



FEDERATION OF TOUR
OPERATORS

FTO EUROPEAN TOURIST ACCOMMODATION SAFETY STUDY:

**An analysis of the common travel associated
infections, their surveillance and control. A view
from the tourist industry**

Report by

Professor Rodney Cartwright and Dr Esteban Delgado

About the report's author

Professor Rodney Cartwright is a registered medical practitioner who specialised in clinical and public health microbiology. He was a Group Director in the Public Health Laboratory Service and the Medical Advisor to the Federation of Tour Operators. He has over thirty years practical experience in working with UK health authorities and governments in tourist destinations.

Dr Esteban Delgado is a scientist with special expertise in hygiene practices in hotels and restaurants. He has been involved in the investigation and management of many outbreaks of infection in tourist establishments. He is the Managing Director of Preverisk, a Majorcan based hygiene consultancy, and is the public health adviser to the FTO.

The Federation of Tour Operators

The vision of the Federation of Tour Operators (FTO) is to ensure the continued long term success of the leisure travel industry by influencing governments and opinion formers on the benefits of providing financially protected, safe and sustainable holidays compared to other forms of holiday arrangements. The FTO and its members have been proactive in the field of holiday health, safety and hygiene for many years.

The FTO has a committed and proactive Health and Safety Committee attended by industry professionals, who are supported by the Destination Services Manager and independent technical experts in areas such as fire safety, gas safety, security, food hygiene, health and transportation. Through partnership, education, information and support, the FTO continues to exercise a powerful influence for change on issues such as, health, safety, hygiene and regulatory improvements overseas.

In 2009 the FTO merged with ABTA – the Travel Association. The FTO and ABTA now work together to represent the interests of tour operators and travel agents in addition to providing health and safety advice, protection for customers, training for members as well as representing the interests of members to government. For more information please visit www.fto.co.uk or www.abta.com.



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Executive Summary

The commissioning of this report by the FTO reflects a very real concern held by tour operators about the varying levels of public health safety across the destinations that UK tour operators serve. Whilst this report should underline that the vast majority of holidays taken by UK holidaymakers are safe there remains problems with some destinations in terms of public health control and infections.

This report reviews the key diseases and infections contracted by UK travellers abroad and makes recommendations on how they can be addressed by UK and destinations health authorities. Although the majority of diseases and infections covered in this report are non-fatal the impact on public health of infection and the net loss of productivity to UK plc is still important.

The key recommendation from this report is that there needs to be a greater dialogue and information sharing between tourist groups, tour operators and public health authorities. We believe that by sharing more information on infections the number of incidences of infection could be reduced. This reports makes a number of recommendations in connection with the aim of improving the public health of travellers.

We believe that with added political priority considerable improvements can be made with relatively little outlay that will deliver results for the travelling public. We encourage those readers within government or related influencer groups to support the recommendations in order that public health of travellers can be improved.

This report recognises the importance of the Health Protection Agency's role in providing an integrated approach to protecting public health in the UK by providing support and advice to the NHS, local authorities, and the Department of Health and the Devolved Administrations. This report is not intended as a critique of the HPA rather as a call to arms to encourage the remit of the HPA to be developed further to formalise greater EU collaboration for reducing some tourist-related infections. We recognise that the HPA are already active in this area and thank them for their efforts in relation to travellers health to date. Where further actions are suggested, it is acknowledged that they are operating within the funding constraints and mandate set by the Department of Health.

Ultimately, many of the challenges raised in this report concerning the role of the HPA both in UK and EU destinations are policy and funding questions for their relevant Departments for Health and we encourage those with an interest in tourism and health to look carefully at how the remit of the various Health Agencies can be further developed to tackle some of the challenges discussed in this report.

Objective

The objective of this report is to investigate the efficacy of surveillance, investigation and control of the principal travel associated infections affecting UK travellers abroad. This report considers whether the current regime within the EU is adequate to protect European travellers and, if not, what steps should be taken to improve infection control and the health of the travelling public.

1. Background

The prevention of illness in travellers has a high priority in the tourist industry and the industry works together in order to protect the travelling public. This is not a new approach and procedures have been developed over the past three decades by the Federation of Tour Operators recognising that they lead the way for other sectors of the industry. Travellers' health crosses the professional boundaries of health and tourism. There is a long recognised

view within the tourism sector that there is a market failure caused by the lack of interaction between tourism and public health professionals in both the origin and destination markets.

Thirty to forty years ago the main health concerns within the sector was with destinations in Europe. These concerns have largely been dissipated by considerable improvements in the public health infrastructure of these destinations and by the adoption of common European health and safety legislation. The ever expanding number of destination countries for travel has, however, shifted the areas of greater health concern outside Europe. The concern is not only for the travellers but on the risks to UK public health from infections brought back into the UK by returning travellers.

The tourist industry has expertise in tourism and aims to provide good safe travel for its customers. The industry recognises the importance of both health and safety and has a general understanding of both and their impact on tourism. It is recognised that the health authorities are the experts in public health matters including the surveillance of disease, outbreak investigation and control measures. Historically, however, tourism groups and health authorities have not enjoyed a close working relationship. A more distant relationship has, we believe, resulted in an inadequate response to travel associated infections.

Over the same period tour operators have also become responsible for ensuring that improvements within a hotel are carried out, irrespective of their actual legal obligations, as they have contractual powers with the hotelier. They have no authority to change the public health infrastructure or the hygiene in restaurants or similar establishments.

As many of the infections may be associated with a hotel the tour operator potentially has a legal responsibility under the Package Travel Regulations. There may be a failing in public health standards within a resort but the tour operator may still be held legally liable by the UK courts. This situation provides for a strong case in hoteliers, accommodation providers, tour operators and home and destination health authorities working together to a greater extent than has been the case.

1.1 Travel associated infections

The list of travel associated infections is very large but the commonest recognised infection associated with travel is traveller's diarrhoea, a condition that has over the years been known by many names such as *Montezuma's Revenge*, *the Pharaoh's Curse*, *Delhi Belly* and *Spanish Trots*. The majority of those afflicted have an illness lasting a few days with no medical involvement and no reporting to national surveillance systems.

Some of the infections are however due to well recognised micro organisms such as salmonella, campylobacter, cryptosporidium and norovirus that may have a wider public health significance. An even smaller number are due to microbes that are a greater risk and include typhoid fever and Hepatitis A. All of these infections are associated with deficiencies in water or food hygiene. In many European destinations the incidence has fallen dramatically as local public health hygiene has improved. Stomach upsets remain a major problem for tourists in many popular destinations outside Europe. Information on the incidence in various destinations has been collected by FTO members (British Federation of Tour Operators) for nearly 30 years and remains the only information source available on these conditions.

The other major infection, recognised in the past twenty years, Legionnaires Disease, has featured as an important travel associated infection and is of particular importance in that the

fatality rate from this disease in this period has remained at about 10%. This is an infection that, however, is well controlled through the European Surveillance Scheme for Travel Associated Legionnaires' Disease (EWGLINET). EWGLINET is supported as a European Union Disease Specific Network (DSN) under Decision 2119/98/EC of the European Parliament.

Both traveller's diarrhoea and legionnaires disease are largely controlled by a good quality public health infrastructure in resorts and good food and water hygiene in hotels. Highlighting these infections does not mean that the many other travel associated infections are of less importance but they are covered by the advice given on the National Travel Health Network and Centre (NaTHNaC) web site (www.nathnac.org).

1.2 The prevention of travel associated infections.

The main preventative measures are one or more of:

- the traveller taking medication e.g. anti malarial drugs
- the traveller being immunised e.g. typhoid, hepatitis A
- the traveller taking avoidance measures e.g. using insect repellents
- the traveller following advice on food and water consumption
- an efficient public health infrastructure in destinations e.g. safe drinking water, sewage disposal, and waste management
- good food and water hygiene in hotels and restaurants

The first four actions involve the travellers taking action before travelling. Information for travellers and health care professionals who may be called upon to provide advice is well covered on the NaTHNaC web site. Tour operators encourage travellers to seek advice well before the commencement of their journey.

The latter two points require action by the public health authorities in the destination countries and the hoteliers and restaurateurs. All countries strive to have a good public health infrastructure but all too frequently priority has been given to tourist complexes while ignoring the areas where the staff of hotels live. The staff can acquire an infection and bring it into a hotel. Hoteliers and restaurateurs need to implement good health and hygiene procedures within their establishments. FTO members have developed programmes to assist through their preferred Code of Practice In order to assist the hoteliers.

It needs to be remembered that in many destinations the public health priorities of the indigenous population are different from those of the tourist. The public health authorities in destinations may take little or no action to reduce the level of illness in tourists because they are unaware of the problem. There is a need to improve communication between the health departments of home and destination countries. Health information from the tourist industry can often be ignored by health authorities in both destination and home countries, as such information is often regarded as suspect or insufficiently robust. This has created a situation whereby important improvements in health control that could have an impact on the health of the travelling public could be being ignored.

1.3 The public health implications of travellers returning to the UK with an infection.

If a tourist returns home with an active infection they may become a source for its spread within the UK. The time it takes for such infections to be recognised will vary depending on

the returned traveller seeking medical advice, laboratory confirmation of the diagnosis and reporting to the Health Protection Agency. Whether or not the infection is recognised as travel associated will depend on the adequate collection and reporting of a relevant travel history. It is worth noting that the draft Health Protection Regulations, the consultation period for which ended on 30 September 2009, does not require a travel history to be recorded. (www.dh.gov.uk/en/Consultations/Liveconsultations/DH_102134)

It should be noted that some infections such as Legionnaires Disease while not a public health hazard as they do not spread from person to person may require the infected person to receive intensive hospital treatment.

2. Some problems experienced by the travel industry

Over the past thirty years the travel industry has recognised the importance of travel associated infections for the health of the traveller and the subsequent potential public health risks. Considerable efforts have been made to work with the UK and destination country health authorities with little success. This appears to be due to a number of factors including the fact that illnesses in travellers occur in the destination country but may be diagnosed in the home country.

A proper investigation would require input from the health authorities of both countries but the funding for such cooperation does not appear to exist. There is also the problem of professional barriers. Health matters are rightly regarded as the province of health authorities but input from the tourist sector, which may have important information, is largely ignored.

Another problem frequently reported by FTO members is protectionism of destinations' reputations and the disincentive that reporting health infections may have on tourist income and reputation. This problem may be of major relevance in those destinations where tourism is the main economic driver of the local economy.

Our research suggests that many of the illnesses experienced by travellers never have a definitive diagnosis and therefore do not appear in health authority records. For example a large outbreak of diarrhoea in a resort with the illness lasting only 3-4 days is unlikely to be investigated by resort health authorities and even if a causative organism is isolated from returning travellers this information is unlikely to be sent back to the resort country health authorities.

In order to protect tourists, the tourist industry has found it necessary to undertake their own investigations but these are limited to the properties in which an incidence occurs. Liaison with municipality authorities is always undertaken and on occasions this has resulted in joint resort health authority and tour operator investigations which the tourist sector broadly welcomes. Examples of this include the problems in the Algarve in the mid 1980s, the typhoid outbreak in Salou, Spain in 1989 and work over many years in the Dominican Republic.

Our study suggests, however, that there is no consistency in the approach to high background levels of illness or an outbreak situation. Tour operators, who may be sued by ill travellers, are required to undertake surveillance, investigation and remedial action with little or no help from any health authorities. These are all functions normally associated with the public health authorities.

The one exception to this is with respect to Legionnaires Disease within Europe and the work of EWGLINET. The health authorities of different countries work together and with the tourist industry on the control of legionnaires disease. This co-operation is widely supported by both tour operators and health authorities and is, we believe, a good example of co-operation that should be embraced across other diseases and infections.

2.1 Assessing illness levels in destinations

Various destinations are known for the higher levels of stomach upsets but there is no hard information from national surveillance systems such as the HPA. The Executive Summary of the Health Protection Agency publication “Foreign Travel-Associated Illness 2007 states that:

“While enhanced surveillance systems exist, or are being developed, for some travel-associated illnesses, the capture of travel history in routine surveillance remains poor. This further limits the usefulness of the data generated, which in any case, generally represents only the more severe end of the clinical spectrum of infections acquired abroad and therefore underestimates the true number of cases. Furthermore, routine laboratory reporting does not collect the information required to determine which particular groups are at risk, nor which preventive measures may be most effective.”

FTO members have partly overcome this by collecting very simple data from customers during the return flight to the UK on stomach upsets. This is purely subjective and does not give any information as to the cause. The information does, however, enable high incidence destinations to be targeted for action by tour operators but this is an often ad hoc rather than a structured approach in tandem with local health authorities.

2.2 Identifying and reporting incidents (outbreaks)

Reports of specific illnesses such as salmonellosis or cryptosporidiosis to the HPA may raise the possibility of an outbreak in a resort. The tour operator is usually aware that there is a problem but does not know the cause as clients report an illness during their holiday. It is unusual for local doctors to undertake any laboratory examinations, and if undertaken, in most occasions they are not communicated to tour operators.

Depending on the organisms reported to the HPA the information may be recorded without action or may be reported to the WHO Regional Office. Reports will also be made to the European Surveillance Scheme at the European Centre for Disease Prevention and Control (ECDC). All these official reporting channels take time measured in weeks or months. The tourist industry needs to respond rapidly to a problem. In the event of an outbreak new travellers may be leaving the UK within a few days or may even be en route to a resort or hotel. The question is ‘is it safe for them or should alternative arrangements be made?’ The necessary time scale for immediate action is hours and days rather than weeks. This is an area where we believe further action should be taken.

3. Travel Associated Disease Surveillance

3.1 Health Protection Agency

Data on travel-associated infection

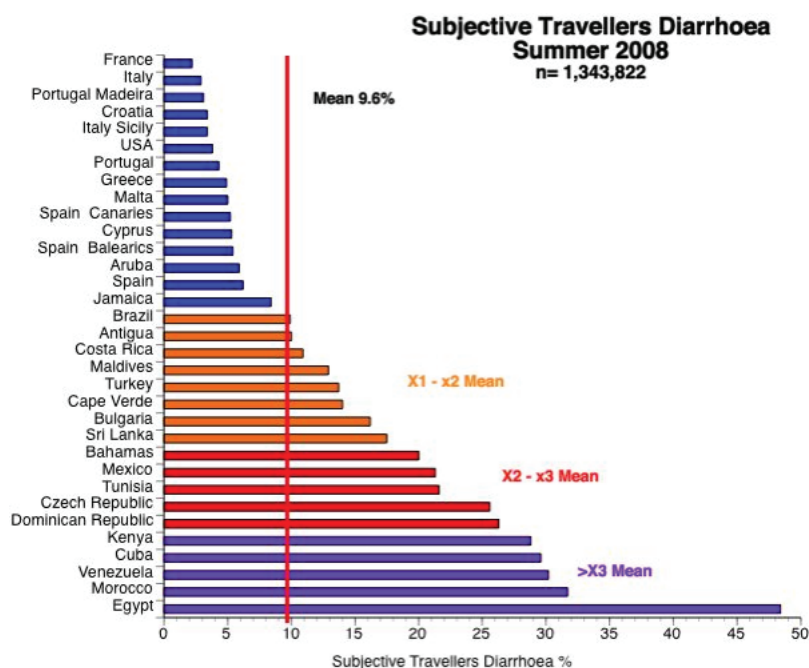
(www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1202115614857)

There are currently three main sources of data which together help to build a picture of the burden of travel-associated infections in the population of England, Wales, and Northern Ireland and which have been used in this report. These are:

- National surveillance of laboratory-confirmed infections reported via LabBase;
- NOIDS (Statutory Notification of Infectious Diseases);
- Information received through enhanced and sentinel surveillance systems.

These three systems each give a slightly different view of the picture. Cases identified through one system are not necessarily represented in the others. It must also be remembered that cases of travel-associated infections recorded through these systems represent only the 'tip of the iceberg' and tend to be biased towards those that are more clinically severe. Some patients may become ill while abroad and seek attention there, never coming to the attention of health services in the UK. Many others may not seek medical attention on their return, if their illness is mild. If they do seek help, their doctor (GP or hospital clinician) may treat on clinical grounds without requesting laboratory investigation of specimens (e.g. sputum, blood, faeces), or without notifying those diseases that are notifiable. Some pathogens may be difficult to identify by laboratories, and even where positive results are obtained, these may not always be reported to the surveillance system or may not include a travel history. All the data presented in this report therefore under-estimate the true burden of travel-associated infection, especially milder and very short incubation period disease. This has implications, both when trying to advise intending travellers and in assessing the public health impact of travel-associated disease in England, Wales, and Northern Ireland.

This system while essential in planning strategies for the prevention of the more clinically severe travel associated illnesses does not record the majority of the illnesses acquired by travellers. The system also only records the number of persons ill without reference to the number of travellers to a destination.



3.2 Federation of Tour Operators

For over 25 years, FTO members have collected data on the incidence of stomach upsets (termed Subjective Travellers Diarrhoea) reported by their customers. The data originates from questionnaires completed by tourists during their return journey flight to the UK. The relevant question is *“Did you have a stomach upset lasting more than 24 hours during your holiday?”* An analysis of the results is presented monthly.

The information is crude and simple but the results correlate well with outbreaks reported for other sources, and they give an overall picture of the public health hygiene of destinations. It does not identify outbreaks in a timely manner although may confirm that one has occurred. The information is shared with Ministers of Tourism of destination countries. Its use has been the key to persuading a number of governments to make significant improvements to the public health infrastructure on tourist areas. This has been to the advantage of the indigenous population as well as tourists.

In summer 2008, data from 1,343,822 tourists was analysed. The destinations most associated with a stomach upset can be clearly seen. These are that destinations that the tourist industry is making representations to their governments. Progress is slow but the FTO is able to measure any change for better or worse.

This approach is generally regarded as to crude and simple by the health authorities but it has been used successfully to bring about beneficial changes.

The results are commercially and politically sensitive and are not therefore made public. They are however made available to the HPA and are used with good success in talking to destination governments. Destination governments are very sensitive about the figures and cooperation on improvements would be hampered by public release of the results. The countries with a high incidence are however well recognised by travel advisory sources and relevant advice is given to travellers visiting these destinations. The results only confirm what is already in the public domain.

- 3.3** There is an interesting example on outbreaks reporting within the travel and tourism industry: the US CDC (Centres for Disease Control and Prevention) has the Vessel Sanitation Program (VSP). This programme aims to assist the cruise ship industry to prevent and control the introduction, transmission, and spread of gastrointestinal illnesses on cruise ships. It applies to all cruises having a foreign itinerary with U.S. ports. The programme includes an electronic syndromic surveillance system that tracks cases of gastrointestinal illnesses. Cruise ship medical staff or other designated personnel are required to maintain a log of reported cases of gastrointestinal illnesses. Cases are self-reported by passengers and crew. Medical staff send a report to VSP that indicates the number of cases. An outbreak investigation is conducted by VSP in the case that a particular threshold of people reporting illness symptoms is reached or in the event of unusual illness symptoms or occurrence is reported.

The US public health authorities, through CDC, have a rapid and proactive global approach to assisting their own citizens who are affected by outbreaks of infection.

4. Action by the FTO

Representatives meet Ministers of Tourism from many countries at the annual World TravelMarket in London. Examples are given below of action being taken in relation to the two countries showing the highest levels of Subjective Travellers Diarrhoea. At present there are ongoing discussions with the Minister of Tourism in Egypt concerning the high level of illness reported among visitors. A document prepared last year is attached. It includes information from the HPA and Health Protection Scotland showing that a range of microorganisms including salmonella, shigella, campylobacter, cryptosporidium, E.coli 0157, Giardia and Hepatitis A. These are all microorganisms of public health importance that have been brought back to the UK by returning tourists.

Discussions are also being held with the Minister of Tourism of Morocco including sharing information from the HPA that in 2008 there were 80 confirmed cases of salmonella infection and 71 due to campylobacter in tourists returning to the UK from Morocco.

HPA travel data is reported in the Health Protection Record quarterly. See www.hpa.org.uk/hpr/infections/travel.htm

An extract from 3rd July 2009 is copied below. Egypt is a country that is high in the lists.

Table 2.

Laboratory reports of other Salmonella spp associated with foreign travel, England and Wales: first quarter 2007

Country of travel	S Enteritidis	S Typhimurium	S Virchow	Other Salmonella spp	Total
India	7	8	1	29	45
Egypt	30	2	1	8	41
Thailand	4	3	3	15	25
Kenya	4	2	1	7	14
The Gambia	–	–	5	8	13
Pakistan	–	1	1	9	11
Morocco	5	3	–	2	10
Tunisia	8	1	–	–	9
Bangladesh	–	1	3	5	9
Mauritius	4	3	–	1	8
Other countries (N=47)	32	17	4	41	94
Country not stated	10	8	2	21	41
Total	104	49	21	146	320

Campylobacter spp

There were 9953 laboratory reports of Campylobacter spp, of which 225 (2%) were associated with recent travel abroad (table 3).

Country of travel	<i>Campylobacter</i> spp
India	60
Thailand	21
Morocco	20
Spain	19
Egypt	11
Pakistan	9
France	5
South Africa	4
Sri Lanka	4
Mexico	4
Other countries (N=39)	57
Country not stated	11
Total	225

Table 3.

Laboratory reports of *Campylobacter* spp associated with foreign travel, England and Wales: first quarter 2009.

Shigella spp

In total, there 373 reports of shigella infection in the first quarter of 2009, of which 61 (16%) were associated with foreign travel. Travel history information was available for 74% for both *S. boydii* and *S. dysenteriae* reports, but for only 22% for *S. sonnei* and *S. flexneri*. Countries of travel are listed for each species in table 4.

Table 4.

Laboratory reports of *Shigella* spp associated with foreign travel, England and Wales: first quarter 2009

Country of travel	<i>Shigella</i> species					Total
	<i>S. flexneri</i>	<i>S. sonnei</i> *	<i>S. boydii</i>	<i>S. dysenteriae</i>	<i>Shigella</i> sp	
Egypt	6	7	2	–	–	15
India	2	3	6	3	–	14
Pakistan	2	1	4	4	–	11
Bangladesh	1	–	1	–	–	2
Sub-Saharan Africa	5	2	2	3	1	13
Spain	1	–	–	–	–	1
United Arab Emirates	–	2	–	–	–	2
Kuwait	–	1	–	–	–	1
Papua New Guinea	–	1	–	–	–	1
Country not stated	–	2	–	–	–	2
Total	17	19	15	10	1	62

* One case of *S. sonnei* had more than one country of travel so is included twice in table.

Cryptosporidium

There were 578 reports of cryptosporidium infection, of which 15 (3%) were associated with recent foreign travel. Countries of travel reported were India (three), Pakistan (two), and Egypt, Chile, Kenya, Cyprus, USA, Asia (unspecified), Cameroon, Malawi and Syria (one each); one report had no country stated. Sentinel surveillance submission forms to the UK Cryptosporidium Reference Unit (CRU) during the same time frame included 13 (8% of total) travel abroad-related cases [3]. Countries of travel reported to CRU were Bulgaria (one *Cryptosporidium parvum*), Burma (one *Cryptosporidium hominis*), Chile (one *C. hominis*), Egypt (one *C. hominis*), India (three *C. hominis*, one *C. meleagridis*), Malawi and Ethiopia (one not typable), Pakistan (one *C. hominis*), South Africa (one *C. parvum*), Spain (one *C. parvum*) and one had no country of travel stated (*C. parvum*).

It is felt that it would be appropriate for UK health authorities to be having discussions with the health authorities of many of these countries and especially those that are popular holiday destinations for British visitors.

Outbreaks of gastro intestinal infections

4.1 The commonest causes

In the experience of the tourist industry the main causes of outbreaks affecting tourists have been Norovirus, Cryptosporidium and Salmonella.

4.1.1 Norovirus is diagnosed initially on clinical grounds due to the predominant symptom being vomiting and the disease lasting in most persons only 2-3 days. Confirmation has been made in some resorts or on return to the UK. It can be a difficult infection to control in a hotel and rarely are public health authorities involved it being left to the tour operators.

4.1.2 Cryptosporidium is an infection that in the travel scenario is generally associated with a contaminated swimming pool although contaminated drinking water may be a factor. The diagnosis is invariably made on return to the UK. The large outbreaks in Majorca in 2000 and 2003 attracted considerable media attention and the investigations were lead by the tourist industry. Communication between UK and Spanish Health Authorities was minimal and was a major factor in preventing a proper investigation. The channels for international communication may be there and were followed but were unhelpful. In 2003 over 200 British nationals in one hotel had a proven cryptosporidium infection. A request for assistance for the HPA was met with the statement that they were not funded for such work. Initially Spanish health authorities did not believe there was an outbreak because they had no official communication from London.

4.1.3 Salmonella infections occur from time to time in all countries and are generally associated with a break down in food hygiene. HPA notifies the FTO if they suspect a holiday source and the outbreak investigation is usually undertaken by the tour operators. The resort health authorities are generally notified of the outbreak by the tour operators. There is often a credibility gap if information has not been received independently from UK health authorities.

4.2 Recognition of an outbreak and timing.

The following table gives an indication of the common scenarios of who is involved in recognising an outbreak and when.

Norovirus	TO in resort as clients report ill	Immediate	Confirmation may follow from U.K 7-10 days later
Cryptosporidium	TO may suspect a problem cause in resort. HPA from returned tourists	Immediate 1 - 4 weeks	Food poisoning is usually suspected initially whereas in the travel context swimming pool contamination is common.
Salmonella	TO may suspect a problem cause in resort. HPA from returned tourists	Immediate Days - 2 wks	

The Tour Operator will only be aware of a problem in resort if the client reports the illness. Some will not report but contact a solicitor with the hope of obtaining compensation. Indeed the first time a tour operator may aware of a problem is when a solicitor's letter is received. As many of the infections are associated with a hotel, action is taken against the operator under the Package Travel Regulations.

4.3 The problem of no confirmed diagnosis

A recurrent problem for tour operators is outbreaks of illness, usually a stomach upset, in a resort with no confirmed diagnosis. Such outbreaks are frequently associated with litigation with lawyers producing a range of possibilities skewed to the advantage of their clients. The lack of any co-ordinated public health action not only has legal consequences for the tour operators but more importantly means that apart from checking general hygiene it is extremely difficult to target any remedial and preventative actions. There is a need for the health authorities in both the home and the destination countries to recognise the importance of investigating outbreaks of illness in tourists. A joint approach is necessary as the tourists will have returned home yet the suspect infection source is in resort. Should there be a different response to that that occurs if someone from Birmingham is affected by an outbreak while on holiday in Bournemouth?

4.4 The investigation of outbreaks

This is normally the responsibility of the local public health department. A good investigation requires detailed information from those exposed to a possible source whether or not they are ill. It may also be necessary to obtain information on the health of hotel staff and the indigenous population. This poses an immediate problem as many of those involved will have returned to the UK. If legal action has begun, claimant lawyers generally advise their clients not to divulge any information.

The examination of the environment, food and water will be in resort but requires specialist facilities for a thorough investigation. Due to the lack of speedy cooperation between and with health authorities, tour operators will commission a private environmental health specialist to undertake an investigation. They are restricted by a lack of access to the travellers and to facilities outside the hotel. Within the hotel access can be required through the contract the tour operator has with the hotelier.

The overall result is unsatisfactory but is the best that can be achieved.

The involvement of litigation or the media can result in further investigations all well after the event.

This situation used to occur with Legionnaires Disease but there is now a well tried procedure for cases within Europe run by EWGLINET. If the source is suspected in a European establishment, the investigation is undertaken by the local public health team according to a defined protocol. In non European establishments the tour operator will usually take the lead. The results are collated by EWGLINET. Unsatisfactory establishments are named on the web. (www.ewgli.org/sites.htm). The EWGLI model should be considered for other travel associated infections. It has distinct advantages in placing the investigation of outbreaks on the local public health authorities and providing information to travellers if standards are not met.

5. Prevention is better than cure

FTO has developed a set of Preferred Codes of Practice that includes chapters on Food Safety, Communicable Disease, Pool Safety and Incident Investigation. The purpose of the guidelines is to inform hoteliers of the requirements of the tour operators and to assist them in achieving these requirements. A copy in either a hard form or as computer disc is given to every hotelier. The Codes have been translated into six languages. This is a unique example of different parts of a very competitive industry working together. As incidents have occurred new codes have been written. The latest has been advice on actions to be taken in the event of a swimming pool associated outbreak of cryptosporidiosis. This was compiled by non health authority experts from the UK and Spain. Copies have been requested by, and sent to, public health officials in many countries.

6. Not a new situation

The Federation of Tour Operators has long held a desire to see greater co-operation between health authorities and tourism bodies in the field of preventing and controlling health infections.

In March 1996, Hansard reports the following:

British Tourists

Mr. Hinchliffe: To ask the Secretary of State for health what structures are in place to ensure that when (a) the Association of British Travel Agents or (b) the Federation of Tour Operators are advised of possible health and safety hazards to tourists at a resort overseas, customers are informed.

Mr. Horam: I refer the hon. Member to the reply I gave him on 11 December 1995, Official Report, at column 529, which gave details of the Department of Health's agreement with the Association of British Travel Agents about notifying it of outbreaks of disease. The Department now has a similar agreement with the Federation of Tour Operators. Once in receipt of the information, it is for the travel industry to decide when it is appropriate to inform customers.

Mr. Hinchliffe: To ask the Secretary of State for Health (1) what steps he is taking to ensure that British tour operators' staff working abroad have training in control procedures concerning legionnaires and other infectious diseases; (2) what plans he has to review communications

concerning outbreaks of serious diseases, between the United Kingdom Government, British tour operators and holiday resort hotels used by United Kingdom tourists; (3) what discussions he has had with United Kingdom tour operators in respect of the factors underlying the delay in informing British tourists of the occurrence of legionnaires disease in the Hotel Imbat, Kusadasi, Turkey.

Mr. Horam: Officials from the Department of Health and the Public Health Laboratory Service are liaising with the Association of British Travel agents and the Federation of Tour Operators to review communications between organisations and clarify what action needs to be taken in response to future reports of travel-related legionnaires disease.

7. Conclusions

There are nine key conclusions from our report:

- 7.1** The procedures for the surveillance and prevention of travel associated infections have many deficiencies especially with respect to the commonest infections which while not life threatening are a major cause of morbidity. This affects not only the health of the travellers and their families but also can be detrimental to the travel and tourism sectors in the home and destination countries.
- 7.2** There is no requirement, even in the draft Health Protection Regulations, for a travel history to be recorded when an infection is notified.
- 7.3** The investigation of outbreaks of travel associated infections is mainly undertaken by the tourist industry with minimal assistance from health authorities in the UK or abroad.
- 7.4** The lack of co-operation between health authorities is detrimental to the control of common infections in tourists.
- 7.5** Although good relationships exist between members of the HPA and FTO there is no formal arrangement.
- 7.6** The failure of rapid communication between health authorities and the tourist industry is detrimental to the health of British travellers.
- 7.7** The formal health regulations that exist within the UK, Europe and globally are too formal and complex to deal with the relatively minor health problems experienced by very many tourists.
- 7.8** Measures to reduce the incidence of common travel associated infections in many resorts have been ad hoc and due to the efforts of the tourist industry not the health authorities.
- 7.9** Although the examples and information above comes from the FTO, the problems apply to all tourists whether package tourists or not.

8. Recommendations

We believe that there are five main recommendations for Government and the tourist sector emerging from this report:

- 8.1** A joint working group should be established between the HPA and the FTO with the aim of reducing the common travel associated infections. This group should look at identifying and overcoming the barriers to more effective co-operation.
- 8.2** To improve the surveillance of travel associated infections by:
 - 8.2.1** Ensuring that a travel history is a requirement in the reporting of notifiable diseases.
 - 8.2.2** By exploring ways of sharing in a timely manner the FTO and the HPA surveillance results bearing in mind both medical and commercial sensitivities.
- 8.3** Working jointly in the development of advisory documents for countries with a high incidence of travel associated infections. This could involve a joint approach to Ministers of Tourism at the annual World Travel Market in London. Political priority must be attached to dealing with these infections. Although we recognise many are low-level there is an advantage for UK plc to be gained from addressing these issues.
- 8.4** Include the surveillance and investigation of travel associated infections described in this paper in the remit of the HPA.
- 8.5** Tackle the problems in the UK first then involve European authorities to ensure that best practice is shared and spread across the EU.

APPENDIX

“Confidential & privileged, please do not pass this documentation on to any third part without our written consent”

The Federation of Tour Operators



STOMACH UPSETS IN UK PACKAGE HOLIDAY TOURISTS VISITING EGYPT

Dr Esteban Delgado
Public Health Advisor

Federation of Tour Operators
November 2008

This is an updated version of the report prepared for,
and presented at, the World Travel Market 2008

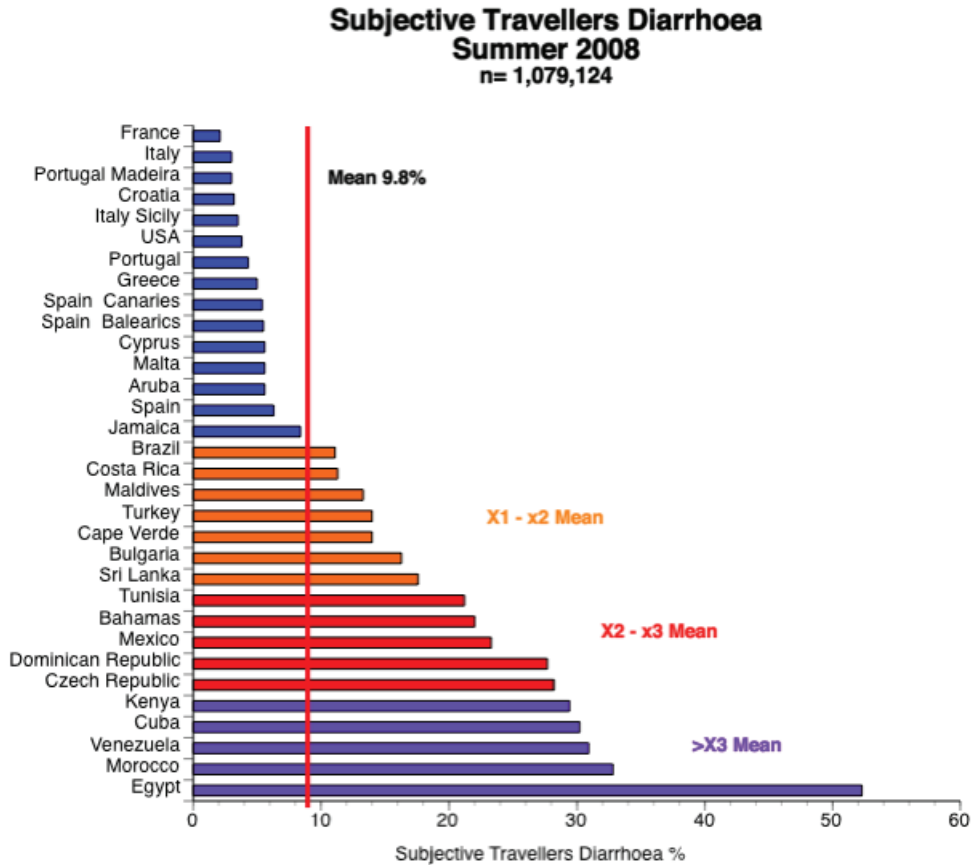
Introduction

1. Egypt continues to be associated with an unacceptably high incidence of stomach upsets in package holiday tourists from the U.K. A paper similar to this was prepared for the 2007 World Travel Market and the Cairo Food Safety Conference in March 2008.
2. The problem continues to be considered by the Health and Safety Committee of the FTO who remain committed to working with the Egyptian authorities to improve the situation.
3. The major holiday associated illness is a stomach upset or travellers' diarrhoea. The incidence varies according to the destination and is a largely preventable problem. In the 1980's it was a major problem in Spain and Portugal but this has largely been remedied with improvements in the public health infrastructure and food hygiene practices.
4. Three of the FTO members, First Choice, TCTO and TUI, use a Client Satisfaction Questionnaire (CSQ) completed during the return flight to the U.K to assess a range of aspects of the holiday. Included in the questionnaire is the question "During your holiday did you have a stomach upset lasting more than 24 hrs". Those giving a positive answer are defined as having suffered from subjective travellers' diarrhoea (STSD). The results for summer 2008 form part of this report.
5. Egypt continues to be associated with a very high level of STD. What is particularly disturbing is that in spite of reporting the situation in previous years the situation has not shown any improvement.
6. It is fortunate that the consumer groups in the U.K and the media are unaware of the situation as experience in other destination has resulted in severe adverse media coverage with a consequent drop in business to that destination. The FTO does not wish to see this happen with Egypt.

Background Information

7. CSQ data

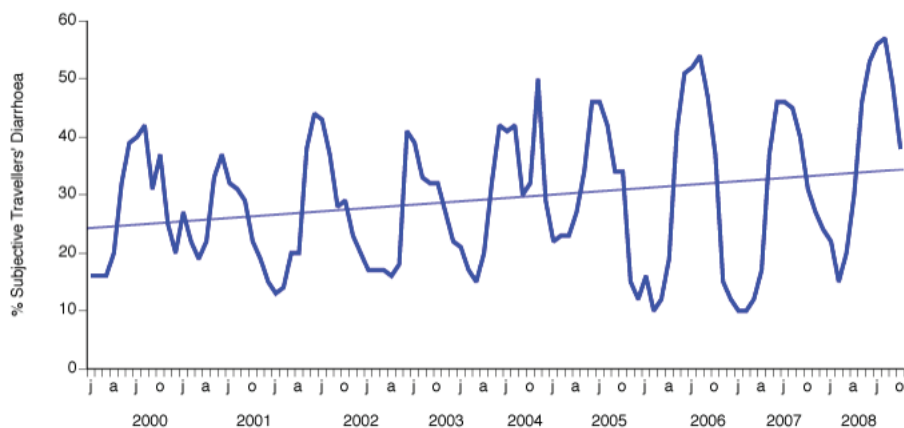
The following charts show the CSQ results for all the countries covered by FTO members providing CSQ data. The total number of passengers sampled for summer 2008 was 1,079,124.



The figures on the next page are for Egypt. The first gives the overall incidence of subjective travellers diarrhoea for each month from 2000 to 2008.

Egypt

Subjective Travellers' Diarrhoea
Actual incidence with linear regression line



An FTO analysis

The table below shows the monthly incidence by resort for the summer of 2008. For each resort the number of completed questionnaires completed is shown with the % of those who indicated a stomach upset lasting more than 24 hours.

EGYPT CSQs Summer 2008 Combined Data First Choice, Thomas Cook, TUI

Excludes resorts with less than 100 pax for the season

	May	June	July	Aug	Sept	Oct	Season
Dahab	26.7% 30	50.0% 24	31.6% 19	15.4% 26	23.8% 21	. 0	29.2% 120
El Gouna	39.0% 141	47.1% 221	49.2% 331	58.6% 181	43.4% 290	25.0% 32	47.0% 1196
Hurghada	50.5% 331	53.3% 486	54.0% 581	58.3% 391	52.7% 529	39.0% 59	53.4% 2377
Luxor	37.9% 525	35.0% 919	38.6% 1437	39.2% 605	34.5% 653	. 0	37.2% 4139
Makadi Bay	49.1% 55	62.4% 125	70.4% 233	59.7% 186	58.3% 199	40.0% 20	61.6% 818
Marsa Alam	46.0% 150	51.4% 109	55.0% 398	62.3% 268	49.4% 251	.0% 1	54.0% 1177
Nile Discovery	10.5% 95	30.4% 23	22.7% 22	20.0% 20	18.2% 55	. 0	16.7% 215
Presidential 3t Cruise	12.5% 32	27.7% 47	40.0% 25	25.0% 16	5.3% 19	. 0	23.0% 139
Presidential 4t Cruise	25.5% 47	32.0% 75	35.4% 48	22.7% 44	27.7% 47	. 0	29.1% 261
Ra Ii Cruise	11.4% 70	24.7% 77	47.2% 72	33.9% 56	11.3% 62	. 0	25.8% 337
Sharm El Sheikh	49.2% 4019	57.5% 5328	62.6% 6443	60.5% 5203	52.0% 6450	40.5% 380	56.5% 27823
Sharm El Sheikh-Cairo	. 0	66.7% 3	66.7% 6	. 0	71.4% 7	. 0	68.8% 16
Soma Bay	80.0% 5	14.3% 7	44.4% 18	45.5% 11	45.5% 22	20.0% 5	42.6% 68
Taba	48.5% 396	55.4% 397	53.6% 543	53.5% 480	40.3% 355	.0% 2	50.8% 2173
Egypt Totals	46.0% 6516	53.0% 8400	56.0% 10963	57.0% 7807	48.7% 9525	38.5% 519	52.3% 43730

8. Data from the Health Protection Agency (HPA) and Health Protection Scotland (HPS).

Report from the Health Protection Agency

Travel-associated illnesses in tourists to Egypt in England, Wales, and Northern Ireland with a confirmed organism with specimen dates in 2008 reported up to 6 October 2008. Results are provisional only and may be under estimated.

There has been a general increase in the number of salmonella infections associated with travel to Egypt in 2008 compared to previous years.

Campylobacter spp	28
Salmonella spp (non Typhoid)	218
Salmonella Typhi	1
Shigella sonnei	25
Shigella flexneri	4
Shigella boydii	3
Shigella sp	2
Giardia lamblia	15
E coli O157	10
Cryptosporidium	7
Vibrio sp	2
Hepatitis A	2

Salmonella breakdown

S Enteritidis total	73	S Saint Paul	2
S Enteritidis PT 15	27	S Senftenberg	2
S Enteritidis PT 1	7	S Braenderup	2
S Enteritidis PT 4	14	S Anatum	2
S Enteritidis PT 14B	3	S Kottbus	2
S Enteritidis PT 12	8	S Liverpool	2
S Enteritidis Other PTs	14	S Mbandaka	1
S Virchow	27	S Ohio	2
S Kentucky	24	S Tennessee	2
S Typhimurium	21	S Cerro	1
S Haifa	10	S Havana	1
S unnamed	8	S Istanbul	1
S Blockley	4	S Monschau	1
S Agona	4	S Muenchen	1
S Galiema	6	S Muenster	1
S Hadar	3	S Oranienburg	1
S Heidelberg	2	S Poona	1
S Newport	5	S Stanley	1
S Bareilly	4	S Virginia	1

A lot of the salmonella reports have been associated with the Holiday Village Red Sea in Sharm El Sheik:

Report from Health Protection Scotland

Potential overseas outbreaks reported to HPS associated with travel to Morocco, Dominican Republic, Kenya and Egypt in 2008

**Data reported 1 Jan to 6 Oct 2008
(6th October 2008)**

Health Protection Scotland (HPS) has a surveillance system for potential outbreaks of infectious intestinal disease believed to have been acquired abroad. A potential outbreak of infectious intestinal disease occurring abroad is defined as two or more confirmed cases of infection or at least one confirmed case where others are alleged to have been ill. Such outbreaks are usually reported to HPS by the NHS board public health teams. They may also, however, be identified by the reference laboratories. This is particularly the case where phage types or molecular profiles rarely seen in Scotland are involved and/or where the individuals affected are resident in disparate regions of Scotland.

Where possible, information is sent to the national surveillance centre in the country where infection is thought to have been acquired, enabling them to facilitate any investigations or control measures they believe to be necessary. HPS communicates directly with the countries within the European Centre for Disease Prevention and Control (ECDC) area and copies information to the Scottish Government, where direct channels of communication do not exist between HPS and national centres, HPS invites the Scottish Government to forward the information to the Department of Health International Division for them to forward to the country concerned. A copy of the information is also sent to ECDC.

Data presented below are for potential overseas outbreaks reported to HPS from 1st January 2008 to 6th October 2008.

A total of 44 potential overseas outbreaks reported to HPS.

Countries reported in potential overseas outbreaks 2008 to 6.10.08

Country	Number of outbreaks
Egypt	5
Morocco	0
Dominican Republic	0
Kenya	1
Others	38
Total	44

The Egyptian Ministry of Health may wish to liaise with the HPA and HPS for further information.

9. The information presented illustrates that there is a real problem with stomach illness in tourists to Egypt and that it cannot be blamed on spicy food, the sun or just travel stress. Of greater importance the information provides some clues as to possible sources of the infection that can be used in planning preventative strategies.

The most probable routes of infection are through contaminated food or water. Contamination can occur at any stage of the food chain from the farm to the plate.

10. Experience in other resorts has shown that attention must be paid to the conditions where the hotel workers live. It is essential that they have a good supply of safe drinking water, good sewage disposal systems and adequate solid waste disposal. All too often the hotels have a good public health infrastructure but this does not apply to the areas inhabited by the hotel workers and their families. Gastro intestinal infections in hotel workers can spread to the guests even if a good level of personal hygiene is practiced.

What can be done?

11. The points below are a repeat of the recommendations made last year. Our views are still valid.
12. Any effective actions should be based on good evidence and will require the co-operation of the Egyptian government – health, public health, environment and tourism, the hoteliers and restaurateurs and the tourist industry such as the FTO.
13. I would suggest that a small (6 –8 person maximum) working group be formed to consider the available information and to formulate a plan of action. The group should include representatives of the relevant Egyptian Ministers and one or two persons from FTO. It should report to Ministers and the Director General of FTO.
14. The members should be senior persons in their field of expertise. The remit of the group should be to assess the information available and to formulate measures to reduce the incidence of stomach upsets in tourists and the indigenous population in tourist areas. It may be necessary to undertake some preliminary further investigations in resorts.
15. Areas and topics that will need to be considered include:
 - a. The likely routes of infection
 - b. Drinking water supplies to hotels, restaurants and the local population.
 - c. Sewage disposal systems serving hotels, restaurants and the local population.
 - d. Solid waste disposal systems serving hotels, restaurants and the local population.
 - e. Gastro intestinal illnesses in the local population.
 - f. Living arrangements and health care facilities of hotel and restaurant staff.
 - g. Food hygiene training for hotel and restaurant staff

16. Although the incidence is high in different resorts I would advise that the situation in one resort be studied first so as not to dissipate resources. I would suggest that consideration be given to Sharm El Sheikh.
17. In order to obtain wide support and co-operation it may be necessary to arrange an open meeting in the chosen resort to include the municipality, hoteliers, restaurateurs etc. The timing and order of any meetings will depend on many factors including local politics and personalities but obtaining good co-operation is essential.
18. The Federation of Tour Operators will make their illness data available to the working group as this will provide a useful guide to effectiveness of any control measures.
19. It is important to recognise at the outset that some solutions could be very costly and any case that is made will need to be backed by solid evidence. Similar exercises in other countries have resulted in new water treatment and sewage treatment plants being built with loans from the world bank. The long term benefits both in repeat tourism and the health of the local populations have been huge.
20. To do nothing will run the risk of major adverse publicity and a consequence fall in tourism.

The information provided by the Health Protection Agency and Health Protection Scotland is gratefully acknowledged

This paper has been prepared by:

Prof. Rodney Cartwright on behalf of the Federation of Tour Operators.
profrc@microdiagnostics.plus.com



FEDERATION OF TOUR
OPERATORS

FTO EUROPEAN TOURIST ACCOMMODATION SAFETY STUDY:

**An analysis of the common travel associated
infections, their surveillance and control. A view
from the tourist industry.**

Contact Information

FTO / ABTA

Luke Pollard

Head of Public Affairs

Tel: 020 3117 0522

Email: lpollard@abta.co.uk

Prof Rodney Cartwright

Medical Advisor to FTO / ABTA

Tel: 01483 887000

Email: profrc@microdiagnostics.plus.com