

Special groups of travellers

According to the World Tourism Organization, approximately 26% of the 800 million international journeys in the year 2005 were for visits to friends and relatives and for religious purposes/pilgrimages. This chapter looks at the health considerations of immigrants visiting friends and relatives and of pilgrims.

Travel to visit friends and relatives

According to the United Nations, international migration rose from 120 million in 1990 to more than 200 million in 2006. In many countries immigrants now constitute more than 20% of the population. Immigrants increasingly travel to their place of origin to visit friends and relatives (VFR), and VFR travel is now a major component of the more than 800 million international journeys that take place annually. The term “VFRs” generally refers to immigrants from a developing country to an industrialized country who subsequently return to their home countries for the purpose of visiting friends and relatives.

Compared with tourists to the same destinations, VFRs are at increased risk of travel-related diseases. These include – but are not limited to – malaria, hepatitis A and B, typhoid fever, rabies, tuberculosis, and the diseases normally preventable by routine childhood vaccination. For example, the global surveillance data of GeoSentinel (an international network of travel medicine providers) on returned travel patients show that eight times more VFR travellers than tourists present with malaria as their diagnosed illness. It is estimated that VFRs account for more than half the total imported malaria cases in Europe and North America.

The greater risk for VFRs is related to a number of factors, including higher risk of exposure and insufficient protective measures. These individuals are less likely to seek pre-travel advice or to be adequately vaccinated, but more likely to stay in remote rural areas, have close contact with local populations, consume high-risk food and beverages, undertake last-minute travel and make trips of greater duration. Risk awareness and risk perception also differ between VFRs and most tourist travellers, resulting in a lower uptake by VFRs of pre-travel vaccinations or malaria prophylaxis. The cost of pre-travel consultation, often not covered by health insurance programmes, may be onerous for VFRs, particular those with large families, and access to travel medicine services may be hampered by cultural and linguistic limitations.

Improving the access of VFRs to pre-travel health counselling is of increasing public health importance. Primary health care providers need to become more aware of the increased risks faced by VFRs. Strategies are needed to increase the awareness among VFRs of travel-related health risks and to facilitate uptake of pre-travel health advice, vaccinations and, where indicated, malaria prophylaxis.

Pilgrimage

Data for quantifying the risk of medical problems related to religious pilgrimages are limited. In terms of health risk, the best documented pilgrimage is the Hajj – the annual Muslim pilgrimage to Mecca and Medina in Saudi Arabia. During the Hajj, more than 2 million Muslims from all over the world congregate to perform their religious rituals. The resulting overcrowding has been associated with stampedes, traffic accidents and fire injuries. Cardiovascular disease is the most common cause of death. Heatstroke and severe dehydration are frequent when the Hajj season falls during the summer months.

Overcrowding also contributes to the potential dissemination of airborne infectious diseases or infections associated with person-to-person transmission during the Hajj. In 1987, an extensive outbreak of meningococcal disease serogroup A among pilgrims prompted the Saudi Arabian health authorities to introduce mandatory vaccination with bivalent A and C vaccine for all pilgrims. Following outbreaks of meningococcal disease serogroup W-135 in 2000 and 2001, all pilgrims must now be given the quadrivalent meningococcal vaccine (protecting against serogroups A, C, Y and W-135) and Hajj visas cannot be issued without proof of vaccination. The most frequently reported complaints among pilgrims are upper respiratory symptoms. Influenza vaccination has been reported to reduce influenza-like illness among pilgrims and should be a highly recommended vaccination for all those making the Hajj. Pneumococcal vaccination should also be recommended for those over the age of 65 years and for those who would benefit from it because of underlying medical conditions (see Chapter 6).

Cholera has caused Hajj-related outbreaks in the past but not since 1989, following improvements to the water supply and sewage systems. Hepatitis A vaccination is recommended for non-immune pilgrims, and routine vaccinations (such as polio, tetanus, diphtheria, tetanus and hepatitis B – see Chapter 6) should be up to date. Yellow fever vaccine is a requirement for pilgrims coming from areas or countries with risk of transmission of yellow fever (see Annex 1).

Since 2005, the Ministry of Health of Saudi Arabia requires that all individuals under 15 years of age who travel to Saudi Arabia from polio-affected countries show proof of vaccination with oral polio vaccine (OPV) 6 weeks before application for entry visa (see also Chapter 6). Irrespective of previous immunization history, all such individuals arriving in Saudi Arabia will also receive oral polio vaccine at border points. Since 2006, in addition to the above, all travellers from Afghanistan, India, Nigeria and Pakistan, regardless of age and previous immunization history, will also receive an additional dose of OPV upon arrival in Saudi Arabia.

Updates on requirements and recommendations for the annual Hajj pilgrimage can be found in the *Weekly Epidemiological Record* (available on line at www.who.int/wer/en).

Further reading

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Trends in total migrant stock: the 2005 revision. Population Division, Department of Economic and Social Affairs, United Nations Secretariat. (Document available at:

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