Autumn/Winter 2018

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW
TRAVEL MEDICINE

emporiatrics

News, views and reviews

from the Faculty of Travel Medicine

In this issue…

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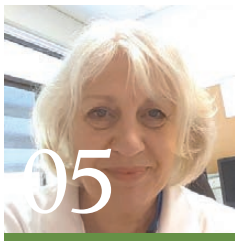

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Editorial

Welcome to the Autumn/Winter edition of Emporiatrics.

It's packed with information on 'flu vaccination (page 12), FGM (page 06) and the updated travel health guidance (page 13). And because we all love travel ourselves, we have adventure tales from India (page 10), Iran (page 11) and Brazil (page 07) – with the built-in health advice you expect from the pros.

You may also notice a certain valedictory feel to this issue, with a tribute to travel heath pioneer Fiona Genasi on page 14. And in his final Dean's Letter (page 3) Andy Green bids an off-beat but gracious Au revoir to his colleagues who are also leaving the FTM Board in October.

So, what better time to say my own farewell! It's been a privilege to edit Emporiatrics since the inaugural issue in 2010. We've covered just about everything that ails travellers, from altitude sickness to Zika, and reported from war zones and pandemic regions as well as from beaches and beauty spots. I'm grateful to the many experts who have contributed over the years. It makes me appreciate how diverse our field is, and how generous are the people who have developed travel health as a specialism in its own right.

I have enjoyed it immensely and I hope you have too. All that's left now is to wish the Faculty and the new Administration every success: I look forward to reading all about it in future editions of Emporiatrics.

Sandra Grieve

Letter from the Dean of the Faculty of Travel Medicine

Group Captain Andy Green FFTM RCPS(Glasg)

Group Captain Andy Green CBE and family, Buckingham Palace October 2018

A valedictory and au revoir from Andy Green FFTM RCPS(Glasg)

They're changing guard at Buckingham Palace -
Christopher Robin went down with Alice.
Alice is marrying one of the guard.
"A soldier's life is terrible hard," says Alice

Buckingham Palace
AA Milne (1882-1956)

I am rubbish at saying goodbye. Not sure why, but it may relate to serving in the Royal Air Force for a long time. In an organisation that's relatively small but geographically dispersed, you frequently make friends and then move on – only to bump into them many years later, often in a hot and dusty place miles away from home. So the French term for farewell is much more appropriate since what you usually mean is, "until we meet again".

Given my views on openness and inclusivity, and having talked in previous Dean's Letters about football, beer and rock'n'roll, it was inevitable that this time (in my final Letter) I should end up talking about sexually transmitted infections. But maybe not quite how you'd expect.

There is a tradition in the Armed Forces that when officers leave a unit after completing a tour of duty, they are 'Dined Out' at a formal dinner in the Officers Mess by their brothers (and sisters) in arms. Since several officers usually leave at the same time it falls to the most senior one to speak on behalf of the group, thanking the Mess for the hospitality and reflecting on the attributes and character of the individuals leaving.

I was once asked to do this when leaving an RAF hospital in Germany – at a time when the fashion was to describe the people leaving as members of a hypothetical team. So, for example, they might be a figurative rowing eight – with one as the stroke (strong, the powerhouse of the team), and another as the cox (quietly in control, steering the boat through choppy waters). Or a football team – with a goalkeeper (catching all the balls missed by others, stopping own goals) and a striker (keen, the leader of the line).

One of my roles as a clinical microbiologist at the hospital had been running the genito-urinary medicine clinics so it seemed entirely appropriate (to me) to give a post-dinner speech in which I described each of the leavers in terms of a sexually transmissible infection. This included the surgeon (a pain in the backside), the physician (irritating, and no matter what you did to get rid of him he kept coming back), the psychiatrist (who made your skin itch), the hospital administrator (who appeared benign, but you didn't find out that she'd completely messed up your life until weeks later), and the senior nurse (worried well, but kept complaining about things of no consequence). Plus, there were some rude ones too.

I thought that the talk was well received, but, strangely I've never been asked to give a post-dinner speech at an Officers Mess since then.

Which brings me around to the subject of my final Dean's Letter, as the term of office of the current Faculty Executive Board ends in October 2018. Rather than look back at successes and achievements over the last three years, I want to reflect on the individuals who are standing down since people are always the most valuable asset for any organisation.

Nothing is impossible, the word itself says "I'm possible"
Audrey Hepburn (1929-1993)
Actress, UNICEF Goodwill Ambassador

Without exception this group has contributed significantly to the smooth running of the Faculty, often in quietly understated ways that nobody (other than the Executive Officers) can see. These are my personal views and in no way representative of anyone else (in other words, blame me and me alone). But the descriptions might help the wider membership see the 'faces behind the masks'.

Continued on Page 4

Letter from the Dean of the Faculty of Travel Medicine - *Continued...*

From left to right: Football, beer and rock'n'roll

Dawn Alldridge (Associate Member)
Rides three Ducati's and a horse. Doesn't always remember which one has a twist-grip throttle though, or when to wear leathers and when to wear a scarlet riding jacket and jodhpurs. Not afraid to talk about the elephant(s) in the room during Board discussions. Fabulous reality-checker for airy-fairy doctors like me.

Ann Bevan (Ordinary Member)
Incredibly widely travelled and has worked in most current war zones, often under fire. The best listener on the Board, maybe because she's a psychologist. Has a disconcerting way of asking the Dean: "How do you feel about what you just said?", and "Did you really mean to say that?" Ardent advocate for representation of non-medically-qualified professionals, and for issues affecting race and social equality.

Sundeep Dhillon (Ordinary Member)
River Deep, Mountain High (close, but not quite Tina Turner). Internationally-renowned for his professional work on expedition medicine and especially mountaineering. Permanently exhausted, probably related to very young twins. Passionate about standards of practice and training. Clear sighted and very articulate in difficult debates.

Angus Menzies MFTM (Honorary Clinical Registrar)
Mirror image of the Dean. Knows a lot about wildlife conservation and the oboe, and is learning ancient languages. Doesn't know much about rock music, beer or football. Remarkably hard working in the background, and responsible for oversight of all question-writing for examinations.

The current examination structure and professional career pathway is largely down to him, first planned out eight years ago. A clear lesson to everyone about how the drive to achieve an aim can succeed, despite barriers thrown in the way.

Carole Tracey (Honorary Clinical Registrar, Foundation and DipTravMed)
Why would a trained SCUBA diver decide to work as a nurse on cruise ships? In the RAF, it's seen as bad form to jump out of an aircraft with a parachute unless you have to. Better not to crash in the first place. Very widely experienced in all aspects of travel medicine and an invaluable counsel when discussing issues that might have unforeseen consequences. Deals objectively and clearly with some extremely challenging disciplinary issues relating to examinations. Not afraid to make difficult decisions.

Margaret Umeed (Honorary Secretary)
Mother of Andrew, a professional County cricketer at Warwickshire. I recall her mixed facial expressions when he played as a substitute fielder for England in a Test Match (happy), but then hearing the commentator David Lloyd describe her boy as the "young Scots lad, Andy Umeed" (not happy). Spends even more bizarre hours on Faculty work than the Dean, as evidenced by the emails date-time stamps. Involved alongside the Vice Dean at the heart of all Faculty activities. Stood in for the Dean on numerous occasions when he took an enforced leave of absence for three months. Nobody at College Council or College Executive noticed, which suggests either her high professionalism or that the Dean has the professional profile of a limbo-dancing snake. Did two tours of duty as Honorary Secretary (a bit like leaving prison and then knocking on the door to be let back in). Probably the single most important reason for the successful outputs of the FTM Board over the last three years.

And – breaking news – I have just had it confirmed that Sandra Grieve is stepping down as Editor of Emporiatrics after eight years in this labour of love. As TS Eliot said, "An editor should tell the author his writing is better than it is. Not a lot better, just a little better." Thank you, Sandra.

Well, that's it then. I think that this Executive Board all enjoyed their time, which in turn usually means that they did a good job. However, this is not 'job done'. The Dean-Elect and new FTM Board will face different and varied challenges. They will rely on the support of the entire membership: I simply ask everyone to contribute in whatever way you can.

Au revoir!

Andy Green
Dean FTM

IN FOCUS

Irmgard Bauer FFTM RCPS(Glasg)

Since retiring, Dr Irmgard Bauer has held adjunct positions in the Division of Tropical Health and Medicine's College of Public Health, Medical and Veterinary Sciences, and the College of Healthcare Sciences at James Cook University in Townsville, Australia.

Q. Did you always want to be a nurse?

A. As a child, I watched movies where nurses worked in the jungle to look after the poor local children…perhaps a doctor who had to operate under extreme circumstances and the nurse would be wiping his brow… I thought that was marvellous! Later, reason suggested a few other career options, but eventually I stumbled back to nursing more by chance. I am still enormously grateful for the brilliant nurse training in my school in the 1970s. We were ready for the world! I adored clinical nursing, but as a third-year student was already starting a pathway into teaching and research.

Q. What sparked your interest in travel health?

A. In 1997, during the Gorgas-Course in Lima, David Freedman talked briefly about travel medicine. I'd never heard of it. Tropical medicine AND travel? How good could it get? I joined ISTM right away and presented my first talk at the 1999 conference in Montreal. But it was always only an aside as I was employed as an academic in nursing.

Q. As a recognised role model, who was (is) yours?

A. I've admired a few people professionally, but the one who really influenced my life was my grandfather, a very wise village teacher with insight and a knowledge way ahead of his time. He taught me from the age of three, but most importantly, instilled in me the joy and excitement of exploring, questioning and lifelong learning. I am who I am because of him.

Q. As an academic, prolific author and researcher, how do you choose topics?

A. Easy. Enthusiasm, interest, open eyes and ears, and a bit of natural cerebral ability: the topics jump at you. In fact, I really can't go anywhere without linking observations to travel health. I'm interested in topics I want to know more about – preferably where little is written – and I'll have to fossick* for information. But I have also written about topics with a massive body of literature in very diverse fields. I research some topics for years before writing them up. I enjoy sharing what I found. I feel the necessary specialisation and increasingly narrow focus in some other health professions easily exclude the big picture. Many different aspects of nursing provide a breadth that so suits the broad field of travel health. That, of course, then invites research into less conventional topics.

Q. When not travelling, what is a typical day for you?

A. I don't have a typical day, rather a typical week with two mornings still at university and one or two days set aside for writing. And I am an undergraduate student again!

Q. What are your favourite destinations and why?

A. Sadly, Yemen, my first 'home from home' and its region are out of bounds right now. What a place to live and travel it was! For almost 25 years, I have been to Peru at least once a year and have visited most other South American countries, but there's still so much to explore, e.g. more of Colombia, actually more of all, but I'd love to see Paraguay. I have taken out a few years of that schedule to see other places. Some favourite destinations are Namibia (with its German towns) and St Helena (of Napoleonic fame). I enjoy rail journeys (some famous, others to obscure places) and small boats. Shortly, I will be on a supply ship to the Marquesas Islands.

Q. Leading such a busy life, how do you relax?

A. Not sure. I haven't even started hobbies yet. Retirement is so time-consuming. But my hammock up in the canopy, parrots and sea breeze included, and a notepad to plan a new trip must suffice for now.

* A new one on us, 'fossick' is an Australian term for rummaging about, typically for gold or gemstones! – ED.

EDUCATION:

Travel Medicine Bites

David Ross QHP FFTM RCPS(Glasg.) looks back on his first year as FTM Director of Education and plans for the future.

Our latest episode of Travel Medicine Bites addresses another difficult and topical issue and Sarah Lang, Cathy O'Malley and Ann McDonald have done sterling work in making this practical session on FGM a must.

I have now been in post for over a year and as well as overseeing some excellent conferences, we are starting to consider what else the Education Board should do and how our short-to-long term strategy should dovetail with the College and Faculty's strategies. We have started addressing issues from an educational point that will make the Faculty the go-to place for professional development and standards for all travel medicine practitioners. Indeed, we have already started collaborative work with the Royal Pharmaceutical Society on standard setting for pharmacists who wish to provide travel medicine services. I hope we will be able to launch these standards at a joint conference next year.

One of my roles within the College is to sit on the Scholarship Committee. In addition to the Triennial FTM Award there are many others that individuals can apply for. We would be happy to support anyone who could take on research or professional development in the UK or overseas.

See **https://rcpsg.ac.uk/travel-medicine/career-support/awards-and-scholarships** for details.

FGM & pre-travel health consultations: Identifying and addressing barriers to promote best practice

It took a video of a woman relating the trauma she experienced as a child undergoing FGM to make Cathy O'Malley FFTM RCPS(Glasg) start asking awkward questions. Here she discusses a new e-learning module devised for busy travel medicine practitioners wanting a short piece of continuing professional development (CPD).

When I first raised the issue of female genital mutilation in a travel consultation, I lacked confidence in my ability to do so. What worried me most was that I might cause offence by asking about it. My knowledge of FGM was good, I understood how important it was to raise the topic, I was familiar with the guidelines and resources, but still I lacked the assurance to get those first few words out. Then I watched a video of a woman – 'Sariane' – relating her experience of FGM as a child and it had a profound effect on me.

Subsequently I looked at the little girl playing with the toy box in my consultation room and thought, what if it happens to her because I was not brave enough to ask? So I got the courage from somewhere and asked her mum about FGM. From then on my confidence grew.

It is clear to me from providing travel health training courses that while healthcare professionals may know about FGM, the law, guidance etc., the implementation of these can be complicated by a number of perceived barriers. Barriers may be individual to the practitioner or be within the processes of the pre-travel service.

This third edition of Travel Medicine Bites is an e-learning module addressing some of the barriers health professionals may encounter when assessing the risk of FGM in a travel consultation in all clinical contexts – primary care, private clinic, pharmacy etc. Possible solutions to each barrier are explored, including practical advice on how to raise the topic and tips for practice.

We have included the video of Sariane relating her experience of having FGM as a child: you may wish to watch it… it just might give you the courage to ask difficult questions.

This FGM e-learning will be launched soon. Look out for news items about it in the very near future, via the College website and social media.

Sarah Lang (co-author) and I thank Ann McDonald and Jane Chiodini for contributing to this e-learning and also Kyle Somerville and the e-learning team.

Cathy O'Mally is a travel health nurse specialist and freelance travel health trainer.

TRAVELLERS' TALES

Brazil: In search of lost cities and… selfies!

Dr Sam Allen FFTM RCPS(Glasg) takes a tour through the history of extreme expeditions to deliver some timely advice to today's adventure travellers.

Ever since the Spanish conquistador Francisco de Orellana set eyes on the Amazon in 1542, the region has captured the imagination of explorers, adventurers, writers and filmmakers. Early depictions of indigenous populations as single-breasted female warriors led to the naming of the Amazonas, derived from Greek mythology.

Tales of 'the one covered in gold' (El Dorado) and the lost cities of Z and Paititi, the final retreat of the Incas, lured many explorers on a race to find a fabled city of gold. Many disappeared in their quest …. or went mad as depicted in Werner Herzog's critically-acclaimed and mesmerizing Aguirre, the Wrath of God and Fitzcarraldo. Some would consider such men mad in the first place.

The disappearance of Col Percy H Fawcett, the feted Royal Geographical Society explorer, with his son and fellow explorer triggered further ill-fated expeditions to solve the mystery of his disappearance, including Peter Fleming, brother of Ian, the creator of James Bond. Another writer inspired by the Lost World was the Edinburgh ophthalmologist Arthur Conan Doyle.

Fast forward to now

The destinations of today's explorers are not so much external as internal. Modern adventurers set themselves physical, endurance or environmental challenges. Wanderlust is its own addiction with incorrigible adrenaline-hunters bagging achievements for their bucket lists.

The Jungle Marathon, Arctic Marathon and Marathon des Sables have taken endurance events to a new level. Idyllic and unusual destinations have become the new unique selling point for travel operators who offer that once-in-a-lifetime 'selfie' experience.

For the Victorians, the discovery of a lost city was the ultimate selfie for it brought fame and fortune. It would have irked Fawcett immeasurably that during the time of his numerous expeditions to locate 'Z' the American explorer, Hiram Bingham, uncovered Machu Picchu in 1911.

Although many of the risks for travellers in South America have been abated through antimalarials, arthropod and animal vector control, other risks that were pertinent in an earlier age remain.

Sir Peter Blake, environmentalist and successive winner of the America's Cup (the international sailing race and oldest international sporting event), was attacked and killed by pirates while raising awareness of the world's water resources in 2001. Amazonian river pirates, known as 'water-rats', operate from small dugout canoes that attach to passing vessels by grappling hooks at dusk to rob western passengers in a modern-day maritime 'stand-and-deliver'.

There were the Prudent, who said: 'This is an extraordinarily foolish thing to do.' There were the Wise, who said: 'This is an extraordinarily foolish thing to do, but at least you will know better next time.' There were the Very Wise, who said: This is a foolish thing to do, but not so foolish as it sounds.'

Peter Fleming, from Brazilian Adventure, 1933

Guarding this huge watery basin is a tall task when the distance from São Paulo to Manaus is almost as far as London is to Cairo.

Last year, Emma Kelty, a 43 year-old teacher and adventurer was robbed and killed while attempting to kayak the Amazon. She had travelled alone and been warned about the risks, but was on a tight schedule so declined an escort. It was only after her assailants had inadvertently triggered her locator beacon that the authorities in São Paulo were alerted.

Lt Commander Marcelo Mendes, Commander of the Brazilian Marine battalion in Manaus, co-ordinated the response and the pirates were apprehended three days later. Her body, disposed of in the fast-flowing piranha river, was never recovered.

When I visited Col Mendes at the Marine base, he advised that travellers should not travel alone. Anyone travelling to remote or isolated regions should carry a suitable GPS alert system, personal locator beacon (PLB) or emergency position-indicating radio-beacon (EPIRB) such as are carried on shipping vessels, and should notify the authorities if they intend to undertake expeditions in the interior.

Who owns global health.... or is it, WHO owns global health?

Dr Robert Bruce-Chwatt MFTM RCPS(Glasg), retired forensic surgeon and former ship's doctor, posits some inconvenient truths about the prospects for global health in the 21st century.

The answer is probably: "Nobody and everybody." Many would suggest the World Health Organization (WHO), founded in 1948, but UNICEF and the World Food Program play a part, as do other UN agencies such as the UN Development Programme.

The key word is health. Not just treatment, alleviation and eradication of c disease, but safe water, food, family planning, secondary education and public health measures such as pit latrine – all contribute to socioeconomic improvement. There are many global charities, though recent negative headlines about Oxfam and the International Red Cross have resulted in substantially-decreased income from donations. While supported by charitable donations, all function as global multinationals.

The first WHO budget in 1949 was US $5 million. The 2016-2017 budget was US $4,384.9 million. To put it into perspective, an Airbus A320 currently costs about $100 million so that's nearly 4,385 aircraft.

This pays for programmes of prevention, eradication and control of malaria, AIDS, the resurgence of TB (both MDR and XDR strains), cancer causes and treatment, cardiovascular disease, diabetes, tobacco-related diseases, maternal health, sanitation, mental health and safe blood transfusion – along with the growing burden of disease among women, children and trauma victims via effective and sustainable health systems.

WHO receives additional funds in response to natural disasters and wars – often civil, such as in Syria and the Yemen, resulting in millions of refugees living in tented encampments, stalked by cholera and other illnesses. Then come all the civilian victims of casual interpersonal violence in sub-Saharan towns and cities, as yet untouched by actual war, where rape is often a weapon.

So who controls global health?

"…who pays the piper"; you might say. For WHO, it's the governments of member states and individual outside donors. The largest contribution comes from the United States, followed (perhaps surprisingly) by Japan, then Germany, the UK and France. Powerful lobbyists, pharmaceutical companies and others apply pressure as do donor nations.

Political pressure inside the recipient country can stymie health programmes, as can religious pressure, even if irrational, over child vaccinations. Cinderella surgical specialties tend to be overlooked, including Op Smile for cleft lip and palate repairs, Orbis for preventable blindness and charities for vesico-vaginal fistula repair in Africa and Asia. The containment effort during the 2013-2016 outbreak of Ebola fever was not entirely altruistic, given its highly-contagious nature, the high mortality and fear of it spreading to Europe.

The flip-side of food production

Agriculture provides food and foreign exchange, but is detrimental to the established flora and fauna of a country – same goes for deforestation in Indonesia and the 10,000 acres of rainforest in Papua New Guinea cleared for the cultivation of oil palm, Elaeis guineensis, for use in food manufacturing and bio-diesel. The Cavendish banana, Musa cavendishii, currently accounts for 99% of all banana exports, but is threatened by fungal infection, Fusarium oxysporum, Panama disease; which did for the Gros Michel banana.

The danger of monoculture and putting all your exports into one species is a looming tragedy for Caribbean countries that depend on this vital export revenue. A domino effect results in loss of income, jobs and tax revenue with collateral unemployment and decreased spending on health care, where it is most needed.

Monoculture is also implicated in wild plant biodiversity loss by pollination deficit as insect pollinators forage in huge monoculture fields with higher floral resources, rather than at natural margins. Genetically modified organisms such as golden rice have raised concerns, though the possible use of 'terminator' technology generated massive negative publicity and was rightly abandoned.

Global health entrepreneurs

Some individuals own important bits of global health. Since 2010 Bill Gates has focused on malaria, a disease that has been around for at least 4,000 years. His goal is to eradicate malaria using genetic engineering of both parasite and mosquito vector. He had the clout and the cash to call a malaria summit meeting in London in April 2018, the same time as the Queen hosted the Commonwealth Conference. This summit considered that, despite all efforts, cases of malaria rose in 2016 from 211 million to 216 million with approximately 550,000 deaths - mostly children under five, 90 % of them in Sub-Saharan Africa. An estimated 300-600 million people get malaria annually, with 42% of the world's population living in malaria-risk areas. Nigeria has about 51 million cases and 207,000 deaths annually.

The original 1993 paper proposing the use of bed nets dipped in permethrin solution was simple and brilliant.

The Gates Foundation, assisted by another billionaire Warren Buffett, has an endowment of US$40bn, spending US$5bn annually on research, mass immunisations and free/subsidised insecticide treated bed nets. The original 1993 paper proposing the use of bed nets dipped in permethrin solution was simple and brilliant. Currently each insecticide treated net (ITN) costs around US$2, lasts for three-four years and protects two people on average, even after three washings before re-dipping.

A recent development is a lasting insecticide net (LLIN) with the chosen insecticide impregnated in the fibres and which lasts three-five years. The treated bed net is the perfect sub-Saharan health project: protective physically and chemically, preventative, cheap, simple, repeatable, effective and easy to explain to both donors and recipients.

A secondary use for these nets, even brand new, has been by local artisanal fisheries, bypassing their original purpose. However, fishing with such nets in seine, scoop and set nets results in the capture of juvenile fish, risking vital protein stocks becoming unsustainable in the long term.

In September 2016, Mark Zuckerberg announced that his foundation would donate US$3 billion to fund a plan to "cure all disease" by the end of the 21st century. A bold ambition for a relatively-small sum to find such varied panaceas and some have dismissed it as mere hubris.

Great idea, but the problem is…

How will we feed, water and house all the people whose lives such measures save? Not a criticism, but a suggestion is to do the maths of consequences of saving lives or, more accurately, delaying death at all stages of life.

Nature's ability to self-regulate is already slewed by the increasing demands of the third world's aspiration to a first world lifestyle, with the consequence of global warming from increasing levels of CO2. Death is a natural form of regulation; which we are delaying and so slewing human evolution as well. More thought is needed about population control and dealing with it in terms of greater awareness, funds and action. Discussions about family planning in Africa lead to accusations of neo-colonialist racism, but ignoring such increases in urban population is blinkered and foolish.

In 2014, Dr James D. Shelton, Science Advisor, Bureau for Global Health, USAID showed that reduced mortality leads to population growth, mainly in sub-Saharan Africa, but with a poorer quality of life. In Nigeria the figures for 1950-2010 showed that, even with lower infant mortality, fertility remained at six children per mother. The figures for Niger are 7.6; despite infant mortality being reduced to 60/1,000 live births. Increased survival creates 'population momentum', as these children will have their own children.

Too little, too late?

Reduced infant mortality can eventually result in decreased fertility, but only in the long term, by which time it will be too little, too late. Even at a median projection allowing for fertility reduction, Nigeria with be approaching one billion people in 2100. It is also incorrect to say that there is population growth reduction in the median term with increased survival rates. The demographics of the 1970s research on the 'child survival hypothesis' are long outdated.

Reduced infant mortality can eventually result in decreased fertility, but only in the long term, by which time it will be too little, too late.

People and the Planet, the Royal Society report in 2012, raised concerns about our current world supplies of food, fuel and water as well as about urbanisation, deforestation and climate change--all driven by demands of uncontrolled population growth. For family planning to succeed, it requires information and motivation; as well as a convenient form of contraception, usually by depot injections, for women in these countries. This empowers the women, giving them control over the number of children they have.

For family planning to succeed, it requires information and motivation; as well as a convenient form of contraception… This empowers women.

Such non-coercive family planning is a major part of a successful drive to reduced infant mortality. The recent example in Ethiopia shows it can be done, resulting in huge benefits to mothers as well as children. Secondary education for both sexes until at least 16 years, if completed by the girls, results in fewer babies.

Women's health is affected by violence: physical, sexual, verbal, economic and social, often in countries with a patriarchal tradition. Meanwhile antenatal sex determination and sex-selective abortion of girls – foetal femicide – has slewed the natural female-male balance in China and India.

Any answer to a complex question muddies the waters, but to provide some closure the final answer to my question is: "Nobody does. You cannot own a moral obligation or an imperative to survival." The WHO does well as next best, but I'm neither optimistic nor pessimistic. Just a realist.

For references please email the Editor.

TRAVELLERS' TALES

Safari India style: Be prepared!

In part two of her Indian adventure, Hilary Simons FFTM RCPS(Glasg) has a bit of a bumpy ride.

'Safari' is the Swahili word for journey but applies particularly to one taken to observe animals in their natural habitat. In India this is a very different beast to an African safari. The habitat is often jungle and/or long grass and the larger animals play hard to get. Anticipation is often the biggest thrill and sitting still in one place, watching and waiting for long periods is part of the experience.

We were lucky. Good guides and patience resulted in some wonderful encounters with wildlife. Safari India on a second time around gave us a tactical advantage so here are a few observations that made our lives easier and might help you or the travellers you advise.

The off-road vehicle of choice is the omnipresent Gypsy, the workhorse of the National Parks of India. High off the ground, getting in and out of a Gypsy can be a challenge for some. Indeed, staying in an open top vehicle can challenge anyone; there are no safety belts and drivers may fly around the park at breakneck speed over difficult terrain. If a warning call of the sambar deer or langur monkey is heard, you are likely in for a fast ride and when you hear "hold tight please"– they mean it!

Be prepared for a bumpy ride. There is little suspension and overlanding, even in established national park routes, can get tough. At the end of the day, at least the first day, you will ache in places you didn't know you had. Take a cushion if you can (for comfort, but also in the unlikely event of a rain shower a cushion will prevent chaffing from a wet, plastic-covered, seat).

Unless you book the whole four-seater Gypsy, your companions are luck of the draw. Ours ranged from a delightful senior lady travelling alone to an obsessive compulsive, aggressive person with a death wish to an 18-month-old child who screamed for the duration. Try to be tolerant – you cannot get out of the vehicle, and nor can they! Be prepared also to get up close with fellow travellers. There may be an option to buy and extra seat which will give you more room.

Play it safe

Be prepared also for wide temperature variations through the day, from 5 a.m. when it's cold enough to shiver to the midday heat of Hades. Dress in warm layers and women will be glad they packed their pashmina (a big scarf). The hairdo is lost as soon as the accelerator hits the floor. Shades will protect your eyes, not only from fierce sunrays, but from cold breezes of dawn and from the evil small black flies that are drawn to unprotected eyeballs. Don't forget your reading glasses, and a spare (mine are currently five-foot-deep in crocodile-infested waters in remote MP and will remain there).

Wear a hat and sun screen, of course, and only drink safe water. Our guides carried boiled, cooled water in a flask. The environmental issue of plastic is a huge problem in India and is, thankfully, being addressed at Government level. We always avoid plastic water bottles and carry our own re-usable ones which can filter and purify water, allowing us to fill up from any fresh water source.

Keep your hands clean. Your throat and mouth may get very dry, especially if driving on dusty roads in the heat. Boiled sweeties and toffee (no wrappers) from the UK proved an immensely popular diversion during the times we sat watching and waiting patiently for a glimpse of the elusive baagh (tiger).

Remember you are likely to be in the vehicle for many hours. 'Bush toilet' is usually not an option as getting out of the Gypsy is strictly forbidden unless at an official rest stop. Our guide's advice to "go to the loo twice before you leave on safari" was wise. Even my acute attack of colic with profuse sweating and a desperate need to 'go' was not considered an excuse to stop for bush toilet. On that occasion, as I concentrated on maintaining some dignity and holding my breath to keep control, my companions were themselves holding their breath and gaping in awe as the nearby tiger ambushed an unsuspecting sambar.

Incredible India …twice is not enough – let the planning begin!

Contact the Editor for resources.

TRAVELLERS' TALES

Iran: A journey along the Silk Road

Yvonne Gibney MFTM RCPS(Glasg) continues her two-part idyll in a country few travellers get to see nowadays.

Naqsh-e-Rustam Necropolis

Persepolis

Celebrating with a gold medallist

Our journey now took us beyond Shiraz to Persepolis. Here were the first structures built as the ceremonial capital of the Archaemenid Empire in 518 BC by King Darius the Great. Darius was buried at the nearby Naqsh-e-Rustam necropolis, a structure carved high into the mountains. Entry to Persepolis is via the Gate of All Nations. The remains are breath-taking – exquisitely-carved, preserved and reconstructed detailed reliefs, with tall towers and terraces. Destroyed in 330 BC it lay under ruins until it was excavated and restored in the 1930s.

The city of Yadz has existed since 3000 BC, with its mud bricked buildings, domed roofs, narrow, dark and low passageways. The 13th century Jameh Mosque has the highest minarets in Iran and is worthy of its World Heritage site title. Ten per cent of the population of Yadz are Zoroastrians and the Fire Temple, the Asahaadha, contains a fire that has burned for the past 3,000 years.

In the Zoroastrian tradition, on death a body can be contaminated by demons and made impure. To prevent this the dead were purified by exposing bodies to the elements on flat towers in the desert called dakhmas, such as the Towers of Silence which we visited. However, with increasing urbanisation resulting in dakhmas being closer to populated areas, the practice is now illegal.

On to Mashhad, the end of the road

Our only means of crossing the Central Desert was to hire transport. Our aptly-named driver Aziz, which means 'respected', was a retired army commander and a veteran of the Iraq/Iran war. On production of his ID as we drove in his battered car through desert checkpoints, we were met with smiles and salutes, and given sweets and bottles of water.

Our destination was a remote village close to the Afghanistan border. As the only hotel guests, we sat on Persian rugs and ate smoked aubergine, fresh herbs and eggs, olives with crushed walnuts in pomegranate juice and freshly-picked figs. Our room, built over a qanat, was cool despite the 38-degree heat. These underground streams are an ancient form of channelling water from a distant aquifer for drinking, irrigation and cooling, and enabled the expanses of lush agricultural growth that appeared in isolated and diverse terrain.

Mashhad was – literally – the end of the road for us. Iran's holiest city is a shrine to the Shiite Islam's eighth Imam, Imam Reza, and is visited by up to 20 million pilgrims every year. By area it is the world's largest mosque. At night it is dazzling, lit by thousands of lights that reflect the gold and crystal inner walls. We were honoured to join a ceremony of remembrance for a fallen solider, where thousands sang and beat their breasts in mourning. The ground vibrated and the emotion was all consuming.

On our flight back to Teheran we sat among returning medal-winning athletes from the Asian Martial Arts Championships, and with the now-familiar Iranian hospitality, we were guests at the athletes' official reception. Such is the generosity of the remarkable and unforgettable Iranian culture.

CLINICAL

Influenza Immunisation for healthcare professionals

Before advising travellers on the value of influenza vaccine, perhaps we should make sure we are protected ourselves. So do you take your own advice?

by Pauline MacDonald

For many years health and social care staff have been advised to have an influenza vaccine each autumn, the rationale being that staff need the best protection against flu each season to provide care. Staff may catch flu from their clients or, having acquired it elsewhere, transmit it to vulnerable clients. They can also pass it on to their own family and friends.

Uptake has historically been low, but slowly increasing over recent years, mainly because of the NHS Employers Flu Fighter campaign and recent incentive payments to trusts for attaining high staff uptake **(www.nhsemployers.org/flufighter).**

So why should staff accept the offer? Vaccination is the best protection against influenza and its complications, which can include chest infection, pneumonia, sepsis and even death.

There is a growing body of evidence suggesting that within eight hours of an individual first being infected the new virus particles are released from the epithelial cells of the respiratory tract and transmitted via the respiratory route to infect others. At this point the person may be symptom-free and unaware of having influenza. Similarly, some people may never develop classic symptoms or be unaware that they are a potential risk to others.

All healthcare staff state they will not go to work if unwell. However, with influenza, they might be seeing and treating vulnerable patients while unwittingly infectious. The exact percentage of people with asymptomatic or subclinical influenza is likely to vary depending on the type and strain of influenza, the person's vaccination status, previous influenza infection, age or health state. This could range between 0-60% of infected persons. Healthcare staff should therefore consider vaccination as an integral part of their organisation's infection prevention strategy.

But why are so many staff reluctant to get vaccinated?

Most healthcare staff will have their Hepatitis B vaccines without hesitating, but many refuse to have an influenza vaccine. Studies assessing staff attitudes reveal that they feel it is too much trouble, they are not at risk or the vaccine would make them feel unwell. This latter point is cited by many people, not just staff, who refuse vaccination.

One explanation is that in many recipients of the influenza vaccine can produce a strong immune response, making them feel unwell. Influenza circulates each winter in the northern and southern hemispheres, and all year round in the equatorial regions – something to consider when advising travellers. Since influenza is a common infection and most countries offer immunisation to at least some of their population, most people either have already been exposed to influenza or been vaccinated.

Consequently, the influenza vaccine can produce an immediate and strong immune response due to pre-existing antibodies. Vaccination mimics infection, producing cellular responses, serum antibodies, lymphocytes, macrophages and the complement system. For these immune cells and chemicals to infiltrate tissues where the vaccine antigens may be, there is an increase in permeability of capillaries with a small but noticeable increase in extracellular fluid.

This immune response results in mild fever, redness and swelling at the injection site, muscle and joint aches, and swollen tissues in the nose and sinuses; all described as 'flu-like' symptoms. These symptoms will often last only 24-48 hours and are generally relieved by mild analgesics, such as paracetamol. They are considerably less than those caused by influenza infection.

Staff involved in advocating immunisation are urged not only to warn patients about these immune responses following influenza vaccination, but also to explain why such symptoms occur. Spending time explaining this may help dispel the myths surrounding influenza vaccines, resulting in higher uptake and protection for more people against this common, unpleasant and occasionally severe infection.

Pauline MacDonald is an independent nurse consultant and Managing Director of Infection Matters Limited **(infectionmatters.com)**, *which aims to prevent infection through immunisation, education and best practice.*

Please email the Editor for references.

CLINICAL

RCN Updated Competencies in Travel Health Nursing 2018

Here's an overview of guidance from the Royal College of Nursing that's relevant to practitioners from all disciplines of travel health.

By Jane Chiodini FFTM RCPS(Glasg)

Although, aside from yellow fever vaccine administration, we have no regulation governing the practice of travel medicine in the United Kingdom, health care practitioners undertaking travel health consultations will need to abide by the Code of Professional Conduct of their registering body, be they doctors (the General Medical Council- GMC), nurses (the Nursing and Midwifery Council - NMC) or pharmacists (the General Pharmaceutical Council - GpHC).

Standards of practice are more closely assessed today, but the process for this is variable and questionably equitable. In England the Care Quality Commission (CQC) will inspect travel health services led by doctors and/or nurses. Where a travel service is delivered in a GP setting, this assessment is part of the general CQC inspection, although the training and delivery of travel health care may not be a subject chosen by the assessment team. Pharmacy-led services come under inspection of the GpHC and occupational settings are assessed by SEQOHS – Safe Effective Quality Occupational Health Service.

Scotland has more recently regulated private clinics that are registered with Health Improvement Scotland, but overall there remains a lack of information regarding assessment of quality of travel health care within the UK.

The Royal College of Nursing has been ahead of the game for many years in terms of outlining competencies for nurses working in the field of travel medicine/health: the document was first published in 2007, updated in 2012 and again recently republished as Competencies: Travel health nursing: career and competence development.[1]

The 2012 edition was reviewed 18 months ago by means of an audit[2] and recommendations were provided to help shape this newly-published third edition. The document has therefore been reviewed to include the content deemed most useful, including making the travel risk assessment and management forms available to download as standalone documents from the RCN website under the heading Related RCN resources / publications at **www.rcn.org.uk/clinical-topics/public-health/travel-health**. These can also still be accessed from items 1 and 2 at, **www.janechiodini.co.uk/tools/**

Travel health nursing has moved on since 2012

A statement is included for those who run Yellow Fever Vaccination Centres in the UK acknowledging that while YF training is not mandatory for all individuals administering the vaccine, both the National Travel Health Network and Centre (NaTHNaC) and Health Protection Scotland (HPS) recommend all those responsible for administering YF vaccine should complete the training for their own accountability and good practice. See page 9 of the publication at **www.rcn.org.uk/professional-development/publications/pdf-006506**

The provision of a travel service and funding issues are in a state of flux right now with new developments happening in Scotland, while a decision on the England situation following a Public Health England evaluation is awaited as outlined on page 8. The Human Medicines Regulations of 2012 made it feasible for the provision of PGDs (patient group directions) for the administration of private travel vaccines in a GP setting and this process is described in a little more detail on page 10.

There is now greater awareness of the potential identification of a traveller within a consultation going abroad for the purpose of FGM (female genital mutilation) or for forced marriage. These topics are included in the sections for young travellers, female travellers and in a separate section on the subjects with links to further resources. Plus FGM is included in the risk assessment form (pages 12, 15, 29). Similarly, issues for LGBT (lesbian, gay, bisexual, transgender) travellers are highlighted on page 13.

New developments

Zika virus wasn't a particular problem in 2012, but bite prevention advice and sexual health advice play a key role for both pregnant travellers and those planning a pregnancy who are travelling to ZIKV risk areas. There is mention of this in the text and in the travel risk management form on page 31.

A newly-developed appointment guidance section has more information to help manage a travel health consultation. A minimum of 20 minutes is still recommended for a travel appointment, longer if the needs are more complex, and it is now stated that **only 10 or 15 minutes would be unsafe** for a new travel appointment.

Continued on Page 14

CLINICAL

RCN Updated Competencies in Travel Health Nursing 2018 - *Continued...*

This section also addresses managing groups of travellers and discusses the challenges of children within an appointment as well on page 18. It is recognised that some GP surgeries in England are 'stopping' their provision of travel health which at the current time is not allowed. Details explaining this incorrect and unsafe behaviour are on page 19.

Ideas are provided for keeping up to date if it is not feasible to access face-to-face training (point 6, page 23) and guidance on training providers is given on page 34. This new document will be available only in electronic format so all links are provided not only for all the references, but throughout the text as well.

It is hoped the updated publication will be read by newcomers to travel health and experienced advisers alike. It has the endorsement of Royal College of Physicians and Surgeons of Glasgow, Health Protection Scotland and NaTHNaC. While it is written for nurses, the document is equally applicable to other qualified practitioners providing travel health services, including doctors and pharmacists.

Please share it as widely as you can.

Jane Chiodini was installed as Dean of the Faculty of Travel Medicine in October 2018.

References

[1] Royal College of Nursing (2018) Competencies: Travel health nursing - career and competence development, London: RCN. **www.rcn.org.uk/clinical-topics/public-health/travel-health**

[2] Currie L, Russell J and Bayliss A (2017) Executive summary: perceptions of the RCN Travel Health Competencies Document, London: RCN **www.rcn.org.uk/professional-development/publications/pdf-006506**

The Risk Assessment and Risk Management Forms are included in the document and as standalone versions on the RCN Public Health Forum, Travel Health pages. **www.rcn.org.uk/clinical-topics/public-health/travel-health**

Editable versions are also available at items 1 and 2 **https://www.janechiodini.co.uk/tools/**

FACULTY NEWS

Best wishes to **Fiona Genasi** FFTM RCPS(Glasg), who has retired from Health Protection Scotland where she led the TRAVAX team (see Emporiatrics, Spring/Summer 2013). As befits a pioneer in the field of travel medicine. Fiona's career is full of 'firsts' – the first nurse consultant, the first nurse elected President of ISTM, a founder member of NECTM and a founder Fellow of the Faculty of Travel Medicine. Au revoir, Fiona.

Congratulations to two Fellows of the Faculty of Travel Medicine recognised in the Queen's Birthday Honours in June 2018. Group Captain **Andy Green**, FTM Dean, was awarded a CBE and former Dean, Professor **Peter Chiodini** (pictured left) an OBE.

Professor **Sadras Panchatacaram Thyagarajan** (left), a teacher and researcher for 48 years in the Tamil Nadu Medical Colleges and an adviser to the World Health Organization, has been awarded an RCPSG Honorary Fellowship. He has strong links with travel medicine education in Glasgow, including an award-winning collaboration with Professor **Eric Walker** (right), and has previously arranged cultural orientation programmes in Chennai for the FTM diploma students.

A new commemorative coin honouring the legacy of **Dr Jonathan Cossar** (left) will be given to individuals who have made a significant contribution to the Faculty. **Niamh Ireland**, a first-year jewellery student at Glasgow School of Art, won a competition for the design of the coin and collected her own award at the College Admissions Ceremony in June.

Karen Rudd (left) and **Jennifer Anderson** won praise at NECTM7 in Stockholm for their session on female genital mutilation. FGM for travel health services (www.rcn.org.uk/professional-development/publications/pub-005783) is a subject which both the Faculty and the RCN have worked hard to bring to the attention of travel health providers. Congratulations to Karen, Jennifer and **Cathy O'Malley (**see Travel Bites on page 06). who were awarded Faculty Fellowships in June.

Conferences

FTM/BGTHA Joint Event
24 November 2018
De Montfort University, Leicester
rcpsg.ac.uk/events/bgtha

Joint RCN / NaTHNaC event
9 February 2019
Royal College of Nursing, London
www.rcn.org.uk/news-and-events/events/travel-health-feb-19

CISTM16
5-9 June 2019
Washington DC
www.istm.org/cistm16

NECTM8
8th Northern European Conference on Travel Medicine
Coming in 2020
The Netherlands
Details to follow at: http://nectm.com/

Travel Medicine Education, Training and CPD
www.rcpsg.ac.uk/travel-medicine/education

From the Journals

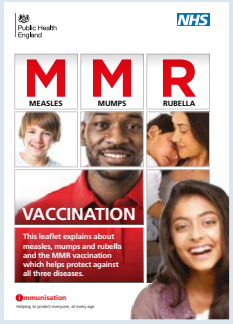
Bauer I (2018) When travel is a challenge: Travel medicine and the 'dis-abled' traveller, *Travel Medicine and Infectious Disease 22 (2018) 66–72. https://doi.org/10.1016/j.tmaid.2018.02.001*

Hitch G and Fleming N (2018) Antibiotic resistance in travellers diarrhoeal disease, an external perspective, *Journal of Travel Medicine, 25 (suppl 1) S27-S37 https://doi.org/10.1093/jtm/tay014*

Lindquist L (2018) Recent and historical trends in the epidemiology of Japanese encephalitis and its implication for risk assessment in travellers, *Journal of Travel Medicine 25 (suppl 1) S3-S9. https://doi.org/10.1093/jtm/tay006*

Nakamuraa S, Wadab K, Yanagisawac N et al (2018) Health risks and precautions for visitors to the Tokyo 2020 Olympic and Paralympic Games, Travel Medicine and Infectious Disease 22 (2018) 3–7 https://doi.org/10.1016/j.tmaid.2018.01.005

BULLETIN BOARD



Remember measles?

As summer ended large outbreaks of measles continued around the world, including Europe and the USA. Although the UK has WHO elimination status, outbreaks here are linked to importation from Europe. Public Health England (PHE) advises healthcare professionals to improve coverage in young children and offer catch-up vaccination to older children and adolescents who are at risk. The MMR vaccine is available to all adults and children who have not had two doses.

travelhealthpro.org.uk/news/337/measles-reminder
www.travax.nhs.uk/diseases/vaccine-preventable/measles-mumps-rubella/#faqs7

https://www.fitfortravel.nhs.uk/advice/disease-prevention-advice/measles

Green Book updates

Among chapters that have been updated or revised in the current Immunisation Against Infectious Disease publication are influenza (chapter 19), Japanese encephalitis (20), rabies (27), tetanus (30), tuberculosis (32) and yellow fever (35).

www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Online Support

Rabies

NaTHNaC at:
travelhealthpro.org.uk/news/326/country-specific-rabies-risk-and-recommendations-2018-updated

TRAVAX at:
www.travax.nhs.uk/news/news-record-page?newsid=22745
Vaccine update: issue 282, August 2018, rabies special edition at:
www.gov.uk/government/publications/vaccine-update-issue-282-august-2018-rabies-special-edition

PHE guidelines on post-exposure treatment:
www.gov.uk/government/collections/rabies-risk-assessment-post-exposure-treatment-management

Yellow fever

World Health Organization country requirements and recommendations (2018) are at:
www.who.int/ith/ith-country-list.pdf?ua=1

NaTHNaC and TRAVAX have updated their country information pages accordingly.

FACULTY OF TRAVEL MEDICINE AND BGTHA JOINT EVENT

This conference aims to promote a multi-disciplinary approach to travel and global health by bringing together the various disciplines involved in global health and the health of travellers.

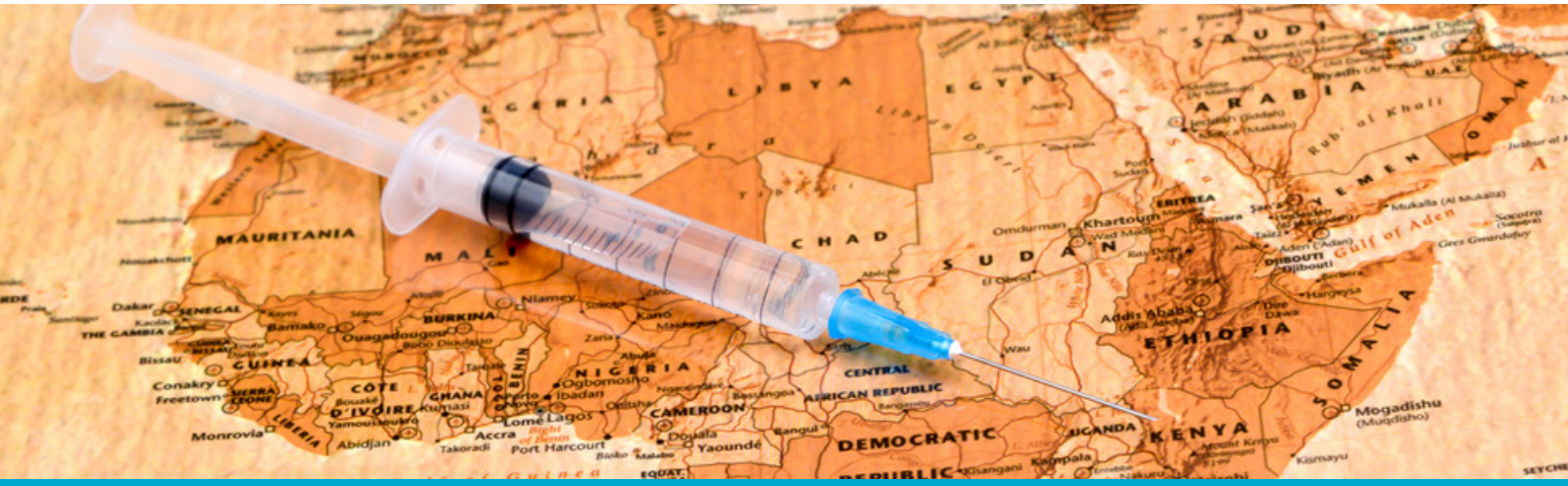
The day will provide information and education on travel and global health issues to increase the understanding of the travel medicine discipline.

Venue: **De Montfort University, Gateway House, Leicester LE1 9BH**

Date: **Saturday 24 November 2018**

BOOK NOW rcp.sg/events

BGTHA
The British Global and Travel Heath Association



FOUNDATION IN **TRAVEL MEDICINE**

PUTTING CAREER DEVELOPMENT FIRST FOR HEALTH PROFESSIONALS IN TRAVEL MEDICINE

The Foundation Course in Travel Medicine provides practitioners with the knowledge required to advise intending travellers on core aspects of travel health.

Topics covered include:

- *Providing a travel medicine service • Pre-travel risk assessment*
- *Infections and epidemiology of infection • Malaria*
- *Immunisation theory, practice and available vaccines*

The next start dates for this 6 month blended learning course is:

Wednesday 20 March 2019
(2 day residential component in Manchester)

Contact Lesley Haldane

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rcp.sg/travelmedicine

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW
TRAVEL MEDICINE