE), japanese encephalitis, and West Nile fever.

Reservoir: Monkeys, humans

Vectors: Mosquitoes (*Aedes* genus, subgenus *stegomyia*, mainly *Aedes aegypti*)

Geographical distribution: ZIKV was first isolated in 1947 from a rhesus monkey in the Zika Forest in Entebbe, Uganda. Until 2007, only isolated cases or small clusters had been diagnosed in Africa and in Southeast Asia. In 2007, the Yap islands (Federated States of Micronesia), Western Pacific, reported a first ZIKV outbreak that was followed by a large outbreak in French Polynesia and other territories in the Pacific in 2013-2014. Between 2013 and 2015, ZIKV was probably introduced from the Pacific to Brazil leading to an outbreak from 2015 onwards that further spread to almost all countries of the Americas and the Caribbean. In 2016 – 2017, there were also ZIKV outbreaks reported in the Pacific islands, Cape Verde, Singapore and Florida. The current distribution of ZIKV and areas with outbreaks can be seen at: https://wwwnc.cdc.gov/travel/page/zika-travel-information

Transmission:
a) Vector-borne (main transmission route): ZIKV is transmitted through *Aedes* (subgenous *stegomyia*) *aegypti / albopictus* mosquitoes in tropical and subtropical regions. These mosquitoes are mainly active during the day and early evening hours. *Aedes* mosquitoes are quite aggressive and prefer to bite humans. They are mainly found in cities. Zika cases transmitted by mosquitoes are the predominant way of infection in humans.

b) Sexual: ZIKV can be transmitted by sexual intercourse. This is possible from both asymptomatic and symptomatic persons through genital, and anal intercourse. Sexual transmission is possible from male to female, male to male, and female to male (Baud et al., 2017). Up to date, the maximal documented time of sexual transmission is 44 days after symptom onset, most reports indicate shorter intervals (Baud et al., 2017, CDC, 2018). Infectious ZIKV particles have been detected through semen up to 69 days after symptom onset (Arsuaga et al., 2016), and in the female genital tract up to 2 days after symptom onset. ZIKV RNA detection has been reported in semen for more than 12 months; however, most cohorts report a shorter interval with an estimated mean time to ZIKV RNA clearance of 54 days (Mead et al., 2018). In the female genital tract, ZIKV RNA was detected up to 180 days after onset of symptoms (Reyes et al., 2019). However, the presence of ZIKV RNA in genital fluids is not necessarily associated with infectivity; hence, the exact duration of possible sexual transmission remains unknown.

c) Transfusion: Transmission via a blood transfusion is possible.

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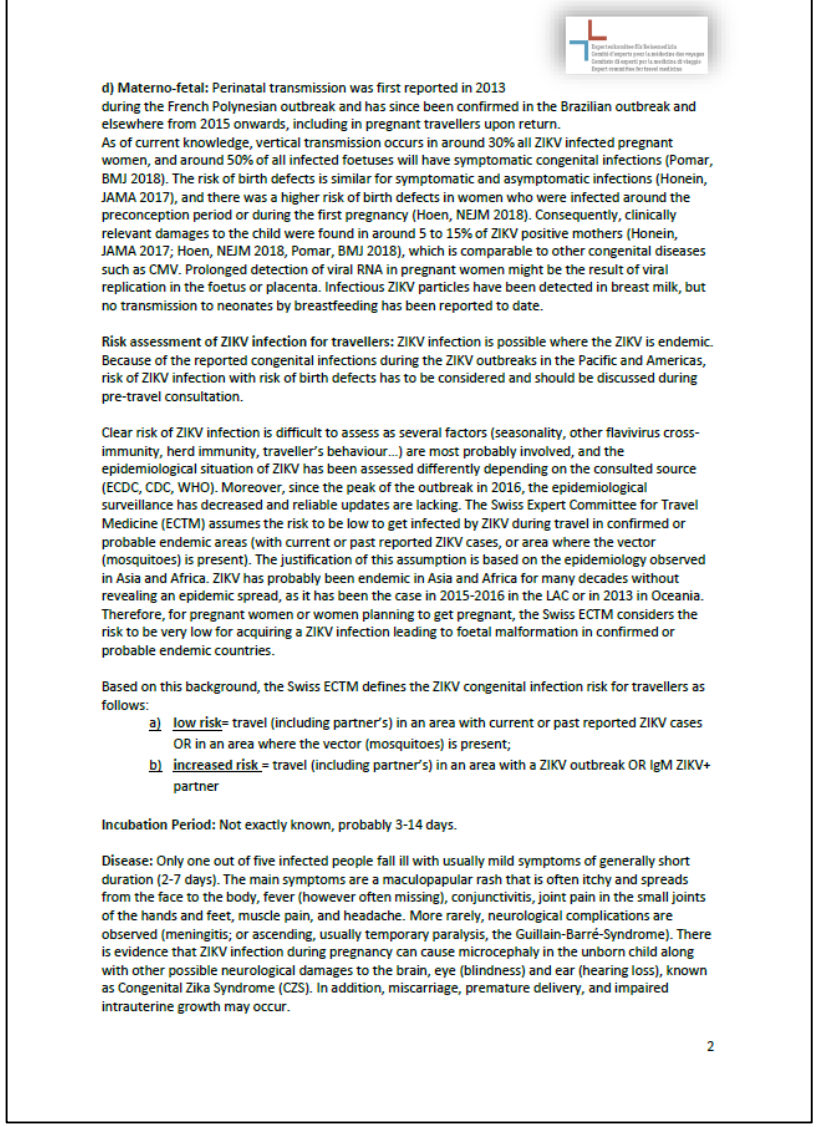


d) Materno-fetal: Perinatal transmission was first reported in 2013 during the French Polynesian outbreak and has since been confirmed in the Brazilian outbreak and elsewhere from 2015 onwards, including in pregnant travellers upon return.
As of current knowledge, vertical transmission occurs in around 30% all ZIKV infected pregnant women, and around 50% of all infected foetuses will have symptomatic congenital infections (Pomar, BMJ 2018). The risk of birth defects is similar for symptomatic and asymptomatic infections (Honein, JAMA 2017), and there was a higher risk of birth defects in women who were infected around the preconception period or during the first pregnancy (Hoen, NEJM 2018). Consequently, clinically relevant damages to the child were found in around 5 to 15% of ZIKV positive mothers (Honein, JAMA 2017; Hoen, NEJM 2018, Pomar, BMJ 2018), which is comparable to other congenital diseases such as CMV. Prolonged detection of viral RNA in pregnant women might be the result of viral replication in the foetus or placenta. Infectious ZIKV particles have been detected in breast milk, but no transmission to neonates by breastfeeding has been reported to date.

Risk assessment of ZIKV infection for travellers: ZIKV infection is possible where the ZIKV is endemic. Because of the reported congenital infections during the ZIKV outbreaks in the Pacific and Americas, risk of ZIKV infection with risk of birth defects has to be considered and should be discussed during pre-travel consultation.

Clear risk of ZIKV infection is difficult to assess as several factors (seasonality, other flavivirus cross-immunity, herd immunity, traveller's behaviour…) are most probably involved, and the epidemiological situation of ZIKV has been assessed differently depending on the consulted source (ECDC, CDC, WHO). Moreover, since the peak of the outbreak in 2016, the epidemiological surveillance has decreased and reliable updates are lacking. The Swiss Expert Committee for Travel Medicine (ECTM) assumes the risk to be low to get infected by ZIKV during travel in confirmed or probable endemic areas (with current or past reported ZIKV cases, or area where the vector (mosquitoes) is present). The justification of this assumption is based on the epidemiology observed in Asia and Africa. ZIKV has probably been endemic in Asia and Africa for many decades without revealing an epidemic spread, as it has been the case in 2015-2016 in the LAC or in 2013 in Oceania. Therefore, for pregnant women or women planning to get pregnant, the Swiss ECTM considers the risk to be very low for acquiring a ZIKV infection leading to foetal malformation in confirmed or probable endemic countries.

Based on this background, the Swiss ECTM defines the ZIKV congenital infection risk for travellers as follows:

a) **low risk**= travel (including partner's) in an area with current or past reported ZIKV cases OR in an area where the vector (mosquitoes) is present;
b) **increased risk** = travel (including partner's) in an area with a ZIKV outbreak OR IgM ZIKV+ partner

Incubation Period: Not exactly known, probably 3-14 days.

Disease: Only one out of five infected people fall ill with usually mild symptoms of generally short duration (2-7 days). The main symptoms are a maculopapular rash that is often itchy and spreads from the face to the body, fever (however often missing), conjunctivitis, joint pain in the small joints of the hands and feet, muscle pain, and headache. More rarely, neurological complications are observed (meningitis; or ascending, usually temporary paralysis, the Guillain-Barré-Syndrome). There is evidence that ZIKV infection during pregnancy can cause microcephaly in the unborn child along with other possible neurological damages to the brain, eye (blindness) and ear (hearing loss), known as Congenital Zika Syndrome (CZS). In addition, miscarriage, premature delivery, and impaired intrauterine growth may occur.

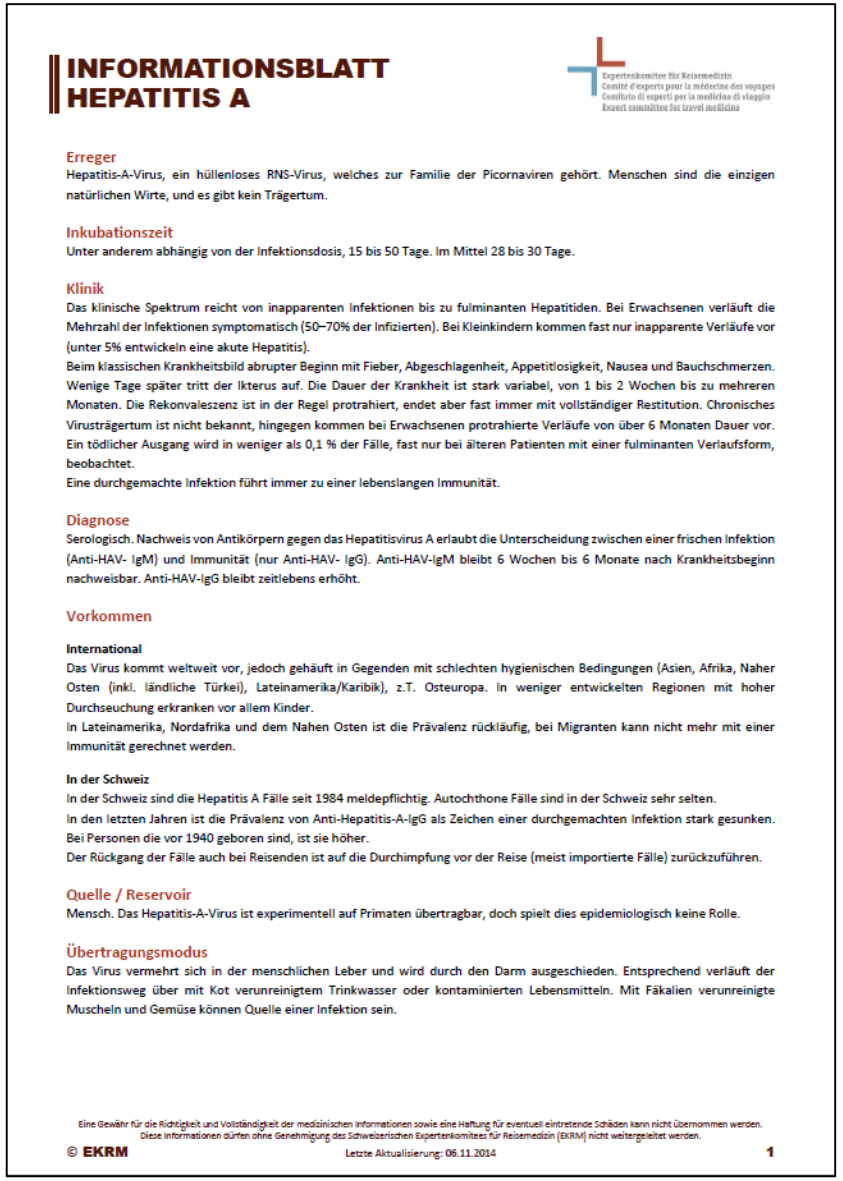
2

INFOSHEET

Provides detailed information for health care providers

Accessible **only** for

- Health care professionals



INFORMATIONSBLATT HEPATITIS A

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Erreger
Hepatitis-A-Virus, ein hüllenloses RNS-Virus, welches zur Familie der Picornaviren gehört. Menschen sind die einzigen natürlichen Wirte, und es gibt kein Trägertum.

Inkubationszeit
Unter anderem abhängig von der Infektionsdosis, 15 bis 50 Tage. Im Mittel 28 bis 30 Tage.

Klinik
Das klinische Spektrum reicht von inapparenten Infektionen bis zu fulminanten Hepatitiden. Bei Erwachsenen verläuft die Mehrzahl der Infektionen symptomatisch (50–70% der Infizierten). Bei Kleinkindern kommen fast nur inapparente Verläufe vor (unter 5% entwickeln eine akute Hepatitis).
Beim klassischen Krankheitsbild abrupter Beginn mit Fieber, Abgeschlagenheit, Appetitlosigkeit, Nausea und Bauchschmerzen. Wenige Tage später tritt der Ikterus auf. Die Dauer der Krankheit ist stark variabel, von 1 bis 2 Wochen bis zu mehreren Monaten. Die Rekonvaleszenz ist in der Regel protrahiert, endet aber fast immer mit vollständiger Restitution. Chronisches Virusträgertum ist nicht bekannt, hingegen kommen bei Erwachsenen protrahierte Verläufe von über 6 Monaten Dauer vor. Ein tödlicher Ausgang wird in weniger als 0,1 % der Fälle, fast nur bei älteren Patienten mit einer fulminanten Verlaufsform, beobachtet.
Eine durchgemachte Infektion führt immer zu einer lebenslangen Immunität.

Diagnose
Serologisch. Nachweis von Antikörpern gegen das Hepatitisvirus A erlaubt die Unterscheidung zwischen einer frischen Infektion (Anti-HAV- IgM) und Immunität (nur Anti-HAV- IgG). Anti-HAV-IgM bleibt 6 Wochen bis 6 Monate nach Krankheitsbeginn nachweisbar. Anti-HAV-IgG bleibt zeitlebens erhöht.

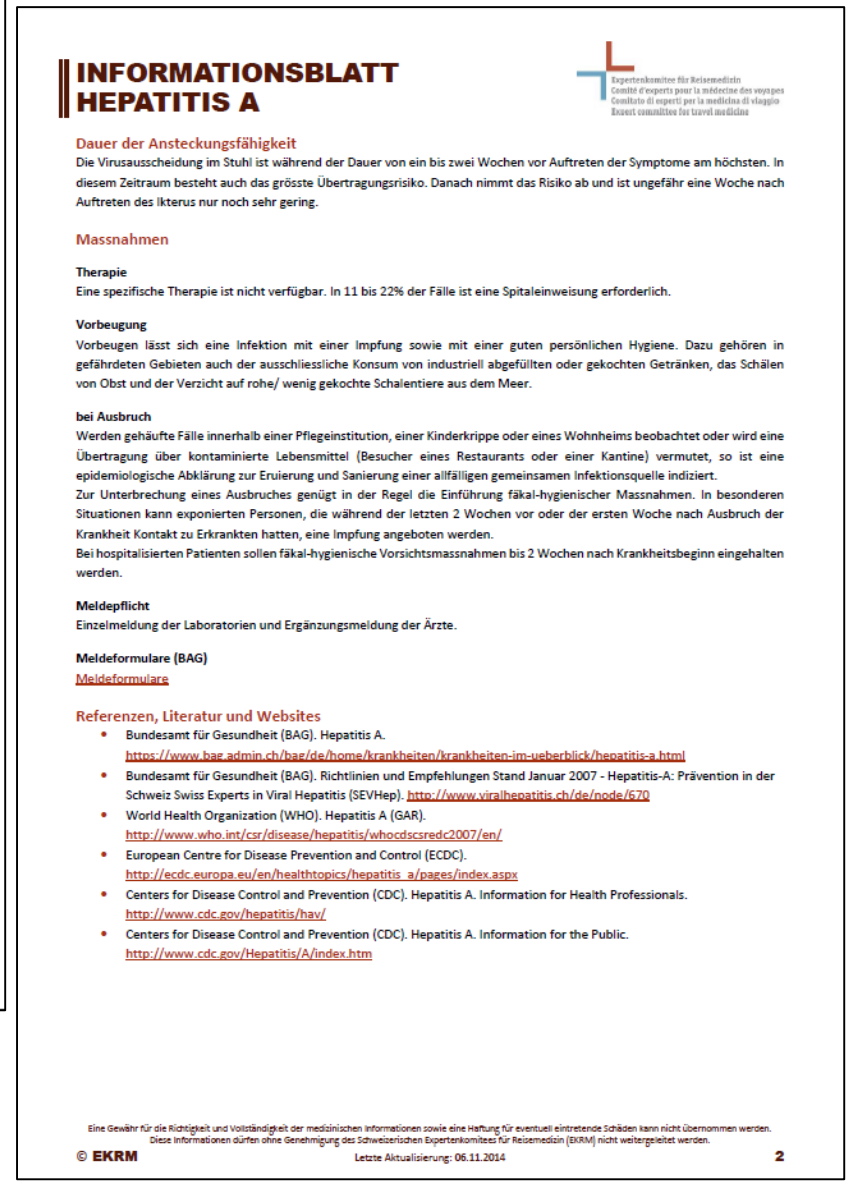
Vorkommen

International
Das Virus kommt weltweit vor, jedoch gehäuft in Gegenden mit schlechten hygienischen Bedingungen (Asien, Afrika, Naher Osten (inkl. ländliche Türkei), Lateinamerika/Karibik), z.T. Osteuropa. In weniger entwickelten Regionen mit hoher Durchseuchung erkranken vor allem Kinder.
In Lateinamerika, Nordafrika und dem Nahen Osten ist die Prävalenz rückläufig, bei Migranten kann nicht mehr mit einer Immunität gerechnet werden.

In der Schweiz
In der Schweiz sind die Hepatitis A Fälle seit 1984 meldepflichtig. Autochthone Fälle sind in der Schweiz sehr selten.
In den letzten Jahren ist die Prävalenz von Anti-Hepatitis-A-IgG als Zeichen einer durchgemachten Infektion stark gesunken. Bei Personen die vor 1940 geboren sind, ist sie höher.
Der Rückgang der Fälle auch bei Reisenden ist auf die Durchimpfung vor der Reise (meist importierte Fälle) zurückzuführen.

Quelle / Reservoir
Mensch. Das Hepatitis-A-Virus ist experimentell auf Primaten übertragbar, doch spielt dies epidemiologisch keine Rolle.

Übertragungsmodus
Das Virus vermehrt sich in der menschlichen Leber und wird durch den Darm ausgeschieden. Entsprechend verläuft der Infektionsweg über mit Kot verunreinigtem Trinkwasser oder kontaminierten Lebensmitteln. Mit Fäkalien verunreinigte Muscheln und Gemüse können Quelle einer Infektion sein.



INFORMATIONSBLATT HEPATITIS A

Expertenkomitee für Reisemedizin
Comité d'experts pour la médecine des voyages
Comitato di esperti per la medicina di viaggio
Expert committee for travel medicine

Dauer der Ansteckungsfähigkeit
Die Virusausscheidung im Stuhl ist während der Dauer von ein bis zwei Wochen vor Auftreten der Symptome am höchsten. In diesem Zeitraum besteht auch das grösste Übertragungsrisiko. Danach nimmt das Risiko ab und ist ungefähr eine Woche nach Auftreten des Ikterus nur noch sehr gering.

Massnahmen

Therapie
Eine spezifische Therapie ist nicht verfügbar. In 11 bis 22% der Fälle ist eine Spitaleinweisung erforderlich.

Vorbeugung
Vorbeugen lässt sich eine Infektion mit einer Impfung sowie mit einer guten persönlichen Hygiene. Dazu gehören in gefährdeten Gebieten auch der ausschliessliche Konsum von industriell abgefüllten oder gekochten Getränken, das Schälen von Obst und der Verzicht auf rohe/ wenig gekochte Schalentiere aus dem Meer.

bei Ausbruch
Werden gehäufte Fälle innerhalb einer Pflegeinstitution, einer Kinderkrippe oder eines Wohnheims beobachtet oder wird eine Übertragung über kontaminierte Lebensmittel (Besucher eines Restaurants oder einer Kantine) vermutet, so ist eine epidemiologische Abklärung zur Eruierung und Sanierung einer allfälligen gemeinsamen Infektionsquelle indiziert.
Zur Unterbrechung eines Ausbruches genügt in der Regel die Einführung fäkal-hygienischer Massnahmen. In besonderen Situationen kann exponierten Personen, die während der letzten 2 Wochen vor oder der ersten Woche nach Ausbruch der Krankheit Kontakt zu Erkrankten hatten, eine Impfung angeboten werden.
Bei hospitalisierten Patienten sollen fäkal-hygienische Vorsichtsmassnahmen bis 2 Wochen nach Krankheitsbeginn eingehalten werden.

Meldepflicht
Einzelmeldung der Laboratorien und Ergänzungsmeldung der Ärzte.

Meldeformulare (BAG)
Meldeformulare

Referenzen, Literatur und Websites

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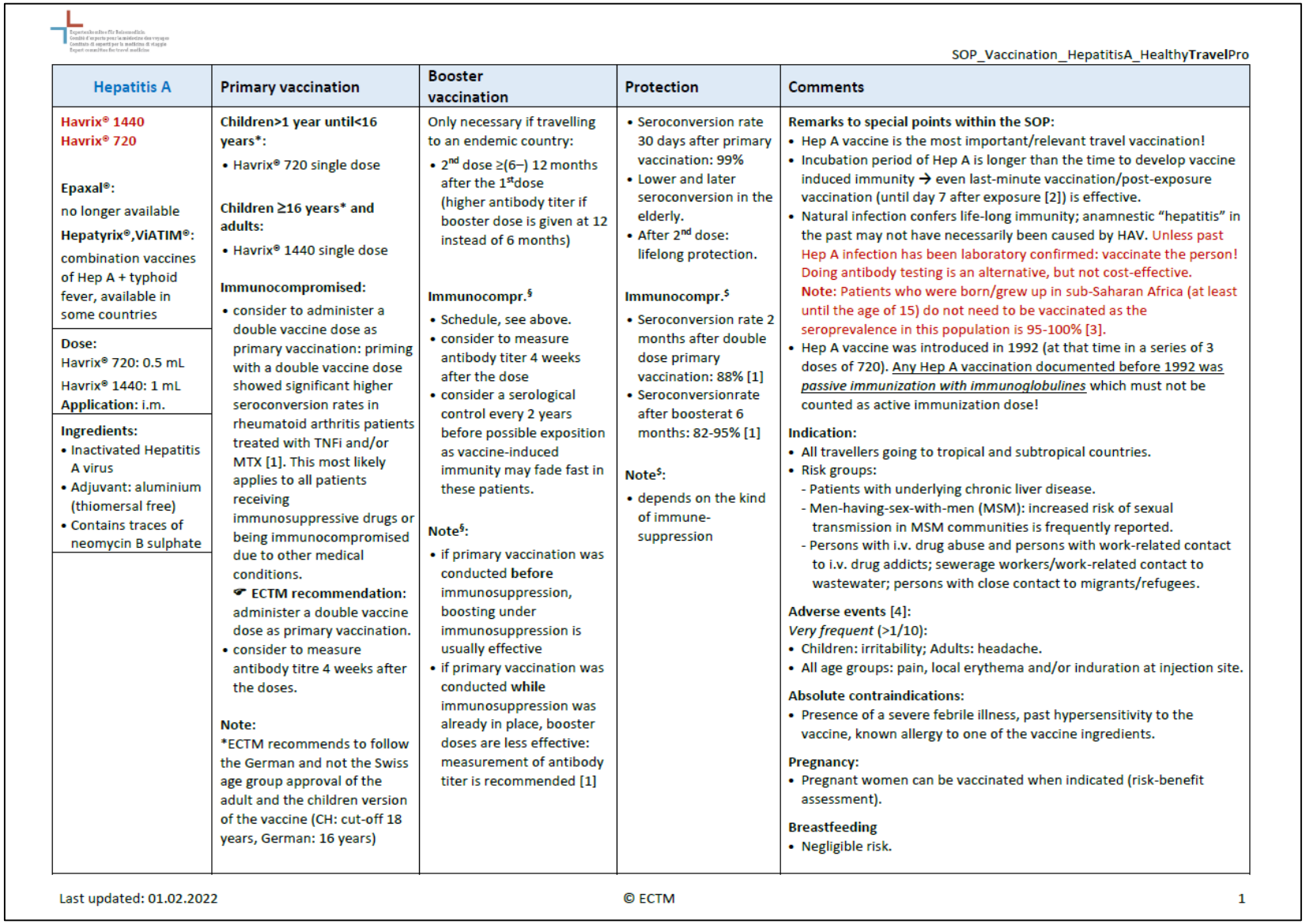
SOP

Standard **O**perating **P**rocedure by vaccination

Provides detailed information by vaccines including expert advice

Accessible **only** for

- Health care professionals



SOP_Vaccination_HepatitisA_HealthyTravelPro

Hepatitis A	Primary vaccination	Booster vaccination	Protection	Comments
Havrix® 1440 **Havrix® 720** **Epaxal®:** no longer available **Hepatyrix®,ViATIM®:** combination vaccines of Hep A + typhoid fever, available in some countries **Dose:** Havrix® 720: 0.5 mL Havrix® 1440: 1 mL **Application:** i.m. **Ingredients:** • Inactivated Hepatitis A virus • Adjuvant: aluminium (thiomersal free) • Contains traces of neomycin B sulphate	**Children>1 year until<16 years*:** • Havrix® 720 single dose **Children ≥16 years* and adults:** • Havrix® 1440 single dose **Immunocompromised:** • consider to administer a double vaccine dose as primary vaccination: priming with a double vaccine dose showed significant higher seroconversion rates in rheumatoid arthritis patients treated with TNFi and/or MTX [1]. This most likely applies to all patients receiving immunosuppressive drugs or being immunocompromised due to other medical conditions. ☛ **ECTM recommendation:** administer a double vaccine dose as primary vaccination. • consider to measure antibody titre 4 weeks after the doses. **Note:** *ECTM recommends to follow the German and not the Swiss age group approval of the adult and the children version of the vaccine (CH: cut-off 18 years, German: 16 years)	Only necessary if travelling to an endemic country: • 2nd dose ≥(6–) 12 months after the 1st dose (higher antibody titer if booster dose is given at 12 instead of 6 months) **Immunocompr.§** • Schedule, see above. • consider to measure antibody titer 4 weeks after the dose • consider a serological control every 2 years before possible exposition as vaccine-induced immunity may fade fast in these patients. **Note§:** • if primary vaccination was conducted **before** immunosuppression, boosting under immunosuppression is usually effective • if primary vaccination was conducted **while** immunosuppression was already in place, booster doses are less effective: measurement of antibody titer is recommended [1]	• Seroconversion rate 30 days after primary vaccination: 99% • Lower and later seroconversion in the elderly. • After 2nd dose: lifelong protection. **Immunocompr.§** • Seroconversion rate 2 months after double dose primary vaccination: 88% [1] • Seroconversionrate after boosterat 6 months: 82-95% [1] **Note§:** • depends on the kind of immune-suppression	**Remarks to special points within the SOP:** • Hep A vaccine is the most important/relevant travel vaccination! • Incubation period of Hep A is longer than the time to develop vaccine induced immunity → even last-minute vaccination/post-exposure vaccination (until day 7 after exposure [2]) is effective. • Natural infection confers life-long immunity; anamnestic "hepatitis" in the past may not have necessarily been caused by HAV. Unless past Hep A infection has been laboratory confirmed: vaccinate the person! Doing antibody testing is an alternative, but not cost-effective. **Note:** Patients who were born/grew up in sub-Saharan Africa (at least until the age of 15) do not need to be vaccinated as the seroprevalence in this population is 95-100% [3]. • Hep A vaccine was introduced in 1992 (at that time in a series of 3 doses of 720). Any Hep A vaccination documented before 1992 was *passive immunization with immunoglobulines* which must not be counted as active immunization dose! **Indication:** • All travellers going to tropical and subtropical countries. • Risk groups: - Patients with underlying chronic liver disease. - Men-having-sex-with-men (MSM): increased risk of sexual transmission in MSM communities is frequently reported. - Persons with i.v. drug abuse and persons with work-related contact to i.v. drug addicts; sewerage workers/work-related contact to wastewater; persons with close contact to migrants/refugees. **Adverse events** [4]: *Very frequent* (>1/10): • Children: irritability; Adults: headache. • All age groups: pain, local erythema and/or induration at injection site. **Absolute contraindications:** • Presence of a severe febrile illness, past hypersensitivity to the vaccine, known allergy to one of the vaccine ingredients. **Pregnancy:** • Pregnant women can be vaccinated when indicated (risk-benefit assessment). **Breastfeeding** • Negligible risk.

Last updated: 01.02.2022 © ECTM 1

Maps

SECTION 5

Vaccinations for **all** travellers

	Risk Area	Factsheet	Flyer	SOP	MAP	Bookmark
+ COVID-19	Worldwide					★
Recommendation	Vaccination recommended, see Swiss Federal Office of Public Health (FOPH), LINK. Entry requirement for some countries, see IATA LINK.					
+ Yellow fever	See map					★
WHO recommendation	**Vaccination recommended** for all travel except for areas listed below. **Vaccination not generally recommended:** Cities of Barranquilla, Cali, Cartagena, Medellín. **Vaccination not recommended:** >2300m, city of Bogotá, department/islands of San Andrès y Providencia.					
Country requirement at entry	Vaccination is mandatory for entry within 6 days from Angola, Brazil, D.R. Congo, Uganda (not for airport transit there). The vaccination must have been administered at least 10 days before entry.					

Find additional information per disease:

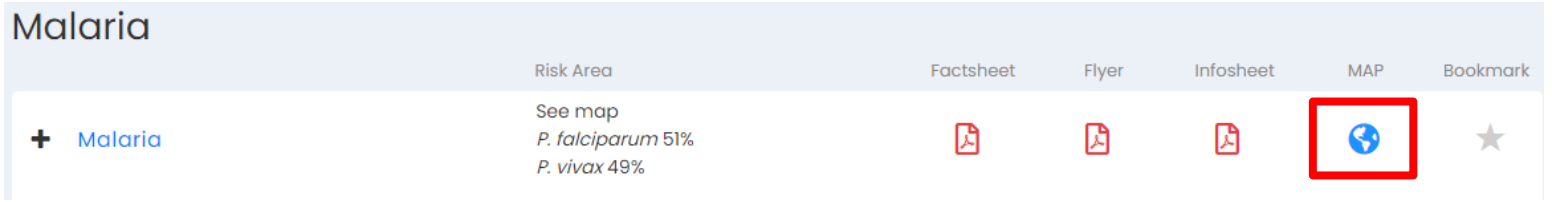
- Factsheet: General Information on the disease for laypersons
- Flyer: General Information on the disease + its medication or treatment. Can be used and given to the client during consultation.
- SOP: Standard Operating Procedure for the use of vaccinations

Where do I find maps?

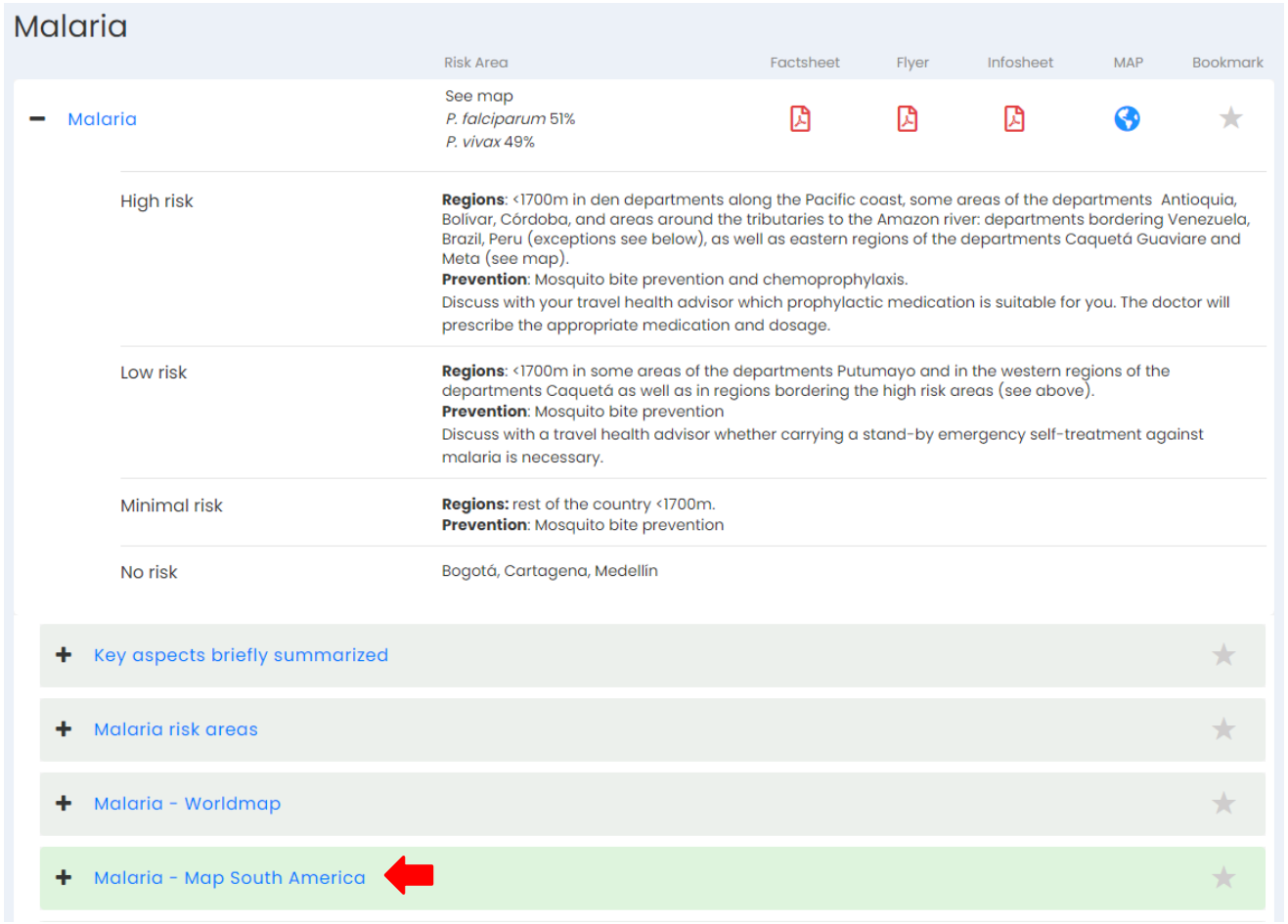
Available for:

- Public: general maps
- Health care professionals: detailed maps

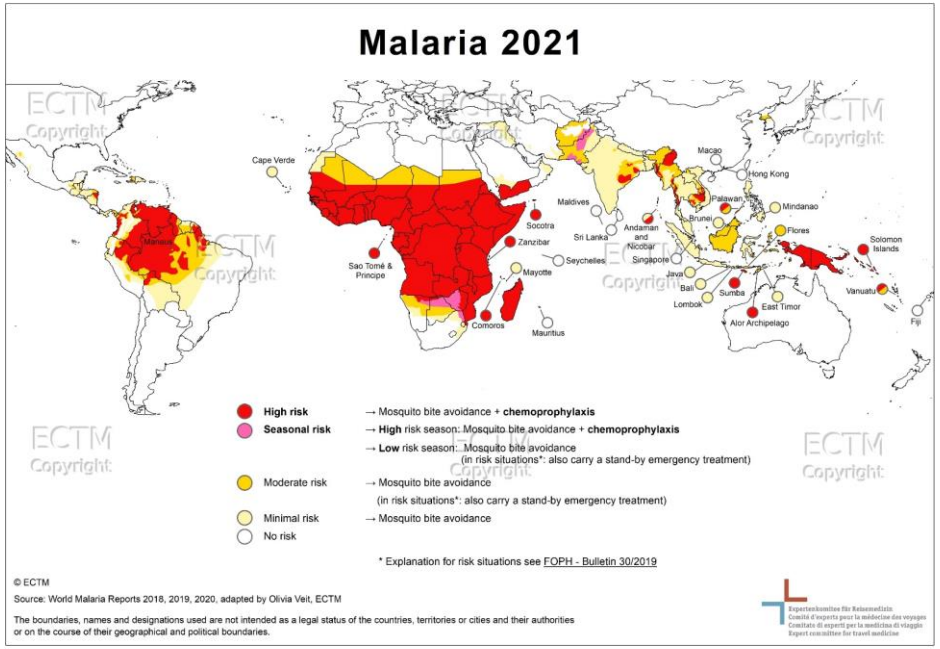
- You can find maps either in the overview line by clicking on the sign OR



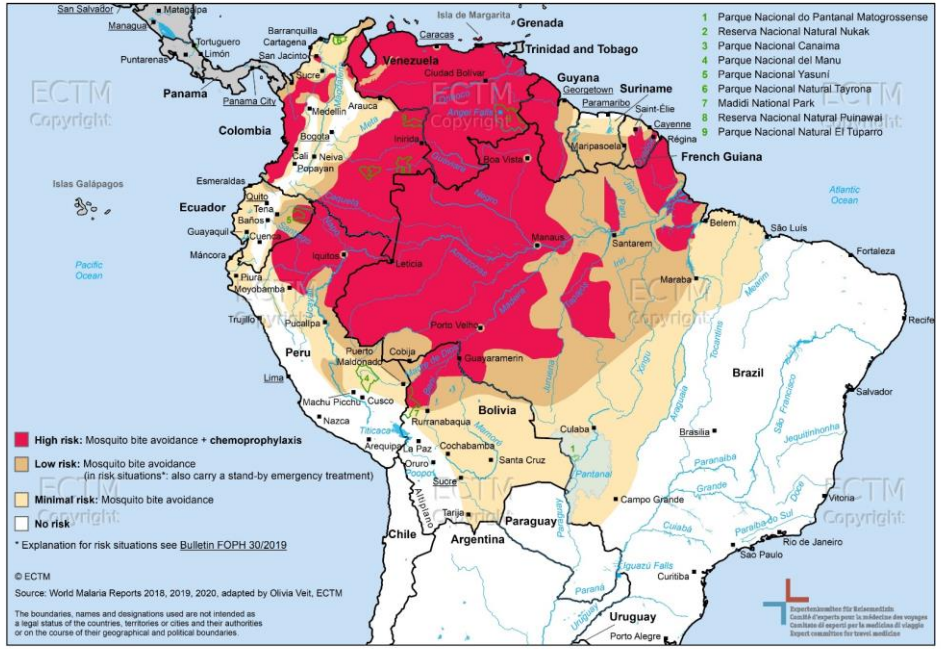
- Within, when opening the vaccination or disease



PUBLIC: MALARIA WORLD MAP



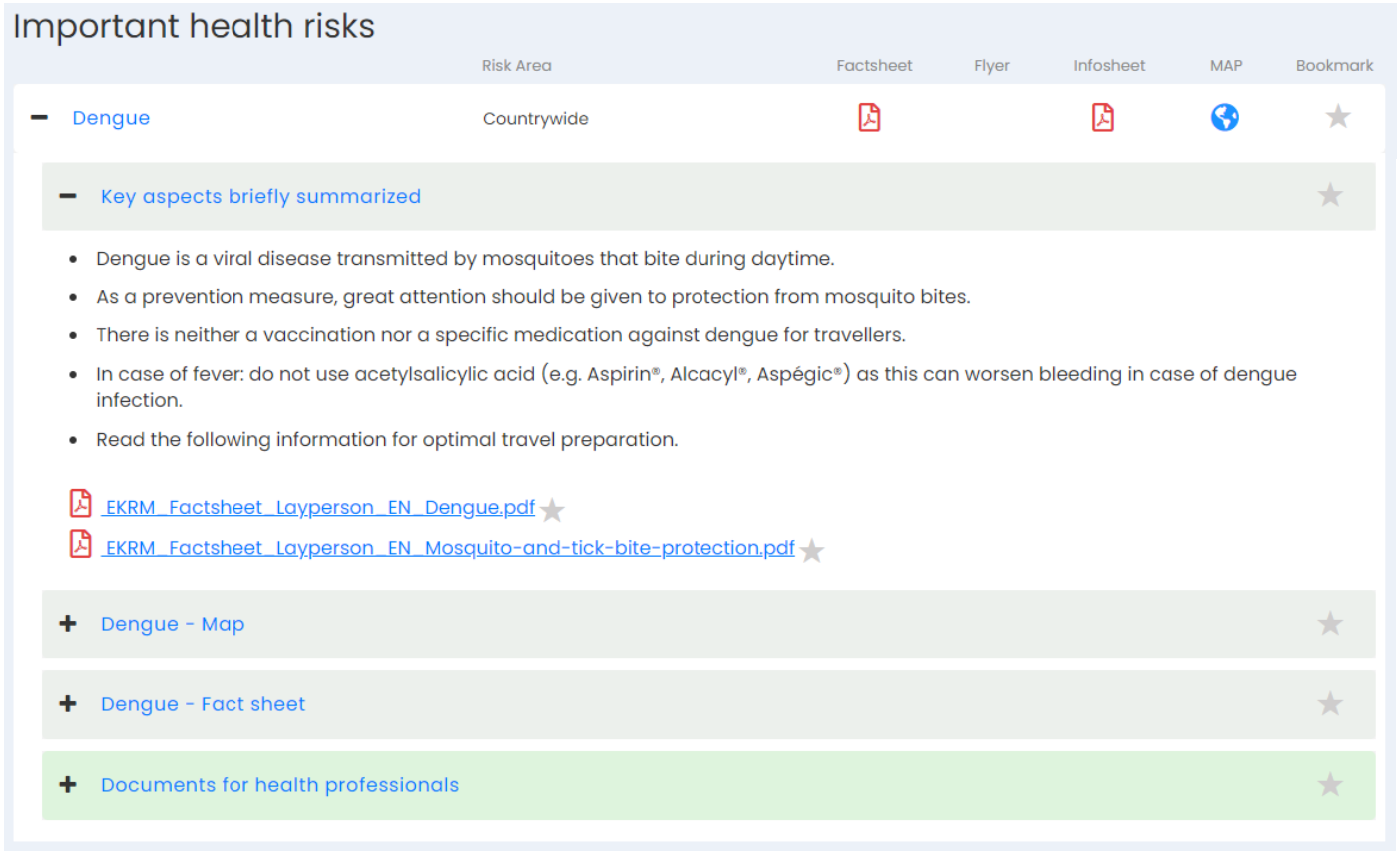
HEALTH CARE PROFESSIONALS: DETAILED MAPS



Additional Information

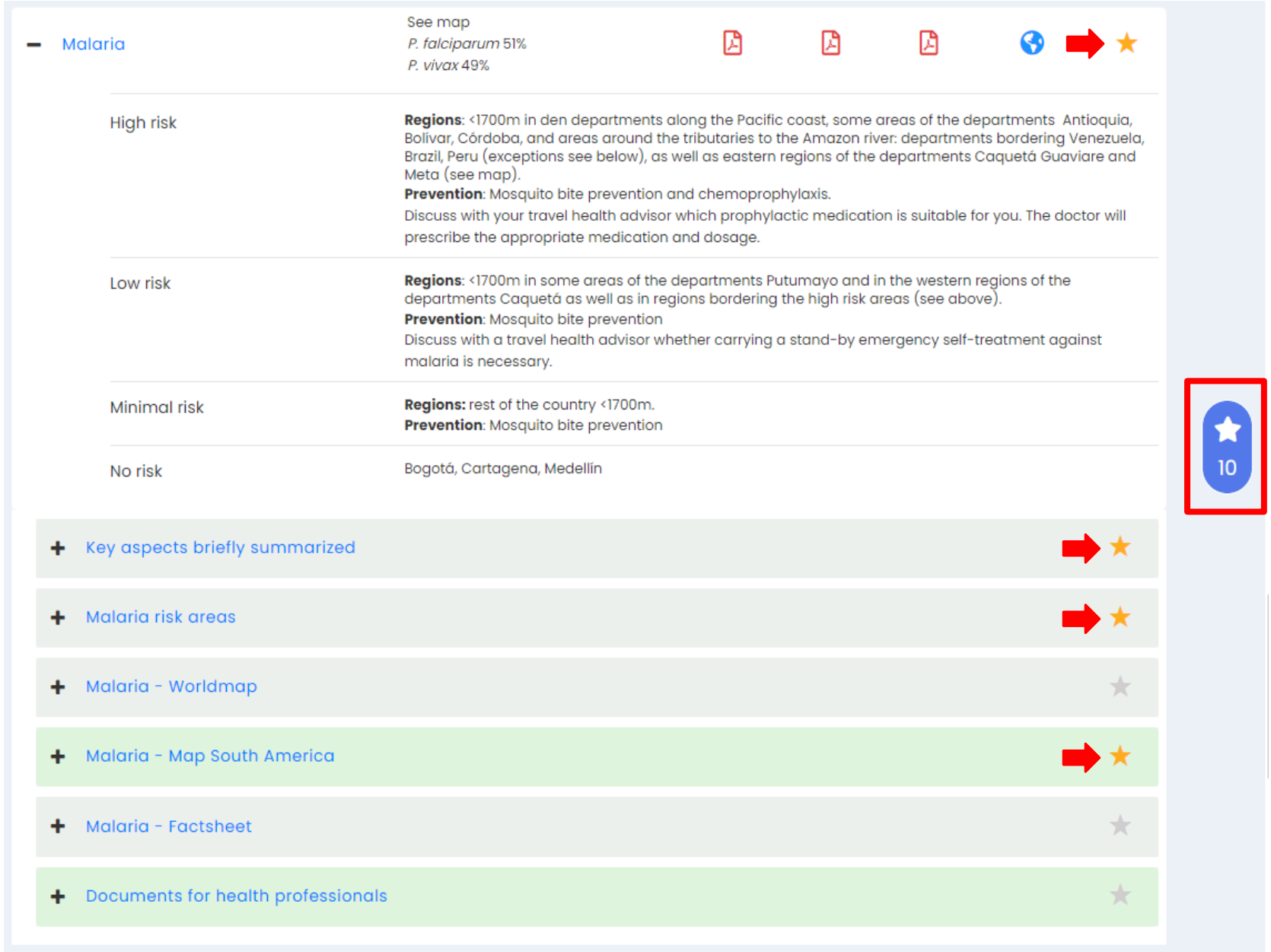
Open the disease on the **+** sign to get more information on

- key aspects on the disease
- maps
- factsheets
- documents for professionals



Content for Report – Bookmark

Set bookmarks on all the topics or content that you would like to print out in a report



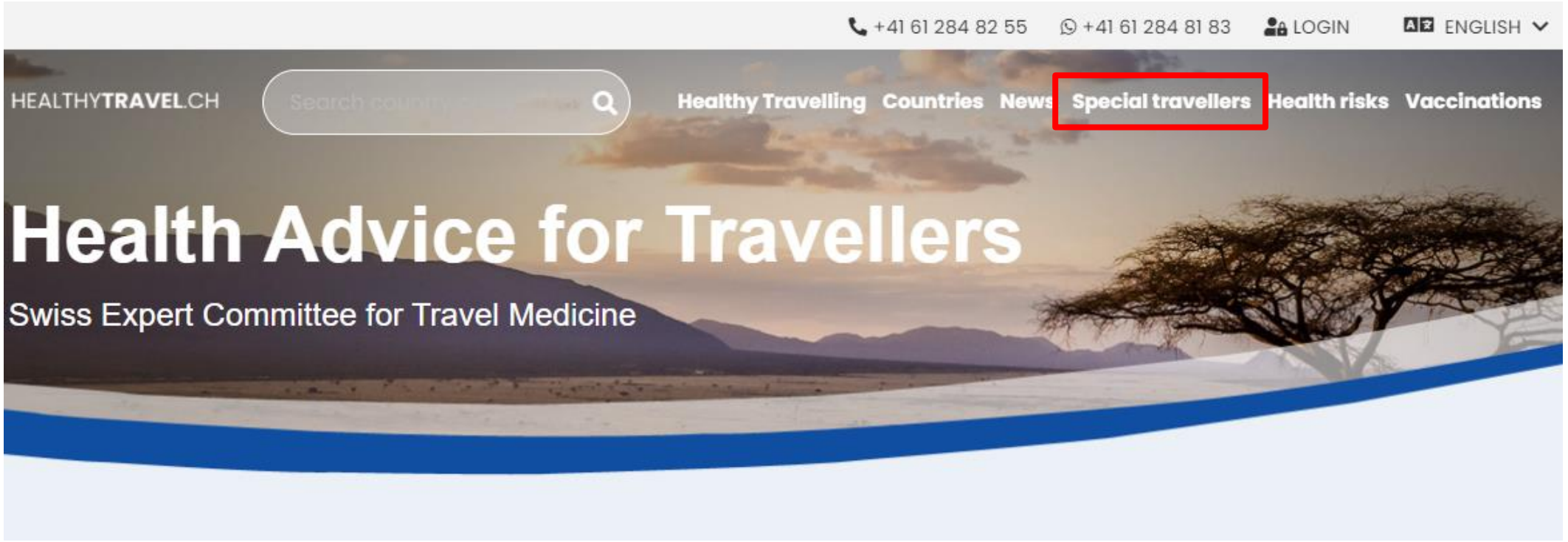
1) Check the content before printing / sending electronically and delete if not needed

2) Generate report

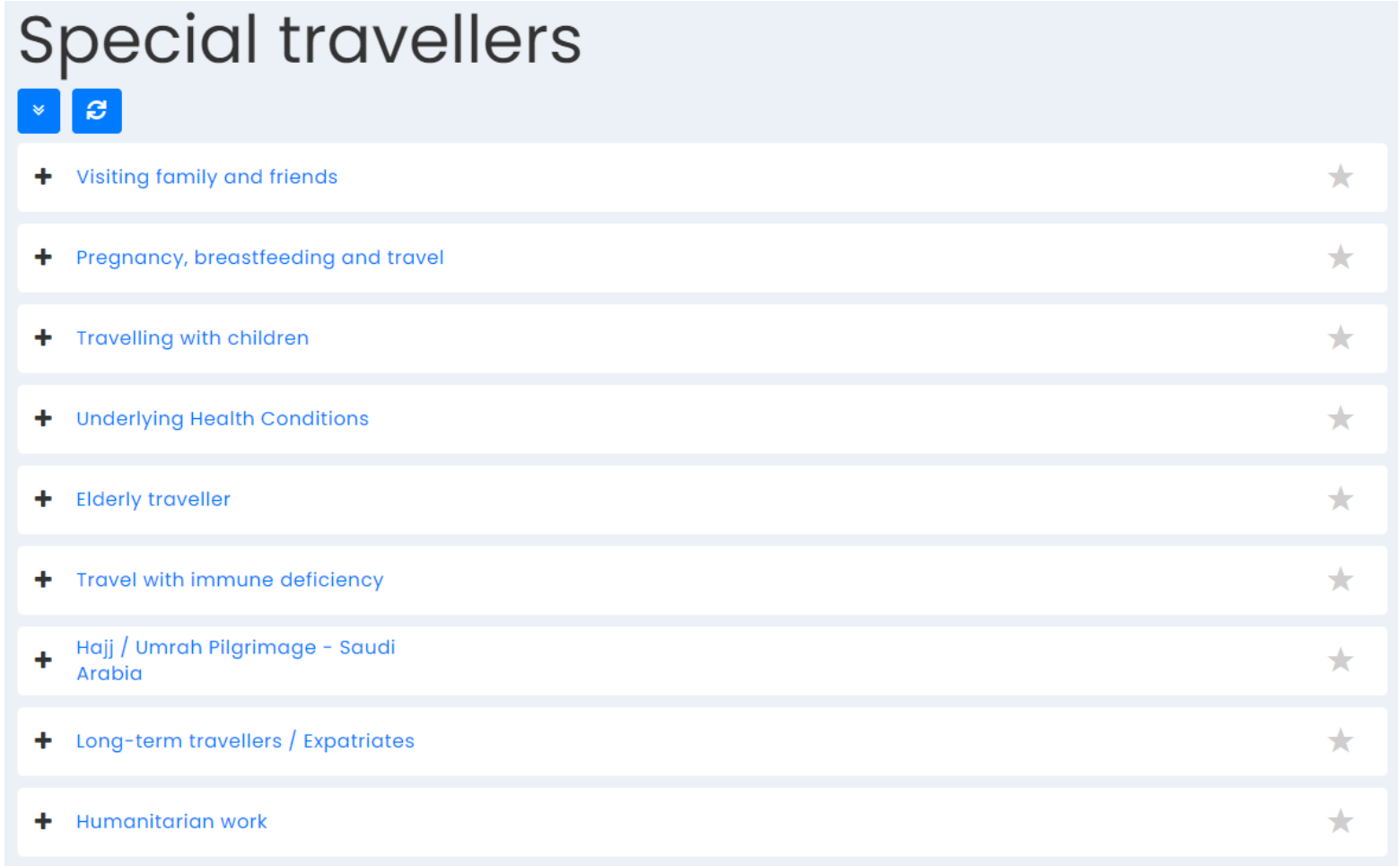
Further Information

SECTION 6

Further information



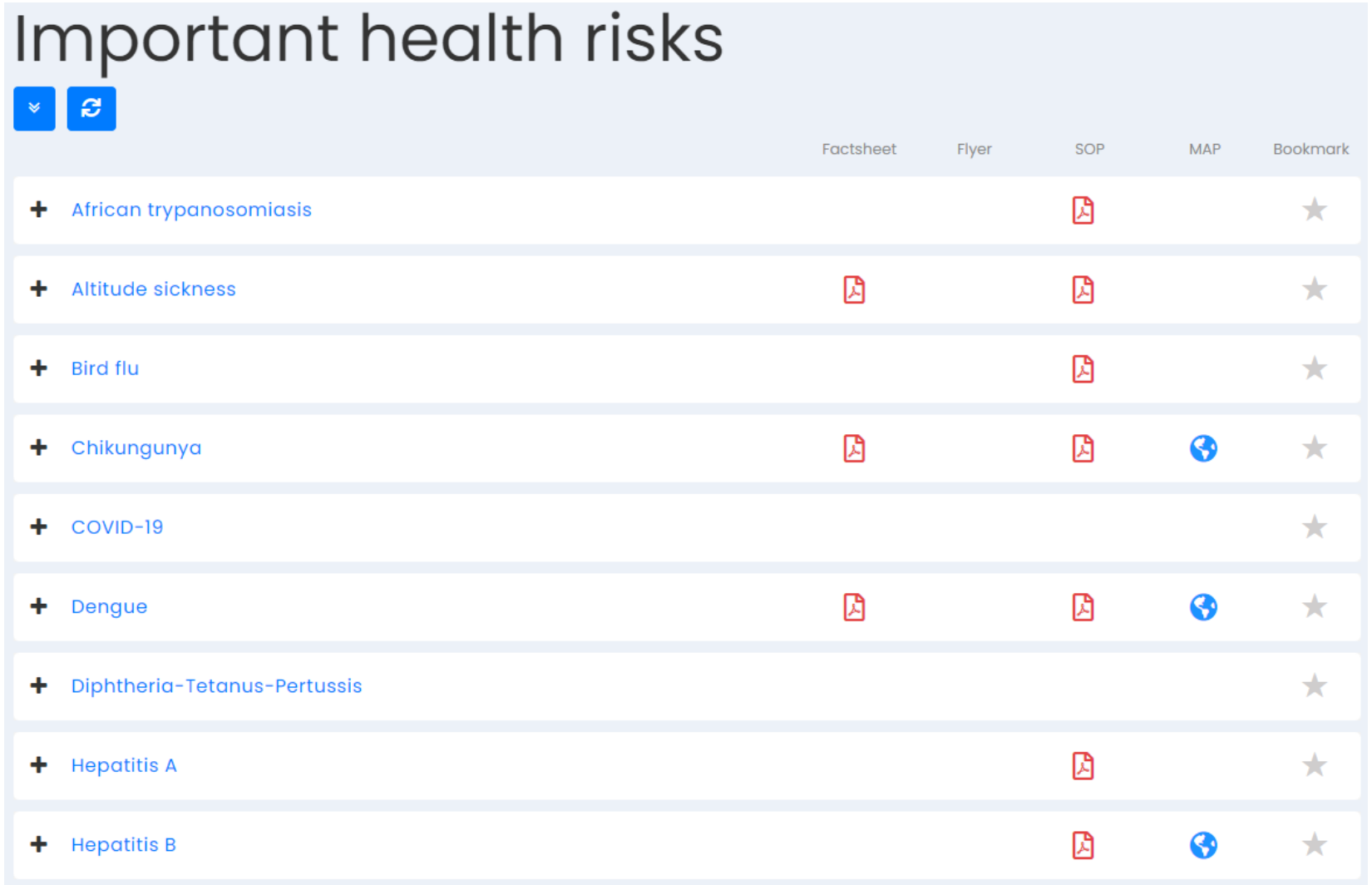
Special travellers



Further information

Health risks

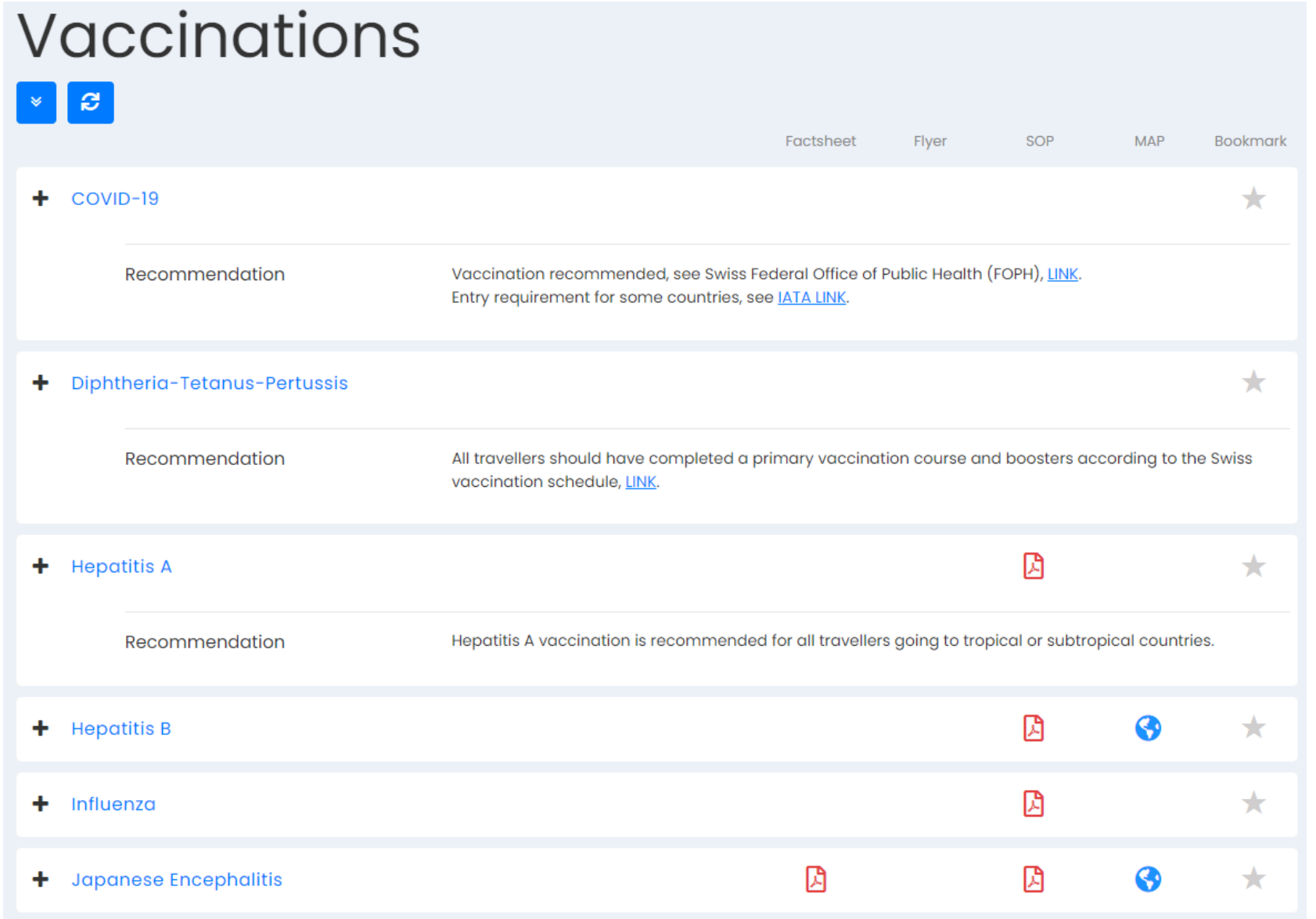
Information in alphabetical order



Further information

Vaccinations

Information in alphabetical order



Feedback

We welcome constructive feedback!

You can let us know your suggestions for improvements to the handling of the website, information that you are missing and more to the following e-mail address:

healthytravel@werdersolutions.ch

A form will be available on the website as soon as possible.

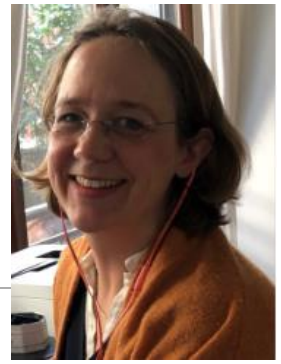
Kontakt - Werder Solutions
werdersolutions.ch

Many thanks!

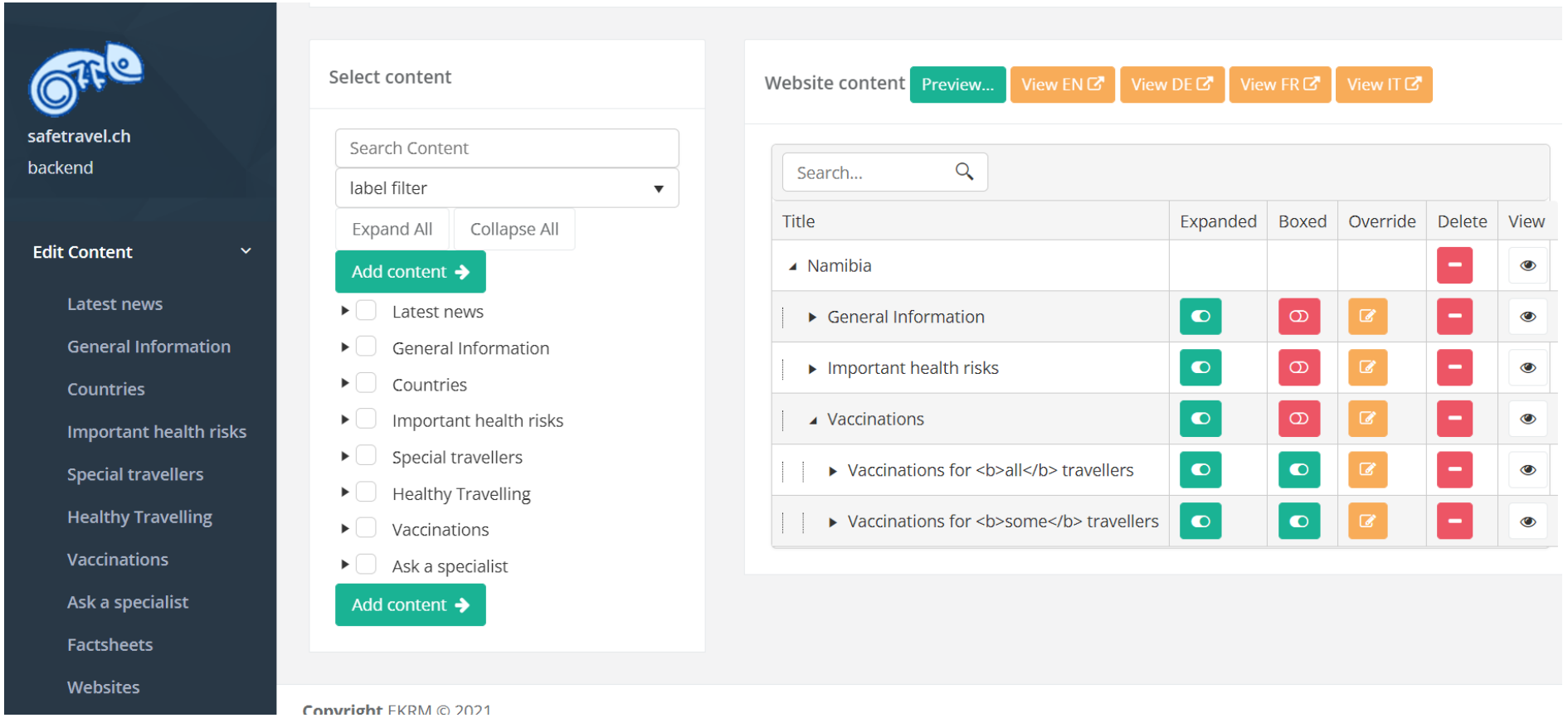
YOUR ECTM CORE GROUP AND PARTNERS

IT-Venture | wir digitalisier...
it-venture.ch

Stefania Digrazio



Content management System (CMS)



Content management System (CMS)