



emporiatics

News, views and reviews
from the Faculty of Travel Medicine



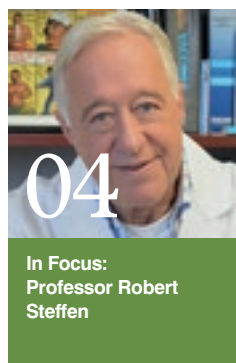
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providing eye care
and treatments in a
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**Female genital
mutilation and
travel health**

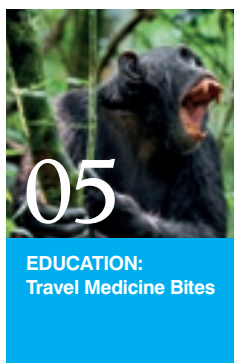
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Bites**

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Professor Robert
Steffen



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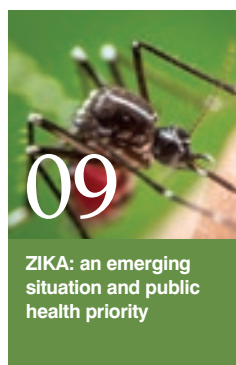
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Production

Editor

Sandra Grieve FFTM RCPS(Glasg)
awcg1@btinternet.com

FTM Executive Board Liaison

Jennifer Anderson MFTM RCPS(Glasg)

Please address all correspondence to the editor

Sub-editors

Sharon Withey
Lucy Adams

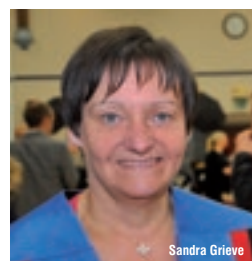
Design

Shaw Marketing and Design
(www.shaw-online.com)

Print

Winter & Simpson Print
01382 813813

For information on membership of the Faculty of Travel Medicine at the Royal College of Physicians and Surgeons of Glasgow, please contact membership@rcpsg.ac.uk



Sandra Grieve

Editorial

Welcome to the Autumn/Winter edition of Emporiatrics.

Welcome to the Autumn/Winter edition of Emporiatrics. The field of travel medicine remains a challenge. The impact of ZIKA virus continues and is discussed on page 09 while guidance for travel health practitioners on FGM is addressed on page 10. Providing ophthalmic care for people in rural Kenya is an eye-opening experience for Ann McDonald on page 06. On a lighter note, the experiences of a medical officer on a movie set in Nepal make for a lively Traveller's Tale on page 12. Faculty educational tools are increasing online as you will see on Page 05. Our In Focus subject on page 04 is Professor Robert Steffen, a founding father of travel medicine. And another founding father, Eric Walker, has published a memoir, reviewed on page 14.

My thanks as always to our contributors.

Sandra Grieve

Letter from the Dean of the Faculty of Travel Medicine

Group Captain Andy Green FFTM RCPS(Glasg)



I am Punk. Are you?

2017 has been interesting on the global stage for various reasons, both health-related and geo-political. They are inextricably linked: if travellers ignore cultural and political norms and sensitivities in other countries, their health will likely suffer. Yet altering their ways and pre-conceptions is challenging.

How to communicate what I really mean? In travel medicine, this often translates to how best to influence behaviour change in both travellers and health professionals. Is accepted wisdom always the correct way to do things, or should we be exploring newer and more innovative techniques?

.....

‘To avoid being mistaken for a sell-out, I chose my friends carefully. The more politically active black students. The foreign students. The Chicanos. The Marxist professors and structural feminists and punk-rock performance poets.’*

.....

Take the Craft Beer movement, now embracing most countries around the world. Brewdog is one of the UK's more controversial proponents, a company started ten years ago by two men (and a dog) setting up a brewery in a shed outside Aberdeen. They challenged traditional thinking and conventional business approaches with novel products, radical marketing and a confrontational attitude towards what they called the complacent ‘fat cats’ of traditional companies. Instead of commercial loans and grants, they used ‘crowd funding’ to raise finance from like-minded individuals. Their enthusiasm and drive (to be honest, also their humour and refreshing refusal of conventional wisdom) led over 50,000 people to invest in their vision.

.....

‘Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek.’*

.....

Their first beer was ‘Punk IPA’, and they have consistently promoted a punk philosophy. Indeed, they call their shareholders ‘Equity Punks’.

In Aberdeen, I recently joined 7,000 others at Brewdog's Annual General Meeting. True to form, the Chairman's Address more closely resembled a stand-up comedy act, ending with a Stranglers gig.

So. Any lessons here for travel medicine?

Considering Brewdog is now one of the fastest-growing companies in the UK and valued at over £1 billion, certainly they have persuaded investors from a population-base that traditionally distrusts conventional business to back their revolutionary ideas. One founder (James Watt) describes the concepts in his recent book and, while many ideas are non-transferable and some no longer new, others bear closer scrutiny – for example, that the key focus for any organisation should be:

- **Personnel** (the most valuable asset, who need to buy into the culture of the group)
- **Product** (focused on high quality rather than low price, that staff and customers believe in)
- **Openness and honesty** (at all levels within the group, and with customers).

Now consider this when reflecting on various Faculty activities started or completed over the last 12 months, and those about to occur. They are, using James Watt's headliners:

- **Personnel** (expand membership to embrace more non-medically qualified people, revise fee structures, seek opinions through the Membership Survey, make it easier for people overseas to join the Faculty)

- **Product** (develop the new Membership Diploma Course to include greater distance-learning components, streamline routes to membership through greater access to examinations and direct admission based on experience and published work, increase access to membership through thematic educational programmes and innovative education methods)
- **Openness and honesty** (the Faculty Strategy describing current activities and future plans, improvements to website structure and function, a Faculty Communication Lead with emphasis on social networking).

Clearly there's still a long way to go, but remember that the College was founded in 1599 so any change within one of the Faculties in such a short period is encouraging.

The same principles can easily transfer to our individual clinical practices. Just focus on your personnel and the product (the standards of care for patient/traveller), and try to be open and honest at all times: not much will go awry.

Andy Green
Dean FTM

** Both quotes from Barack Obama, 44th President of the United States. Perhaps not immediately spring to mind as someone embracing punk philosophy, but he quite probably does these days.*

James Watt (2016) Business for Punks: Break All the Rules – the Brewdog Way, Portfolio Penguin.

IN FOCUS:

Professor Robert Steffen FFTM RCPS(Glasg)

Dr Steffen is Emeritus Professor at the University of Zurich in Switzerland, where he concentrates on research projects at the Epidemiology, Biostatistics and Prevention Institute in the WHO Collaborating Centre for Travellers' Health.



Q. Did you always want to be a doctor?

A. As a boy I found fewer wild strawberries in the woods than my sister did so inherited colour blindness ruled out being a pilot or engine driver. My parents managed a large restaurant in Zurich, fuelling my ambitions for a nine-to-five job in chemistry. Concerned that medicine was too broad for my little brain I decided on dentistry. After two years, it was clear that I had no talent to work with my fingers and an examiner convinced me to become a doctor after all.

Q. How did you get into travel medicine?

A. I enjoyed locums in Poland, Italy and Spain with the medical student exchange programme and moved up the echelons to become President of the International Federation of Medical Student Associations, representing over 200,000 students in 50-member countries. Aged 26 and visiting students in Latin America, Africa and Asia, I realised that vaccination and malaria prevention recommendations were contradictory, with a clear lack of evidence base. Thus, in the early 1970s, after setting up simple research projects, I decided to devote my professional life to keeping travellers alive and healthy.

Q. When did you move into more strategic roles?

A. The beginning was difficult, particularly since some big shots in tropical medicine belittled my ambitions. I'd opened my private practice in general internal medicine near Zurich in 1978 and two years later was surprised – and delighted – to be invited by the Professor of the Institute of Social and Preventive Medicine at Zurich University to accept a 50% job there, leading the smallpox and other vaccinations centre for travellers.

I'd been friends since the 1980s with 'Bert' DuPont from Houston, who shared my interest in travellers' diarrhoea research. Then Hans Lobel from the CDC malaria branch in Atlanta enabled me to broaden my horizons. As an experiment, we invited people to a first international conference related to travel medicine (we had many discussions on what name to choose). Over 400 came to that pivotal meeting in Zurich, April 1988.

Q. What was your role in developing the International Society of Travel Medicine?

A. I was exhausted after the Zurich meeting and no more than lukewarm when my American partners suggested creating a Society. I was

concerned that we would waste energy on administration rather than concentrating on research and future meetings. I was soon convinced, especially when Phyllis Kozarsky joined us to organise the second international meeting at Atlanta in 1991, when ISTM was created. Between the four of us we formulated by-laws and had – occasionally heated – discussions about further steps.

Q. What's your vision for the next 25 years of ISTM?

A. Initially, travel medicine sometimes gave me a bad conscience as being a sort of 'luxury medicine' for those in industrialised countries who could afford to visit lower income countries with suboptimal hygienic conditions or other major health risks. I've always hoped that less privileged populations would ultimately benefit from travel medicine – for example through new products like vaccines. Remember that hepatitis A vaccine was originally developed for travellers, but in various countries is now recommended for the entire population.

I'm pleased that ISTM leadership now devotes energy and funds to "close the gap" – that is, to interest colleagues in countries starting to have increasingly social strata to collaborate and travel to join us.

Together with Joe Torresi from Melbourne I have outlined future research needs in an article to be published shortly in our *Journal of Travel Medicine*.

Q. What is a typical day for you?

A. As Emeritus, I no longer have to care for my team. When home-based I spend four hours a day at my private practice where I counsel travellers, examine pilots and see patients as a GP. I also enjoy writing articles and preparing lectures. My quality of life is much improved. No longer in a hurry, I just pull slides from the drawer, but have more time to study the most recent publications, sit at my desk overlooking our garden and Lake Zurich, and thoroughly think over my steps. In the evening, my wife Eve and I – alone or with friends – cherish a good dinner with a bottle of wine.

Q. What is your favourite destination and why?

A. I would name three: Chile, Namibia and New Zealand. I just love beautiful landscapes. But surprise: twice a week I watch the changing seasons on a trail near Zurich Zoo, and would like to spend more time hiking in the Swiss mountains.

EDUCATION

Travel Medicine Bites start, appropriately enough, with rabies

By David Ross QHP FFTM RCPS(Glasg),
Director of Education, Faculty of Travel Medicine.



Continuing Professional Development (CPD) is an essential element of doctor and nurse revalidation through their respective regulators and being a member of other professional bodies.

Most specialties are moving away from using points as a way of recording CPD and require individuals to write reflective notes on any learning they have undertaken. Individuals who are not used to writing reflective notes often see this as an additional burden after doing a CPD activity. Also, healthcare professionals are often constrained by time as to how much CPD activity they can undertake so it is important for providers of education to tailor educational resources to meet this challenge.

Following my predecessor's innovative launch of the Travel Medicine Hub, the Faculty's Educational Board has considered how we can build on this excellent tool while recognising that production of the Hub was very labour intensive and was only a success because of Jane Chiodini's personal dedication. We have therefore decided to produce short pieces of CPD using one section of the Hub, which we have called Travel Medicine Bites.

The first edition of "Travel Medicine Bites" can be accessed through the following link:
<http://rcp.sg/TMBitesRabies>

This edition is on rabies. The background material focuses on a traveller bitten by a monkey and was provided by Dr Susanna Roughton, a student from the 2014/15 Diploma cohort who was awarded the Cameron Lockie prize for overall best student.

Within this edition you will become familiar with international and national guidelines on the management of individuals who may have been exposed to rabies and be able to test your knowledge on what you already know and what you have learned through the "Travel Medicine Bites" activity. It can be completed in 15 minutes, but if you want to do more reading around the subject then you can simply record that as additional time claimed in your reflective note.



I tend to use four questions to structure my CPD reflective note:

- Why did I choose this activity for my CPD?
- What have I learned from doing it?
- How am I going to apply this learning in my work?
- What am I going to do in future to develop this learning further and/or meet any gaps in my knowledge or skills?

Finally, if readers have material for future editions of "Travel Medicine Bites" or feedback as to how we could improve future editions then e-mail me at: david.ross@rcpsg.ac.uk

Enjoy!

KENYA:

Ophthalmology in a rural setting: providing eye care and treatments

Ann McDonald FFTM RCPS(Glasg)

Ann McDonald's first trip to Kenya* with her husband John (also a nurse) has led to two more, each offering quite different experiences. Here, they look in on an outreach service restoring sight to people living in remote parts of the country.

In 2016, we met up with a group of healthcare professionals and other volunteers from the UK who had also committed time to work in the Kenyan Healthcare Outreach Programme. Together, we would deliver primary healthcare services for rural communities in the Tsavo area of Eastern Kenya. Access to Kenyan healthcare services is not like ours in the UK and patients do not have free primary care.

After three flights and a six-hour truck journey to Tsavo, we arrived tired, but with a tangible sense of excitement for what was to come.

An orientation day was arranged to meet with our Kenyan healthcare colleagues who would be collectively sharing professional knowledge and practice. Following introductions and wonderful lunch of local cuisine, the day was organised around workshops including a Kenyan dentist, midwife, nurses, interpreters and laboratory public health staff, to share ideas and local information.

Clinic days

We awoke to a vibrant blue sky and flat landscapes for miles – heading out on red dusty roads was quite different from last year when the El Niño rains made some roads impassable.

Each visit to Kenya has been unique. This year the most striking difference was the initial welcome at each village with only a few children greeting us as the schools were on holiday during the programme. Regardless, there were smiles and cheers when the trucks came with equipment for the day's clinics.

Setting up was like a military operation with all hands on deck. Teams transformed classrooms into clinical rooms – desks and tables rearranged for consultation and waiting areas, signs in English and Swahili pinned to the doors, curtains pinned across a strategically-placed rope for privacy as nurses provided treatments. Crowds gathered under newly-erected tarpaulins, sheltering from the sun's heat.

There were hubs of activity across the school compounds. Midwives providing antenatal care used a Doppler foetal monitor and it was wonderful to witness the mothers' faces as they heard their baby's heartbeat for the first time.

Services providing dental care and tooth extraction were also busy and this year's extended services provided fillings to save teeth.

Some consultations were ordinary primary care cases, while others – like leprosy – we were more likely to encounter in a tropical medicine textbook. Services included health promotion, pharmacy, skin clinics and sexual health screening services.





Ophthalmic Clinic

I had a particular interest in working with staff from the Kwale Eye Centre in their clinic, which provides eye care and treatments for the community in outreach programme services. Last year over 3,000 patients were seen at these clinics. The ratio of ophthalmologists to the Kenyan population is around 1:500,000, and mainly concentrated in major cities. By comparison, the UK ratio is around 1:70,000 (EfEA, 2017). Bringing much-needed eye services to these isolated communities is vital to improving the general health of the population. Many people become blind or visually disabled from lack of access to quality eye care.

In the ophthalmic clinic, we tested the visual acuity of over 100 patients a day, ranging in age from three months to 85 years. They presented with an assortment of eye conditions, from red itchy eyes in children, caused by the dry dusty environment, to corneal infections and scarring from accidents and injuries. Several patients presented with strabismus resulting in amblyopia, a long-term consequence of measles in childhood.

Preventative eye care was carried out, prescription glasses dispensed and care provided for a particular group of patients with complex health issues whose eyes are particularly susceptible to sunlight. These children are cared for by the Kwale Eye Centre staff and closely followed up in the community.

Albino children

Albinism is a genetic condition, classified into two broad categories: ocular albinism affects the eyes with minimal-to-no skin involvement, while oculocutaneous albinism affects the eyes, hair and skin. People with albinism produce a low amount of the chemical melanin (NHS, 2016), which results in decreased pigmentation. Children with albinism can suffer from stigma because they look different to everybody else in their community.

Melanin helps protect the eyes from harmful ultraviolet (UV) damage. Those with lighter coloured eyes are at a higher risk, with lack of pigmentation and therefore less protective melanin. For this reason, those with albinism need to be carefully monitored. They can suffer from poor eye sight and protection is especially needed from the strong UV rays and glare of the African sun.

Kwale eye staff take a holistic approach, encouraging patients to wear sunglasses with UV protection when outdoors, cover their skin with long sleeves and trousers, wear a sun hat and use a high factor sun cream to protect the skin. These are the precautionary measures that we as volunteers followed to protect ourselves in a tropical environment.

Giving birth to an albino child is not always acceptable in some areas, with many myths and fears around these children. Thus, the staff also act as a resource for families, schools and other professionals, ensuring that families are supported in every way. By educating the wider communities, they enable children to live in a safer environment.

Cataract surgery

In Kenya, one person in a hundred is blind and an estimated 80% of these cases are preventable (EFeA, 2017). The two main causes are cataract and glaucoma, frequently diagnosed in the community. At the clinic glaucoma cases were treated with Timolol eye drops. Patients were asked if family members were attending the outreach clinic as they too could be assessed. Staff offered health education to families regarding diagnosis and early interventions that can save their eyesight.

On our last day of the eye clinic Hillary (another nurse with a keen interest in ophthalmology), John and I visited Taita Eye Clinic, a satellite hospital where eye treatments and surgery are performed. Just getting there was an adventure, starting with a long journey overland north of Voi. At the entrance, patients were on the veranda, queuing to be seen for surgery and sheltering their eyes from the bright sun. There was a lot of chatting and excitement as some recognised us from the clinics they had previously attended. It was lovely to witness the complete patient journey from consultation to surgery within two weeks.

That day 27 patients were booked for cataract removal surgery. Money raised in the UK and donated by nurses achieved this. We dressed in green theatre gowns, paper hats and boots to see the procedures. Patients were assessed and documentation completed. In the calm atmosphere of the waiting area, patients were given local anaesthetic drops into the affected eye before being escorted into the theatre area.

One nurse helped position the patient's head into the optimal position for the procedure. The theatre where Lillian, the surgeon, operated was a room prepared as a surgical field with a table, sterile instruments trolley, cauterising machine and microscope. It was fascinating to watch the cataract being carefully removed and a new lens inserted. You could immediately see the change from a cloudy opaque lens to a bright new one.

As Lillian explained each step of the procedure, it was enlightening to witness such skills, knowledge and enjoyment in the team with lots of laughs and incredible work done that day. As the afternoon wore on patients whose surgery was complete re-joined the group sitting in the shade of the veranda, each now with a dressing covering one eye. Having experienced a life-enhancing procedure, they were telling stories and singing.

On our return journey to the camp that day, we were joined by four women and a man who had been treated for glaucoma and shared their stories.

Having experienced another year with the programme as a volunteer nurse I had time to reflect on how many improvements had been achieved in this rural community and what an amazing learning experience it had been for us, working with the ophthalmic team.

**Ann McDonald FFTM RCPS(Glasg). Previous 'holidays' in Africa were covered in Emporiatics (Spring/Summer 2014 issue) and (Spring/Summer 2015 issue).*

References (accessed on (September 2017))

- <http://campsinternational.com/product/healthcare-volunteering/>
- Eyes for East Africa (2017). Available at: www.eyesforeastafrica.org/
- NHS Choices, Albinism. Available at: www.nhs.uk/conditions/albinism/Pages/introduction.aspx



ZIKA: An emerging situation and public health priority

By Mary Gawthrop, NaTHNaC Travel Nurse

Zika virus (ZIKV), a flavivirus similar to dengue, was first recognised by Ugandan scientists in 1947. The virus gradually moved from East Africa to West Africa and Asia, with the first large human outbreak reported in the Federated States of Micronesia in 2007.

ZIKV infection is typically mild and severe illness is unusual. However, ZIKV has been associated with Guillain-Barré syndrome and there is also now scientific consensus that infection in pregnancy is a cause of microcephaly and other congenital anomalies (congenital Zika syndrome). ZIKV is spread by day biting mosquitoes, although a small number of cases with human-to-human sexual transmission have also been reported.

Since 2015, a widespread ZIKV outbreak has been reported in parts of Asia, the Caribbean, Central and South America, and Oceania. Local transmission has also been reported in Florida and Texas in the USA.

ZIKV is not found in the United Kingdom and almost all cases are associated with travel to countries, territories or areas with active ZIKV transmission. Since the start of this outbreak, as of 26 July 2017, Public Health England (PHE) has reported 14 travel-associated cases diagnosed in the UK for 2017. The majority of cases were in travellers who had visited the Caribbean.

As sexual transmission of ZIKV has been occasionally reported, because of the risk to the developing foetus, guidance on prevention of sexual transmission is also essential. PHE has produced useful guidance on how to advise individual travellers on the preventive measures against sexual transmission of ZIKV: www.gov.uk/guidance/zika-virus-preventing-infection-by-sexual-transmission

World Health Organization (WHO) no longer declares the congenital abnormalities associated with Zika a Public Health Emergency of International Concern. However, WHO still considers ZIKV infection, and the potential associated consequences, an international public health priority and challenge requiring a sustained and co-ordinated global response.

WHO in conjunction with the US Centers for Disease Control and Prevention and the European Centre for Disease Prevention and Control developed a revised ZIKV country classification scheme which was published on 10 March 2017. PHE and NaTHNaC have reviewed the WHO revised classification scheme and issued UK guidance, available at: www.gov.uk/government/collections/zika-virus-zikv-clinical-and-travel-guidance

The TravelHealthPro website country information pages provide specific destination advice: <https://travelhealthpro.org.uk/countries>

Health professionals advising travellers, especially pregnant women or male and female travellers planning to conceive, should ensure they access current sources of advice, as ZIKV epidemiology is evolving and guidance is likely to change. A number of UK resources (see below) exist to help health professionals advising travellers to affected areas.

Pregnant women who cannot avoid travel to affected areas should be advised of the risks ZIKV infection may present. All travellers should be advised to follow scrupulous mosquito bite avoidance measures day and night, but especially mid-morning and late afternoon to dusk, when mosquitoes are most active. This is particularly important for pregnant travellers.



Resources (All Internet addresses accessed (September 2017).)

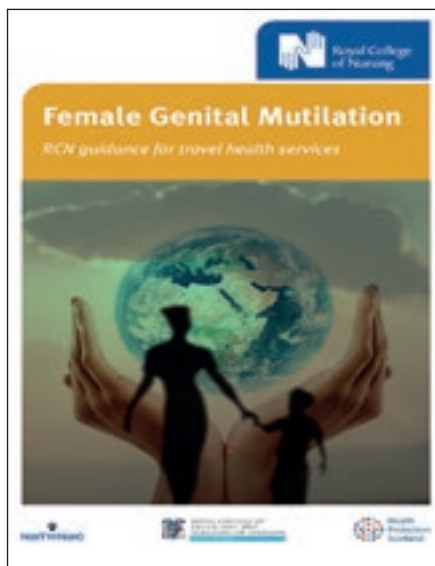
- TravelHealthPro Zika virus – update and advice for travellers: <https://travelhealthpro.org.uk/news/4/zika-virus--update-and-advice-for-travellers->
- TravelHealthPro. Insect and tick bite avoidance: <http://travelhealthpro.org.uk/factsheet/38/insect-and-tick-bite-avoidance>
- Public Health England. Zika virus: sexual transmission advice algorithm: www.gov.uk/government/publications/zika-virus-sexual-transmission-advice-algorithm
- Public Health England. Zika virus: epidemiology and cases diagnosed in the UK: www.gov.uk/government/publications/zika-virus-epidemiology-and-cases-diagnosed-in-the-uk

Female genital mutilation and travel health

Project Manager Jennifer Bourne reports on the Department of Health FGM Prevention Programme for NHS England.

Following a Royal College of Nursing joint travel health conference in September 2015 when female genital mutilation (FGM) and the risks for travel were discussed in my presentation, many of the attendees requested specific guidance for this field of practice. The Department of Health FGM Prevention Programme agreed to fund this piece of work and the team worked with the RCN and travel health specialists to produce the guidance (RCN, 2016).

FGM is illegal in England, Wales and Northern Ireland under the FGM Act 2003 and in Scotland under the Prohibition of Female Genital Mutilation (Scotland) Act 2005. FGM is child abuse and safeguarding against the practice is a responsibility for all health professionals.



What is FGM?

The World Health Organization (WHO) describes FGM as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons". WHO classifies FGM into four types, ranging from a small nick to the clitoral hood to total removal of the female genital organs with the formation of a scar to cover the urethra and vaginal opening. This type is sometimes called infibulation (WHO, 2016).

According to a report from UNICEF at least 200 million girls and women in over 30 countries worldwide have undergone some form of FGM (UNICEF, 2016). In 2015 a report from City University London estimated there are 66,000 girls born to mothers in England and Wales who have themselves had FGM.

Many men and women from practising communities can be unaware of the link between FGM and subsequent poor physical and mental health. In countries where FGM prevalence is high, many women and girls experience health difficulties, some of which are very significant. However, most do not seek medical advice for their health difficulties as these can often be seen as a common occurrence among women with FGM in the community.

The practice is mostly carried out on young girls at sometime between infancy and adolescence, and the risk can vary throughout childhood, depending on the background of the family. An immediate family history of FGM is a potential high risk to the girl and it is essential to safeguard her over a long period of time.

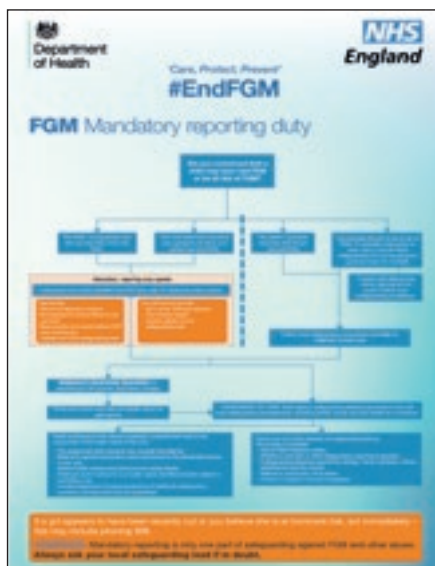
Travel is a key risk for FGM

Girls can be taken outside of the UK in order to be cut. Health professionals working within travel settings play an important part in identifying and safeguarding girls at potential risk, especially when families present for advice and vaccinations prior to travel.

It is best practice for travel health practitioners to include a pre-travel risk assessment, which forms the basis of subsequent decisions, advice and prophylactic treatment given. A question about FGM should be included in this questionnaire and can be asked of all travellers. It is important that practitioners have knowledge and awareness of the practice of FGM, the health consequences and the relevant legislation, and are aware of how to act on any concerns about FGM.

Some key risk indicators which may present in travel settings:

- families planning a long time away on holiday, especially during the summer
- girls presenting for travel vaccinations to countries with high FGM prevalence
- girls talking about a special ceremony while on holiday
- girls who may not be travelling to country of origin; it must be noted that FGM can potentially take place in any destination.



Best practice in travel health

Services need to ensure:

- Policies and procedures take into account statutory guidance (HMG, 2016).
- There are established links with local children's social care and practitioners who know how to make a referral.
- A question about FGM is included in the pre-travel risk assessment.
- Services only use accredited trained interpreters, where possible.
- Compliance with the FGM Enhanced Dataset requirement (acute trust, mental health trust, general practice within NHS services in England).

Health practitioners must:

- ask about FGM directly but with sensitivity.
- carry out a risk assessment to help decide what steps to take – using local or DH Safeguarding Guidance. www.gov.uk/dh/fgm.
- know how to make a police report under the Mandatory Reporting Duty.
- talk to your local Safeguarding Lead.
- record actions within the individual's records.
- share safeguarding information as appropriate with relevant professionals.

Talking to women about FGM requires sensitivity, but direct and non-judgmental questions are important. It may be difficult for survivors of the practice to talk about their experiences; however, it is important for safeguarding and supporting girls and women that practitioners open the discussion. Talking about FGM may trigger flashbacks and distress, therefore a sensitive approach is crucial.

Questions you may ask:

- Do you, your partner or your parents come from a community where FGM/cutting or circumcision is practised?
- Do you know what that is? Have you been cut? (Do consider using other terms or phrases.) (RCN, 2016)

The questions should be asked to the patient directly, or if the patient is under 18, the questions can be asked to their parent or legal guardian, if appropriate. Health professionals should be prepared to take action on their findings and, where appropriate, initiate child safeguarding procedures and/or referral for further care. If a woman or girl does not speak English, then an accredited interpreting service needs to be provided.

Mandatory Data Recording

All NHS acute trusts, mental health trusts and GP practices in England have to submit data about FGM to NHS Digital. The Information Standard Notice provided health professionals with details of what and how to record FGM, including new clinical codes. Individual professionals need to ensure their organisation is submitting this information if they are required to do so. All clinicians must ensure they are capturing the right information within the patient's healthcare record and that they are appropriately sharing any information required for safeguarding purposes. The data will support commissioning and the provision of appropriate services to meet the needs of women and girls with FGM.

Mandatory Reporting Duty

Since October 2015 under the Serious Crime Act healthcare professionals in England and Wales have a mandatory professional duty to report to the police if a girl discloses to them that she has had FGM, or if it is identified through the delivery of routine care. Reports can be made by calling the police non-emergency telephone number, 101. Professionals are also advised to speak to their safeguarding lead and document in the notes. www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare.

Finally

Female genital mutilation is a harmful practice. The World Health Organization, UNICEF and the UK Government are committed to ending the practice in a generation. Professionals working within travel health are important to ensure the safeguarding of girls who may be at risk of FGM, especially through travel abroad. It is essential, therefore, that all those working within travel settings keep up to date with policies and procedures which support safeguarding and working to end the practice.

Prevalence of Female Genital Mutilation in England and Wales, <http://openaccess.city.ac.uk/12382/>

Resources (All Internet addresses accessed (September 2017).)

- Safeguarding Care Pathway www.gov.uk/government/uploads/system/uploads/attachment_data/file/542650/FGM_Flowchart.pdf
- Female Genital Mutilation Risk and Safeguarding Guidance for professionals www.gov.uk/government/uploads/system/uploads/attachment_data/file/525390/FGM_safeguarding_report_A.pdf
- Health Education England, e-Learning to improve awareness and understanding of Female Genital Mutilation www.e-lfh.org.uk/programmes/female-genital-mutilation/
- How to report female genital mutilation: guidance for health professionals www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare/how-to-report-female-genital-mutilation-guidance-for-health-professionals
- UNICEF (2016) Female Genital Mutilation/Cutting, A Global Concern www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf



- Female Genital Mutilation: RCN Guidance for travel health services. Royal College of Nursing (2016) www.rcn.org.uk/professional-development/publications.
- World Health Organization (2016) www.who.int/mediacentre/factsheets/fs241/en/
- Editor's Note: Barnardos national FGM Centre has a useful world map showing individual country prevalence, age when FGM is performed, the law etc. www.nationalfgmcentre.org.uk/

TRAVELLERS' TALES

Bhutan and Nepal 1992: A movie set with real life drama

By Dr Robert Bruce-Chwatt MFTM RCPS(Glasg)

Back in 1992 Dr Robert Bruce-Chwatt MFTM RCPS(Glasg) spent three months in Nepal and Bhutan as medical officer to a Bernardo Bertolucci film crew. Thumbing through his day book, he reflects on expedition medicine from a distance of 25 years.



Paro, Rinpung Dzong, Bhutan - 1992

My task on the film crew was to provide full medical care for 120 people including three actor children and nine Oscar winners from *The Last Emperor*, Bernardo's previous film. My equipment arrived with me: ECG, defibrillator, Entonox, scoop stretcher, nebuliser, glucometer, optical haemaglobinometer, inflatable limb splints and cervical collars (no mini pulse oximeters then). Medicines were cheap and easy to source locally.

Medical services were mainly required for Bhutan and after two weeks filming in Nepal, we flew to Paro Airport, Bhutan's international hub. The location was Rinpung Dzong, a 1644 fortress monastery overlooking the river. I set up shop daily in a monastery storeroom and awaited patients. Given the crew's obsession with blood pressure and monks' with doctors, I didn't wait long.

Back then there was a high incidence of epilepsy and TB. Dental care was dreadful, made worse by the use of pa'an, chewed for its stimulant and psychoactive effects, and spat out in a bright red stream, like a tubercular haemoptysis. I pulled monks' teeth with Swiss Army knife pliers. In return, one gave me fleas. Adding to potential problems, *P. falciparum* malaria was endemic in the south and rabies and pi-dogs were common.

Although Bhutan is a stunningly beautiful scenic mountain kingdom with alpine fresh air, making films is like watching paint dry while awaiting a medical disaster. "Buono, ancora", followed each take until finally, "Bella, buono" meant moving to the next storyboard. The crew worked 12 hours, six days a week, and local banana-flavoured whisky 'Bhutan Mist' was decidedly helpful in the evening.

The BBC World Service signal was good and "Lillibullero" a reassuring tune every hour on the hour while I wrote up the day's case notes or tried my hand at watercolours. No Internet or medical back-up, the only hospital a two-hour drive to Thimpu. Barring a monk's epileptic fit and a child falling off a wall (no bones broken), nothing dreadful happened during the three weeks.



The pros and cons of 'civilisation'

Returning to Kathmandu for filming in Bhaktapur brought the delights of the Yak & Yeti Hotel, endless hot water, laundry service, satellite TV and a fridge, but also air pollution and dehydration. The dry dusty climate brought on two renal colics and several chest infections, including my own pneumonia, with night sweats, rigors and temperatures up to 103.5° F. It responded to room service, the Hyderabad taste teaser and amoxicillin.

Frequent pyrexias of unknown origin (PUOs) in descending order: chest infections, viral infections, typhoid, hepatitis, dengue (peaking in October with the influx of travellers from India and Thailand) and malaria.

A film crew with elephants at Bhaktapur, eight miles from the capital, brought six weeks of financial largesse to this area (now a World Heritage Site which was badly hit by the 2015 earthquake). Easy hospital and x-ray access made life more relaxed and enjoyable, but during filming at

Bhoudanath Stupa at Kathmandu, hippies' casual medical enquiries were tedious. All claimed to be friends of Bernardo and were otherwise found in Tamel on Freak Street, Durbar Square and at the Hanuman Dhoka. Nepali touts offered to change their money or obtain hashish, rickshaws or Ayurvedic massages.

Final locations filming river scenes were in the Royal Chitwan National Park. By now mid-December with cold nights, the malaria risk was less. Early calls, leaving a warm bed to catch the cinematographer's hour of mist and long shadows as the sun rose, were a struggle. The crew, buoyed by thoughts of home and Christmas, stayed well. Nepali patients were poetic in their descriptive symptomatology. "Diamonds in the eye" was a migraine, "Dickie is weeping" was a man with an STI.

Final figures noted at the end of my tour: 360 film crew consultations, no record of monks, local dignitaries, their families and other locals, but these were mainly minor. Daily D&V (diarrhoea and vomiting) figures were recorded as a distinct entity, highest being four. Daily general consultations, ranged from 10 to one, averaging four, and tailing off as they scented the end. Nobody died, got pregnant or caught malaria.

It's a wrap...

With the final scene in the can, we headed home. The 'Chinese hand bills', traditional film crew severance notices, were already two weeks old. The valley road drive to Kathmandu was wonderful, if dangerous. Stunning views, terrifying corners, overloaded trucks and buses, drivers by the roadside nonchalantly holding burning branches under tanks of cheap Chinese diesel to stop them 'waxing' in the chill evening air. Distant Himalayan snow-covered peaks seen through the trees, with traces of pink Alpenglühen, the evening heavy with the scent of jasmine blossom and wood smoke.

I flew from Delhi to snowy Gatwick with Bertolucci. His final words: "Dottore, you are a Conradian figure" did not help as he boarded a big, shiny limousine heading for London while I waited on a cold platform for a train to the same destination.

The film? Little Buddha. On the credits, I was second to last, just above the cappuccino maker. Poetic...

Conferences

Faculty of Travel Medicine Annual Symposium and AGM
Enabling travellers – the hidden challenges
5 October 2017 Glasgow
 Royal College of Physicians and Surgeons of Glasgow
rcp.sg/FTM2017

18th International Congress on Infectious Diseases
1-4 March 2018 Buenos Aires, Argentina
www.isid.org/icid

4th Commonwealth Nurses and Midwives Conference
10-11 March 2018
 Royal College of Physicians, London
www.commonwealthnurses.org/conference2018/

Joint FTM/BGTHA meeting
March 2018 Leicester
rcp.sg/events

12th Asia Pacific Travel Health Conference
21-24 March 2018 Bangkok, Thailand
www.apthc2018.org

Joint IAPOS/FTM event
11 May 2018 London
rcp.sg/events

FTM Nets and Bolts
6 June 2018 Lichfield
rcp.sg/events

Pan African Travel Medicine Congress
 Focus on Reality 2018
12-15 September 2018 Cape Town, South Africa
www.sastm.org.za/TMC/Details/18

ISTM International Conference on Migration
1-3 October 2018 Rome
www.istm.org/

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

BOOK REVIEW:

A Doctor's Reflections On Change by Dr Eric Walker MBE FFTM RCPS(Glasg)

Reviewed by Sandra Grieve FFTM RCPS(Glasg)

Eric Walker's role as founding Dean of the Faculty of Travel Medicine is well documented, but a more intimate story of his life and times can be found in this memoir.

Eric Walker was born near Birmingham during World War II, but his lifelong love of nature was fuelled during holidays with Scottish grandparents. In post-war Britain, his family grew fruit and vegetables, and he had his own patch with chickens and angora rabbits as well as vegetables. He learned bee-keeping from his mother, a passion that he enjoys to this day. Soon the entrepreneurial youth was selling produce at the local market.

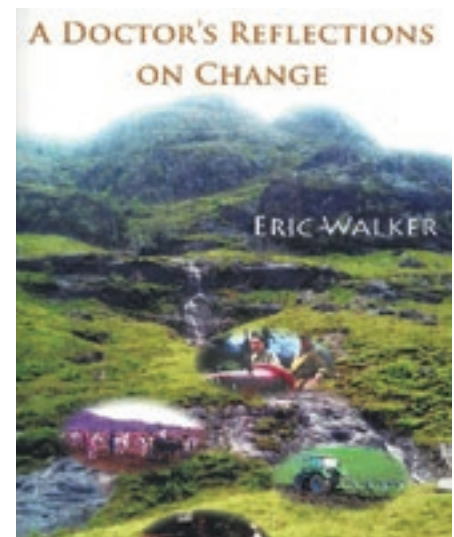
Eric's gap year travels around Europe provided different experiences from today, and his yen to travel was already in place by medical school, when he asked for time off at the end of his pre-clinical years to go around the world. That was refused, but later he was chosen for a three-month student exchange in Harare Medical School, Rhodesia, and it was this African experience that first enforced his awareness of the relationship between health and the environment. The Rhodesian war of independence was raging at the time, giving rise to other well-told stories.

A sabbatical year in Cambridge saw the same Eric who had struggled with Latin at school briefly study Greek and Roman philosophy, and the history of science as he embarked on work as a general practice locum to offset costs.

Environmental and ecological awareness continued as Eric and his growing family travelled to the Christian Medical College and Hospital (CMCH) in Vellore, India. Their journey on a jumbo jet ended at an airport made of bamboo and thatch. He was also unprepared for the hospital strikes and need for security, but heartened by the support and friendship of local people. His account of time in India is filled with observations on the environment, farming and health issues.

Sharing knowledge

Returning to the UK and medical practice, Eric was determined to carry on the simple way of life he had found in India. That experience equipped him for an infectious diseases clinical lecturer appointment at Glasgow University and the family moved north. He relates his clinical experiences in a selection from the period.



Changes to health service provision in Scotland led to a consultant appointment with Health Protection Scotland and responsibilities for surveillance and the prevention of tropical and travel-related diseases. He reflects that without the political upheaval at the time, he might never have had opportunities to participate in the development of travel medicine as a speciality.

The rest, as they say, is history. Establishing the travel medicine service and TRAVAX, the now world-renowned 'Glasgow Courses' and the Faculty of Travel Medicine followed as did several honours, including an MBE.

For Eric retirement is just a concept as he continues to be involved in global and travel health initiatives, teaching and his ongoing connection to CMCH – not forgetting the orchestra and charity work. Eric's memoir is a piece of history, setting the foundations for travel medicine practice today. His passion for bee-keeping remains strong and who knows where his talents will take him next – watch this space!

Available from Amazon or contact the Editor to request a signed copy in return for a donation to CMCH.

From the Journals

Angelo KM, Libman M, Caumes E *et al* for the GeoSentinel Network (2017). **Malaria after international travel: a GeoSentinel analysis, 2003-2016.** *Malaria Journal* 2017 16:293 DOI 10.1186/s12936-017-1936-3.

Bauer IL (2017) **More harm than good? The questionable ethics of medical volunteering and international student placements.** *Tropical Diseases, Travel Medicine and Vaccines* (2017) 3:5. DOI 10.1186/s40794-017-0048-y.

Chen LH, Leder K, Wilson ME. (2017) **Closing the gap in travel medicine: reframing research questions for a new era.** *Journal of Travel Medicine*, 2017, 24 (4) 1–9 doi: 10.1093/jtm/tax001

Rees E, Saavedra-Campos M, Usdin M *et al* (2017) **Trend analysis of imported malaria in London, observational study 2000 to 2014.** *Travel Medicine and Infectious Disease*, 17 (2017) 35e42. <http://dx.doi.org/10.1016/j.tmaid.2017.04.004>

Riddle MS, Connor BA, Beeching NJ *et al* (2017). **Guidelines for the prevention and treatment of travelers' diarrhoea: a graded expert panel report.** *Journal of Travel Medicine*, 2017 Vol 24, Suppl 1, S2-S19. <https://doi.org/10.1093/jtm/tax026>

BULLETIN BOARD

FTM courses

Foundation in Travel Medicine

- 13-14 November 2017 with 2-day residential component in Glasgow
- 21- 22 March 2018 with 2-day residential component in London

Membership Diploma in Travel Medicine

- 21 May 2018 with 4-day residential component in Glasgow (21-24 May) and examination in December.

The International Diploma in Expedition and Wilderness Medicine

Course dates: <https://rcpsg.ac.uk/diploma-in-expedition-and-wilderness-medicine>

RCN updates competencies guide

Following a survey of the wider travel health community to gain views and experience of the Royal College of Nursing's 2012 guidance, a revised version of Travel Health Nursing: Career and Competence Development RCN Guidance (2012) is being prepared by the authors. Survey analysed data at: www.rcn.org.uk/clinical-topics/public-health/specialist-areas/travel-health

Vaccine advice from PHE

During vaccine shortages, Public Health England published temporary recommendations, dose sparing and prioritising for those most at risk. Advice on supplies purchased directly from the manufacturer for non-routine programmes (e.g. travel purposes) is at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/640220/Vaccine_Update_269_August_2017.pdf

A hexavalent vaccine offering protection against; diphtheria, tetanus, acellular pertussis, polio, Haemophilus influenza type b (Hib), and hepatitis B has been added to the UK national routine childhood immunisation schedule.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/628602/Greenbook_chapter__18.pdf

Malaria Imported into the United Kingdom: 2016 implications for those advising travellers

PHE reports a 15% rise in imported malaria cases (1,618) and six deaths in the UK during 2016, most from falciparum malaria acquired in Sub Saharan and Southern Africa. The majority (80%) were VFRs. Where information was available 83% had not taken chemoprophylaxis. The PHE recommends using new patient checks or childhood immunisation appointments to engage with VFRs and the elderly about future travel plans.

Healthy travel, a pocket guide for seniors

Coming this autumn from International Association for Medical Assistance to Travelers (www.iamat.org).

NECTM7

Registration and abstract submissions are now open for the upcoming Northern European Conference on Travel Medicine (2-4 May 2018) in Stockholm. NECTM7 will focus on travel health education and travel-related public health issues in a global context, with tick-borne diseases featuring alongside a scientific programme of the latest TH research. https://mkon.nu/nectm_7

Nurses: A Voice to Lead

The International Council of Nurses has compiled fascinating case studies on the role of nurses worldwide in achieving the Sustainable Development Goals.

www.icnvoicetolead.com/

Working Internationally, a guide to humanitarian and development work for nurses and midwives features updated advice from the RCN, Royal College of Midwives, Médecins Sans Frontières and Voluntary Services Overseas www.rcn.org.uk

Taking students abroad?

School excursions open up a world of positive experiences for children – but can bring increased risks too. Updated guidance from the Travel and International Health Team (TRAVAX) at Health Protection Scotland is for excursion organisers, parents and pupils. www.fitfortravel.nhs.uk/advice/general-travel-health-advice/school-groups.aspx



Royal College Membership Diploma in Travel Medicine

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The Royal College Membership Diploma in Travel Medicine is a package combining a blended-learning exam preparatory course and a two-part examination.

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Returning travellers

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- ✓ Online support and resources
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