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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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Regulars

People

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Editorial

Editorial

From Ebola to e-learning

Thanks to everyone who voiced support when the future of Emporiatrics was in doubt, and thanks to our Dean, the Faculty of Travel Medicine Board and the Royal College of Physicians and Surgeons of Glasgow for bringing us back with this packed edition.

There is never a shortage of material, but with the worst outbreak of Ebola in history, travel medicine has been high profile around the world. Andy Green has been at the heart of the crisis and offers his insights on page 6.

Because all travel health professionals like to travel too, Sharon Graham shows us her snapshots from Costa Rica on page 12 and Ann MacDonald resumes her narrative on volunteering in an outreach programme in Kenya on page 10.

As TRAVAX celebrates its 30th birthday, Fiona Genasi tells us what life was like before and after its development. Fiona's achievements are inspirational as you will see from her In Focus interview on page 9. Communication has changed dramatically since TRAVAX began and Jane Chiodini updates us on the latest apps on page 15.

Jane Dickson tells how a pharmacist can move from the dispensary to clinical practice on page 13.

Carmel Bagness challenges us to be aware of the risk of girls being taken abroad for female genital mutilation on page 5. And we celebrate the life of Cameron Lockie on page 8.

My thanks as always to our contributors. See you in Quebec!

Sandra Grieve

Letter from the Dean of the Faculty of Travel Medicine

Dr Mike Jones FFTM RCPS(Glasg)

So here I am in a snapshot taken last September on a salt lake at Kosi Bay in South Africa. After the South African Society of Travel Medicine (SASTM) conference in Durban, my wife and I had a wonderful few days of sight-seeing with Professor Annelies Wilder-Smith, and Albie and Therese de Frey who had organised the trip. That afternoon became even more exciting when George, the boatman, spotted a stolen canoe and we returned triumphantly with it strapped to our boat. No wonder I'm smiling!

I was enormously impressed by the SASTM programme, Quo Vadis, with its superb presentations to keen South African practitioners. It was my privilege to say something about the Faculty of Travel Medicine and participate in workshops on viral haemorrhagic fever (VHF) and malaria. We are looking forward to holding the MFTM (Membership of the Faculty of Travel Medicine) Part 1 examination there next September and there is likely to be a return visit next year for an International Society of Travel Medicine (ISTM) Regional conference.

Changes to the Faculty Board

In the last six months we've welcomed Dr Sundeep Dhillon and Joanne Lane-Sansum to the Board after the elections last year. Joanne now represents us on the College Membership Services Board. Having to prioritise commitments, Dr Jim Bond resigned in December, part way through his term, and we are delighted that Dr Katie Geary has agreed to take his place. Currently the Board lacks a pharmacist but I very much hope that this gap will be rectified in forthcoming elections.

Meanwhile, I am delighted to announce that Gp Capt Andy Green will be the next Dean of the Faculty, taking over in October at the next AGM, after which I will disappear from view!

Oman visit

Our host was Dr Seif Al Abri, Director General for Disease Surveillance and Control. Following a visit earlier in 2014 by the College President, Dr Frank Dunn, Dr Al Abri asked Margaret Umeed and me to undertake a consultation on establishing a Travel Medicine Service in Oman for the Ministry of Health. In November we returned for an intensive four-day trip, visiting the Ministry of Health, health centres and hospitals in Muscat and Rustaq, 100km up the coast. We submitted our report in December.

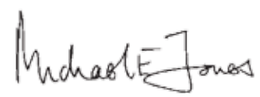
We returned in February for a travel medicine conference organised jointly by the Ministry of Health and our Faculty of Travel Medicine (see page 14). This was highly successful with 200 delegates from Oman and beyond and strengthened by the expertise of Dr Nick Beeching, Professor David Lalloo and Dr Dipti Patel from the UK, Professor Eskild Petersen from Denmark and local experts, all participating in the international speakers' panel. We believe this was the first travel medicine conference ever held in the Arabian Gulf.

News from the education front

The Diploma in Travel Medicine (Dip Trav Med) and Diploma in Expedition Medicine (Dip Exp Med) are being referred for validation by Glasgow Caledonian University and we hope that process will be completed by mid-2015. As well as adding academic recognition to the Dip Trav Med, this opens the way to restoring the possibility of successful students extending to an MSc with a dissertation. We are delighted that Dr Jon Dallimore and his colleagues have asked the College and Faculty to host the Dip Exp Med and we believe this will extend and strengthen the education portfolio offered by the Faculty.

Continuing the theme, I congratulate Carolyn Driver, Margaret Umeed and the Faculty of Travel Medicine Board on excellent joint conferences held in London and Leicester in March with the Royal Pharmaceutical Society and our friends in the British Global and Travel Health Association (BGTHA). Presentations and attendance were excellent.

And finally, we are hugely grateful to the President and Executive Board of the College for supporting publication of Emporiatrics through the College's Lock Fund.



Bulletin Board

New FTM position paper

Protecting the health of travellers from the UK and Ireland acknowledges that injury and illness sustained both during travel and on return home, cause a considerable medical and economic burden. High quality pre travel advice can help to mitigate and reduce this risk, thus the lack of structure and delivery of travel medicine services and the absence of a formal training pathway to a recognised professional standard must be addressed. **http://rcp.sg/healthoftravellers**

Chikungunya update

Just under 300 cases of Chikungunya were reported in England, Wales and Northern Ireland in 2014, a 12-fold increase on 2013 - most acquired in the Caribbean and South America. Travellers to these destinations were advised by Public Health England to seek pre-travel advice.

Climate change and vector-borne disease

The authors of Health effects of climate change in the UK (March 2015) predict the UK is becoming a more hospitable environment for mosquitoes and ticks with outbreak conditions similar to tropical climates – an effect mirrored across Europe.

www.thelancet.com/pb/assets/raw/Lancet/pdfs/S1473309915700915.pdf

Rabies post-exposure treatment

Latest guidance from Public Health England (PHE) includes a new category of 'partially immune' for individuals who have received vaccine in the past.

www.gov.uk/government/collections/rabies-risk-assessment-post-exposure-treatment-management

There's nothing Mickey Mouse about measles!

A recent measles outbreak in 17 US states was probably triggered by a traveller who became infected overseas, then visited the Disney theme park in California, according to the Centres for Disease Control and Prevention (CDC). Some 24 million people visit Disney parks each year, many from countries where measles is endemic. The National Travel Health Network and Centre UK updated their measles information sheet and emphasised the importance of immunisation for travellers.

http://nathnac.org/pro/clinical_updates/measles_reminder_180215.htm

MenACWY immunisation advice

After a rise in cases of meningococcal group W, the UK Joint Committee on Vaccination and Immunisation advises a combined MenACWY immunisation for young people aged 14-18 years.

www.gov.uk/government/news/meningococcal-group-w-menw-immunisation-advised-for-14-to-18-year-olds

The latest from the World Health Organization

- WHO's first guidance on chronic hepatitis B infection includes the needs of specific groups such as co-infected populations. www.who.int/hiv/pub/hepatitis/hepatitis-b-guidelines/en/ [*Image: WHO Heb B Guidelines]
- The Japanese Encephalitis Vaccines Update focuses on availability, safety, immunogenicity and effectiveness of JE vaccines and their duration of protection www.who.int/wer/2015/wer9009.pdf?ua=1
- WHO calls for worldwide use of 'smart' syringes with guidelines for intramuscular, intradermal and subcutaneous injections.

www.who.int/injection_safety/global-campaign/injection-safety_guidline.pdf?ua=1

Watch this space!

Senior travellers: The importance of travel medicine in domestic travel

A growing number of older people are using their extra time and resources to travel as never before. They may not be dangling off mountain tops or venturing into jungles, but senior travellers can face real challenges in some of those quiet, away-from-it-all destinations. Take Australia's Lord Howe Island –with no mobile phones, one policeman, six miles of paved road and limited access to the outside world, it's paradise on earth until …

In our next issue, Irmgard L Bauer and Peter Reed draw on research from this idyllic island to highlight the risks that senior travellers should be aware of before they go – with insights that apply to pre-travel consultations the world over.

Female genital mutilation:

When a holiday abroad risks a crime against girls and young women

Nurses especially need to be aware of and understand the socio-cultural, legal and health issues surrounding female genital mutilation (FGM). Carmel Bagness, Professional Lead in Midwifery and Woman's Health at the Royal College of Nursing, tells us why.

Female genital mutilation (FGM), sometimes referred to as 'female circumcision', is a challenging subject to understand and manage. It affects the lives and health of an estimated 125 million girls and women living in countries where the practice is prevalent.

FGM is physical abuse of young girls, yet only in recent years has it been generally accepted as a safeguarding issue, requiring the same attention as any other form of abuse or risk of abuse. It is therefore critically important that nurses engaged in travel health practices have a contemporary understanding of what is a violation of human rights and a violent crime.

FGM is illegal in the UK, and it is also illegal to take a girl abroad for this practice.

FGM is described as 'the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons'.[1] A newly published RCN resource[2] provides further details on the extent of damage that may be perpetrated, and the short and long-term health consequences of the mutilation to the genitalia of girls from infancy up to teenage years. This can result in death or serious physical injury, leading to physical and psychological ill health, including complications in urogynaecology, sexual health, severe bleeding, infection and infertility, and can have tragic consequences in childbirth, for both mother and baby.

In 2014, the World Health Organisation (WHO) estimated that globally more than 125 million girls and women have been mutilated.[3] WHO and many governments are committed to eradication of FGM from communities where it is still practised. It is largely but not exclusively practised in countries in the Horn of Africa, however growing intelligence shows that some far eastern communities also practice FGM—for example, in Indonesia.

Nurses who deal with requests for immunisations or support with papers for people travelling abroad need to understand which communities are more likely to be affected. FGM is illegal in the UK, and it is also illegal to take a girl abroad for this practice. Parents and guardians can now be prosecuted for any involvement in procuring, aiding or counselling with regard to FGM.

In the past year, the Department of Health introduced mandatory reporting of FGM, further enhancing the responsibility of healthcare professionals to report cases of FGM. Meanwhile, current safeguarding procedures require all nurses to consider whether any girl or woman in their practice may be at risk and act according to local guidelines. Nurses should be aware of whom to contact locally should they have any suspicion that a girl in their care may be at risk.

Health professionals must have the confidence and skills to challenge and ask the right questions.

Equally important, health professionals must not be constrained by beliefs about FGM and must have the confidence and skills to challenge and ask the right questions. FGM is often surrounded by misunderstanding, and despite being rooted in some cultures, there is no evidence to support any traditional religious connections.

FGM is quite simply a crime against the human rights of girls who can be affected both physically and mentally: their lives are in danger and their long-term physical, psychological and psychosexual health is threatened by this abuse. All nurses who come in contact with women and girls travelling abroad need to understand the risk of FGM and know their responsibility for preventing it.

Indeed, there is a role for everyone to play in the fight to eradicate this violence, and an overall need for greater professional curiosity about it.

References

1 WHO (2011) An update on WHO's work on FGM. Progress report www.who.int/reproductivehealth/publications/fgm/rhr_11_18/en/ (accessed 2 April 2015)

2 RCN (2015) FGM: An RCN resource for nursing and midwifery practice (2nd edition) Publication code: 004 773 www.rcn.org.uk/__data/assets/pdf_file/0010/608914/RCNguidance_FGM_WEB.pdf (accessed 2 April 2015)

3 WHO (2014) Female genital mutilation Fact sheet N°241 Updated February 2014 http://www.who.int/mediacentre/factsheets/fs241/en/ (accessed 2 April 2015)

Also see:

Mohammed, G F, Hassan, M M and Eyada, M M. (2014) FGMM/Cutting: Will it continue? The Journal of Sexual Medicine, 11(11), pp. 2756-2763

RCM, RCN, RCOG, Equality Now, UNITE (2013) Tackling FGM in the UK: Intercollegiate recommendations for identifying, recording, and reporting. www.rcn.org.uk/__data/assets/pdf_file/0004/547996/Tackling_FGM_in_the_UK_Intercollegiate_recommendations_for_identifying,_recording_and_reporting.pdf (accessed 6 April 2015)

FGM: The facts

- **FGM is child abuse and a violation of human rights**
- **All nurses have a duty to care for all women and girls in their care**
- **Globally, 6,000 girls a day are at risk of FGM**

In it for the long haul:
The Ebola virus outbreak and aeromedical evacuations

As the Ebola crisis in West Africa has impacted on the advice we give travellers worldwide, Group Captain Andy Green FFTM RCPS(Glasg) FRCPath RAF has been at the centre of the international effort to evacuate seriously ill patients to their home countries. His co-authors in this overview are Sqn Ldr Dave Mulvaney and Dr David Hagen, who until his recent retirement counted Gatwick Airport among his responsibilities as the public health consultant at Crawley.

In retrospect, the first case of Ebola in the 2014-15 crisis probably occurred in rural Guinea during December 2013, with subsequent spread to neighbouring areas of Liberia and Sierra Leone. Progression to an outbreak was reported in March 2014, but it was not until August that the World Health Organization (WHO) declared a Public Health Emergency of International Concern (PHEIC).

The outbreak was in many ways typical of the 24 previously-recorded outbreaks of Ebola since it was first identified in 1976. Each probably began with a human-animal interaction, although the details of the chain of transmission are never entirely clear.

The asymptomatic reservoir host appears to be the fruit bat, which then transmits infection up the food chain, facilitated by the practice of consuming 'bushmeat' to provide protein from wild animals in diets where domesticated sources are expensive or scarce. Bushmeat sources range from small animals such as rats, deer or bats to chimpanzees, gorillas or monkeys.

> The UK support to the outbreak response will continue for as long as assistance is required.

Given that all the countries involved have very low states of healthcare infrastructure, preparedness and resources, it is hardly surprising that the outbreak rapidly escalated from a small local incident to a regional outbreak.

By early 2014, WHO, the individual countries concerned and multinational companies were all drawing criticism from, most notably, Medecins Sans Frontieres, for not accurately reporting the increasing numbers of cases. Thereafter, by failing to recognise the scale of the outbreak and implement control measures until the declaration of a PHEIC, they attracted significant negative comment.

As of 25 March 2015, the total number of reported cases was 24,907, of which there were 10,326 deaths.1

The epidemiology suggested that control measures had made an impact by this time, and that numbers of new cases were falling. Final control of the outbreak was estimated to be achievable by late 2015.

Screening of travellers begins

In common with many Western countries, the UK introduced passenger screening of returning travellers in October 2014. Standardised passenger questionnaires gathered information on demographic and travel history as well as contact with suspected Ebola cases and the current health status of travellers. Medical screening relied on tympanic temperature measurement to supplement history taking. Although there are numerous issues in detecting affected passengers, this seemed to fulfil the primary role of ensuring people arriving from or passing through high-risk countries were aware of the symptoms, as well as giving them timely information about how to access healthcare services. This procedure required liaison between a number of different government agencies, both locally and nationally, and will lead in the future to an improved early response to similar episodes of infectious disease.

> Most aeromedical organisations had not planned to move such high risk patients, yet it rapidly became clear that there was a national and international requirement

A C-17 unloading an army ambulance in Sierra Leone.

Aeromedical evacuation

Prior to 2014, aeromedical evacuation operators had rarely dealt with cases of viral haemorrhagic fever and expertise was confined to a handful of organisations. Most international aeromedical organisations had not planned to move such high risk patients, yet it rapidly became clear in mid-2014 that there was a national and international requirement for this capability.

From July onwards, patients were moved by air to the UK, United States, Netherlands, Denmark, Sweden, Norway, Italy, Spain, Switzerland and France. The aeromedical transportation systems used have incorporated a variety of specially designed isolation units (portable and wheeled units, or larger units fixed inside airframes). These generally have included a combination of negative pressure, HEPA (highly efficient particulate air) filtration, a flexible or fixed protective envelope, and some with the capability of being carried aboard fixed-wing and rotary aircraft.

In September the WHO estimated that there would be an international requirement for seven international aeromedical evacuations each month for the duration of the outbreak response, requiring at least three providers of this capability.2 This estimate proved to be very accurate.

By 31 March 2015, some 65 international aeromedical evacuations had been conducted over the preceding eight months by at least seven different organisations.3 All were conducted without reported incident. The spectrum of patients ranged from asymptomatic individuals who had suffered 'high risk possible exposure' to Ebola virus to severely ill patients with significant symptoms associated with increased disease transmission (such as profuse diarrhoea).

Meanwhile, the RAF had used an air transportable isolator (ATI) to move seven patients from West Africa and one patient within the UK (from Glasgow to London). These aeromedical evacuations required significant liaison both between nations and between different national government departments and non-governmental organisations.

The longest day

Timelines for moves from West Africa frequently were greater than 24 hours, taking into account preparation and transfer of the patient to the airhead, loading and stabilisation, flight time and, on arrival in the UK, subsequent disembarkation and road transfer. Tasking of a military aircraft prior to each move and deploying stand-by specialist medical personnel generally required a further 24 hours prior to each patient being embarked, while turnaround time after each move required an additional 24-48 hours. An entire mission therefore would generally commit aircraft and personnel for up to 4-5 days.

Providing the necessary capability involved not only procurement of sufficient patient isolation systems for use in aircraft, but also identification and training of specialist aeromedical personnel. The small numbers of aircraft available also led to delays in some evacuations, while the limited number of high security isolation unit beds in home countries meant that relatively few receiving airports were used. The latter in turn needed to have well-rehearsed plans for management and transfer of patients on arrival.

The outbreak, although fading from the international media spotlight, has moved from the large cities back into rural locations where control measures are much more difficult to implement. The work of finding cases and tracing contacts will continue, as will the need for international health care workers to support local personnel. This in turn will mean that the likelihood of these workers becoming infected will remain for some time to come, and that in fact the risks may increase as new cases present atypically and in locations where resources and expertise are scarce. The UK support to the outbreak response will continue for as long as assistance is required.

Andy Green, Dean-elect of the Faculty of Travel Medicine, is Director of Infection Prevention and Control, and Defence Consultant Adviser in Communicable Diseases at the Royal Centre for Defence Medicine, Birmingham.

References

1 Ebola Situation Report incorporating the WHO Activity Report. World Health Organization. 25 March 2015

2 Ebola Virus Disease Outbreak: Overview of needs and requirements. United Nations Office for the Coordination of Humanitarian Affairs (OCHA), World Health Organization. September 2014

3 http://ecdc.europa.eu/en/healthtopics/Ebola_marburg_fevers/Pages/medical-evacuations.aspx (accessed 30 March 2015)

First signals - March 2014

WHO is publishing a series of Ebola Diaries, with first-person accounts from staff and others deployed to the field for Ebola response since the first cases were reported in West Africa. Read the first at: www.who.int/features/2015/Ebola-diaries-formenty/en/

TRAVAX at 30: Trailblazers in travel health

TRAVAX First Diploma Glasgow University, including Fiona Genasi, who runs the today's organisation, at the far left.

This is a memorable year for the Travel and International Health Team at Health Protection Scotland (HPS) as their national database TRAVAX celebrates its 30th anniversary.

Created to fulfil the demand for travel health information from those providing travel health services in Scotland, the resource is now used throughout the UK and abroad. TRAVAX has been the pioneering voice of travel medicine since its inception with a reputation now renowned worldwide. The statistics speak for themselves: 17,000 TRAVAX users in 24 countries and 7 million pages viewed annually.

TRAVAX is marking the occasion with various activities and newsletters showcasing some of those who have contributed to its success – among them, Dr Cameron Lockie, who passed away in February.

Timeline

1985
TRAVAX launched in Ceefax format to fewer than 200 health professionals across Scotland.

1990
The first internet version of TRAVAX goes live. Development designs on public information site, Fit for Travel. HPS offers short courses and study days.

1995
TRAVAX now has several thousand users. Fit for Travel gets over a million hits. The University of Glasgow launches the Diploma and MSc in travel medicine with support from HPS.

2000
TREC (Travel-Health Related Education and Care) takes over short courses UK-wide. Diploma and MSc courses offered through collaboration between HPS and the Royal College of Physicians and Surgeons of Glasgow.

2006
Fit for Travel website has a major re-design. HPS co-hosts major international travel medicine conference with over 1,000 delegates (see NECTM on the back page)

2007
Faculty of Travel Medicine is formed at the Royal College of Physicians and Surgeons of Glasgow. TRAVAX goes global. TRAVAX consultant nurse is first nurse to be International Society of Travel Medicine president. Royal College of Nursing publishes first career and competency framework for nurses in travel health.

2012
TRAVAX adds a forum, outbreak news, email updates and a patient suitcase.

2014
www.fitfortravel.nhs.uk gets over ten million hits per year. HPS expands global health surveillance for Commonwealth Games. TRAVAX team of nine includes clinicians, scientists and customer support. 17,000 TRAVAX users across 24 countries.

2015
Celebrating 30 years of TRAVAX and travel medicine in Scotland.

The first TRAVAX Polypocket

Travax on Ceefax

In memoriam: Dr Cameron Lockie MBE

Dr Cameron Lockie, who has died at 76, was a respected physician who practised in Stratford-Upon-Avon for 27 years. A proud Scot, he studied at Edinburgh University and qualified as a GP before service as an RAF medical officer whetted his appetite for travel health.

This passion continued throughout his long years in practice, during which he helped develop the travel medicine education now known as 'The Glasgow Courses', initially in conjunction with the University of Glasgow and now facilitated by the Royal College of Physicians and Surgeons of Glasgow. The Cameron Lockie Prize is awarded annually to the best Diploma student.

Cameron was also instrumental in forming the British Travel Health Association (now British Global and Travel Health Association). After retiring in 1998 he became a visiting Professor of Family Medicine at Muscat University in Oman. He was awarded an MBE for services to medicine in 1999. He is survived by Rosemary, his wife of 50 years, and their three children and four grandchildren.

Donations in his memory will be divided between Galanos House Amenities Fund and Alzheimer's Research UK and can be made c/o A.E. Bennett & Sons, 34 Sheep Street, Stratford-Upon-Avon CV37 6EE.

IN FOCUS:
Fiona Genasi FFTM RCPS(Glasg)

As TRAVAX celebrates its 30th anniversary, we caught up with Fiona Genasi, who leads the team at Health Protection Scotland (HPS) that informs both health professionals and the travelling public throughout the world. But TRAVAX is just part of a busy day for the UK's only Nurse Consultant in Travel Medicine.

How did you get into travel medicine?

I qualified in 1984 at Glasgow Technical College (now Glasgow Caledonian University) in one of the first nurse degree courses and began working as a staff nurse in an acute medical ward. HIV was an emerging concern at the time and I was keen to work with that patient group. I was fortunate enough to be taken on as a staff nurse at Ruchill, the fever hospital in Glasgow at that time, where patients with HIV were admitted, as well as those with tropical and infectious diseases. And that's where I met Dr Eric Walker, the travel medicine 'guru'.

I took time out to qualify as a midwife, but that was definitely not for me so I went back to Ruchill to work with Eric as a travel and immunisation nurse specialist. It was 1989, travel medicine was becoming a more defined specialty and that's when we really started to develop the services.

How has the specialism evolved?

In 1989 Eric was still keeping country-specific information in wall-hanging pockets and running TRAVAX in a Ceefax format. We soon developed an internet version, the first variation of TRAVAX as you see it today. A public site – Fit for Travel – followed soon after.

We also started study days and short courses in travel health because there was a real ask from GPs and particularly practice nurses. These were quite informal– people would bring in home-baking for our afternoon sessions in the 'White House' library at Ruchill. But demand was growing from outside Scotland and our team was expanding as well.

What is your relationship with the Faculty of Travel Medicine?

By 1995, recognising the need for a 'proper' course, we launched diploma and masters courses in travel medicine in conjunction with the University of Glasgow. Under Dr Cameron Lockie's watchful eye, this was a world first and they ran for 10 years. HPS moved the courses to the Royal College of Physicians and Surgeons of Glasgow in 2000 and ran them jointly until 2006 when the diploma course was fully incorporated within the College. Meanwhile, the short courses were turned over to Sheila Hall and TREC Travel, serving the whole of the UK, and that continues to this day.

So we were in at the start, and it grew out of Eric and myself sitting in the library at Ruchill, eating scones with colleagues from primary care.

How is the service running today?

We became part of HPS NHS Services in 2005. Eric retired in 2006 and I took over at the helm. Currently our team consists of me and eight others, including nurses, scientists, a medic and a customer services person.

TRAVAX is a major part of what we do, but we are involved with travel health provision across Scotland, and also the yellow fever centres. We have a telephone service taking calls from health professionals, and we are unique in that the clinical members of the team participate in a weekly travel clinic at the Brownlee Centre for Infectious and Communicable Diseases. This hands-on role keeps us in touch with what is really going on in our field. It's a referral clinic for travellers with difficult itineraries or complicated conditions like pregnancy, allergies, HIV - the ones that get you thinking.

What first whetted your interest in travel health?

It's largely preventative medicine, at least in pre-travel, and this suits my skills as a nurse. But whether pre or post-travel, individuals always have great stories to tell around where they've been and what they've done. It's the travellers themselves who make it interesting.

I also like travelling and that helps me give practical advice about risks and interventions. I've worked in India on research projects and volunteered with refugees in Iraq during the Gulf conflicts.

I've also served six years with the International Society of Travel Medicine – I was the first UK citizen to be ISTM President, and the first nurse, which was great because it recognised the important role that nurses play in travel health. That's given me many more opportunities to travel.

And then there's my family – my husband is half-Guatemalan so we visit Central America and the Caribbean quite often.

Your dream holiday?

Well, I have it at least once a year, spending time with my family in Antigua in Guatemala. Some years from now you might see me opening a travel clinic out there. You never know, and for the six months a year I'd want to spend in Scotland, I'd certainly be needing some locums ...

A TRAVELLER'S TALE

Kenya: The challenges of maternity care where each new life begins in 'a sunny place'

Previously in Emporiatrics, Ann McDonald MFTM RCPS(Glasg) described a day in her life as a volunteer nurse in a rural clinic in Kenya. She takes up the story again on a visit to a maternity unit in the Msambweni hospital.

Each nurse in our group travelling from the UK in 2013 brought different specialties. As a former midwife I was particularly keen to work in a maternity unit and observe the experiences and challenges presented to midwives in Kenya.

Kenya is a low-income country with a population of 34 million and a wide ethnic diversity. Life expectancy at birth is around 54 years. As I was writing this article, Dr Frank Dunn, President of the Royal College of Physicians and Surgeons of Glasgow, met with other leading experts to discuss strategies for reducing the incidence of maternal death. Currently in the UK and Ireland, ten in every 100,000 pregnancies result in maternal death. This is in stark contrast to Kenya where 488 deaths per 100,000 live births occur each year.

We set off first thing that morning on a long drive, travelling through many villages on our way to join the hospital staff. It was a hot, dusty road with many sights, sounds and smells to indicate that the villagers were awakening to start the day's business. The children walking to school shouted "jambo" and waved as we passed by. Women with babies strapped to their backs walked along the roadside, some perhaps going long distances to access hospital healthcare.

Foetal heart rates were checked using a Pinard stethoscope, a horn-like device used for centuries to listen to the foetal heart

Mothers in waiting

On arrival we saw long queues of people seated in outpatients, waiting under an open canopied area that protected them from the sun's baking heat. Some pregnant women were shaded by large umbrellas. I later learned that the hospital's name—Mswebweni—translates as 'a sunny place'.

Our nurse group had a warm welcome and a tour to familiarise ourselves with the hospital layout. There were many jobs to be done. We were given a choice of departments, from the children's ward, accident & emergency, theatre—or the maternity unit, where I was of course delighted to help with some general duties. I've been a midwife in the UK and overseas, but currently I am not practising so could not undertake midwifery duties. But with lots of care needing to be given, this wasn't an issue. I was introduced to the two midwives covering the 40-bed maternity unit that day and it wasn't long before I was asked if I'd like to help out in the labour room.

He was resuscitated, wrapped up in a towel and handed to his mother, screaming to announce his arrival into the world

emporiatrics | News, views and reviews from the Faculty of Travel Medicine

The labour ward

This was a room at the end of a long corridor. On the wall was a stark poster, which reminded me how challenging it must be for midwives working in a country with a low economic state. The poster illustrated horrific statistics such as the numbers of maternal deaths, antepartum and postpartum haemorrhages, eclampsia, obstructed labours and other maternal emergencies that can occur. The list appeared endless and showed how skilled and knowledgeable these midwives must be to provide care in such circumstances and adversity.

On that particular morning there were 24 patients on the unit—four antenatal women in early labour, three in established labour, 17 postnatal mothers and babies, and also the special care nursery with two premature babies in incubators. There seemed to be a lot of movement within the unit, pregnant women in established labour coming to the door for admission and mothers with new babies preparing to make the journey home. My extra hands were certainly welcomed by those two midwives on the early morning shift!

My first task was to sit in the labour room with the three women in established labour. In English the word midwife means 'with woman'. As the room was a communal space, each bed was curtained off to allow privacy during delivery. The room was well ventilated with a breeze through the windows – a mesh screen to deter mosquitoes and other insects, and a reminder that those pregnant women were particularly vulnerable to severe falciparum malaria.

The room was functional, if sparsely-equipped, with three beds and baby cots, a resuscitaire with overhead heater in one corner and a resuscitation trolley in the other—a stark reminder that women who opt for a hospital delivery in this area of Kenya are there mainly because they've been identified as high risk for obstetric and medical complications.

I spent an hour getting to know these mothers, exchanging smiles and giggles as they looked at me in bemusement when I practised smatterings of Swahili. Before long, one who spoke English was showing signs of entering the second stage of labour and the birth was imminent. Routine monitoring of the mother was completed and foetal heart rates checked using a Pinard stethoscope, a horn-like device used for centuries to listen to the foetal heart.

The moment had finally come: the delivery pack was opened and I was asked to take my position at the head of the bed, out of the way of the midwife preparing to deliver this baby. This was a really exciting moment for me as a midwife. It reminded me of my student days, observing deliveries and watching the skills and techniques of the midwives as they carefully delivered new babies.

You never tire of the moment when a new life is brought into the world. I was privileged to hold the hand of this woman who had laboured without the help of analgesia. Finally, after long occipital posterior labour and some very tense moments a baby boy was delivered, flaccid and silent. He was immediately resuscitated by the second midwife, wrapped up in a towel and handed to his mother, screaming at the top of his voice to announce his arrival into the world.

Post-delivery ward

Later that day I visited mother and son, and chatted about her labour and the experience of having her first baby. We exchanged stories about motherhood and baby names. I was delighted when she told me she had chosen to name her son Hamisha. I had great pleasure in telling her that we have a Scottish name that sounds very similar - Hamish.

At the end of our day, we distributed a baby hat to each mother in the unit as a small token of our appreciation for allowing us to share their experiences.

These hats were generously donated by a group of my colleagues who recognise the importance of retaining heat in newborns.

This year I am looking forward to returning once again to work with the Kenyan Healthcare Programme, arming with a new Swahili translation phrasebook, baby clothes and more hand-knitted hats.

COSTA RICA:
Travelling alone and coming back with friends!

Sharon Graham MFTM RCPS(Glasg) has been off on yet another jungle adventure, locating all four native primates - plus both types of sloth and the resplendent quetzal sighted.

This time there was no need for malaria prophylaxis—just regular, serious applications of DEET—and no concerns about how pleasant or not my personal aroma might be. So it was safety first with dengue as the main concern. Our guide was good at ensuring we wore appropriate clothing and reminding everyone to top up the insect repellent.

The trip took us from San Jose down to the Caribbean coast and waterways to Tortuguero—then up and over the Arenel Volcano region to the Pacific Coast. Visiting areas of secondary and primary rainforest, the machete stayed with our leader – don't think they trusted me with sharps!

I experienced sleeping below, within and above the clouds. Temperatures varied from a cool 12ºC to a steamy 35ºC so layers were the order of every day. For me the nights in the lodge outside the primary rainforest area were the best – listening all night to the sound of frogs, toads and insects going about their business.

Resplendent quetzal with its iridescent plumage

Nurses abroad

Going alone you never know who you will spend your time with, but to find three other former practice nurses must be unique outside of a specialist trip. A number of others had worked in some health professional capacity—a midwife, three psychologists, a psychoanalyst and a health and social care lecturer were among our group of 16.

For me two nights of sleeping at around 3,000 metres was the hardest part—listening to my heart beat all night and having some limitation to my daily activities from the altitude, and then being seriously annoyed when the person with asthma took that day's climb with no problem at all. Fortunately this was my only adverse health-related issue and all-in-all it was a healthy trip.

One of the party who chose not to take a walk one day ended up with serious sunburn to the lower legs and feet. Unfortunately, this person was a little too stoical, saying nothing until oedema, cellulitis and blistering were established. All we could do was try to enforce rest, elevation and analgesia as we were a long way from a pharmacy.

On return one of our companions sent a photo of the friend she brought back with her – a bot fly (see inset). I almost felt jealous: I only came back with my memories and photos.

Hanging out with the sloths

PHARMACY
From dispensary to clinic!

Jane Dickson MFTM RCPS(Glasg) takes us along the route she followed from the dispensary to her current role in an NHS GP practice.

I am a pharmacist working in Blackpool for a doctors' practice as their pharmacist prescriber. My role encompasses a wide variety of work ranging from audit and medicine management to various clinics such as smoking cessation, travel health and minor ailments.

So how did I go from the dispensary to running my own clinics and working in practice?

Originally I worked in community pharmacies for a number of years, first as a pharmacy manager and then as a locum. During my time as a locum I worked for the local primary care trust, providing prescribing advice in various GP practices on the Fylde coast. The local GP out-of-hours consortium also decided to employ pharmacists and nurses to help with the workload—that would enable minor ailments to be channelled appropriately and let doctors deal with more urgent cases. This was an exciting new opportunity to diversify, working on telephone triage and some face-to-face consultations as well as supervising dispensing in the out-of-hours pharmacy.

Pandemic flu 2009

Although flu may not necessarily be considered a disease of travellers, the speed at which this particular strain was spreading caused the WHO to declare a pandemic. Pharmacists working in general practice were called upon to staff the local antiviral collection point and I became heavily involved. Demand was high that winter for influenza vaccines so we were trained to administer this. Thus we were developing clinical skills fairly quickly to cope with the demand placed on primary care services. Pandemic flu demonstrated how small our world really is: the virus was spreading rapidly across the globe.

> Pandemic flu demonstrated how small our world really is

Post- flu, what next?

Having developed skills for vaccine administration, it became apparent to me that there were other avenues to explore - ways that had previously been confined to other healthcare professions. Travel medicine came to mind as a means of keeping up my vaccination skills and diversifying into a speciality that not only was interesting but offered a good service to the practice.

In our role as pharmacists we are used to providing advice regarding the management of minor ailments and medicine management issues. Diversifying into a specialised area means further study to give credibility in our role.

My employer requires anyone who runs a clinic to have suitable qualifications in order to practice safely and effectively. I needed a recognised course and that's why I decided on the foundation course at the Royal College of Physicians and Surgeons of Glasgow. I completed this in 2010, and then went on to complete the diploma in 2012. Having achieved associate membership of the Faculty of Travel Medicine, it seemed the natural decision to complete the course by attaining membership (MFTM) through one further exam.

The practice manager and I put a business case together to expand the travel health service at the surgery and we also applied to be a Yellow Fever Vaccination Centre. I had been a volunteer pharmacist at the London 2012 Olympic Games, working in the health centre pharmacy at the Athlete's Village. My duties included minor ailment assessments and dispensing, and this experience was invaluable, working alongside pharmacists from hospital and retail backgrounds. It let me interact and learn with peers in a unique environment.

In short, travel medicine is a speciality that's like travel itself – you never know where your study will take you!

Conferences

Oman Travel Health Conference

Margaret Umeed FFTM RCPS(Glasg) reports

This first-ever event, held in Muscat in February, was organised by the Oman Ministry of Health (MoH) in collaboration with RCPSG for over 200 doctors, nurses and laboratory specialists. FTM Dean Dr Mike Jones reports briefly on this on page 3. In addition to distinguished international speakers, the conference was enriched by local speakers reflecting on the successful malaria eradication programme in Oman.

From Oman's perspective, the general objectives of the conference were:

- better understanding of the scope of travel medicine
- a forum for ideas on improving services
- improving service delivery
- exploring training options
- the impact of VFR (visiting friends and relatives) travellers on local health services
- understanding why VFRs are a challenging group
- a comparative study of Oman with the epidemiology of the UK

Congratulations to Dr Seif Al Abri and his organising team for a stimulating programme which easily met these objectives – their approach to travel health is truly inspirational.

The Adventurous Traveller

BGTHA/FTM joint conference

Richard III, whose adventures ended abruptly at nearby Bosworth Field, was being reburied along the road in Leicester as BGTHA Chair Tania John and FTM Dean Mike Jones welcomed 80 delegates to a day on the many risks modern travellers face. Among those at risk: gap year adventurers, immunocompromised travellers and injured service personnel. Heat, cold and height – key components of environmental risk – were also covered, along with risk-taking behaviour. Read more about it on:

www.rcpsg.ac.uk and **www.bgtha.org**

Coming soon...

24-28 May 2015

CISTM14
Québec City, Canada
www.istm.org/cistm14

26 June 2015

Joint FTM/MASTA/NHS Education for Scotland (NES)
The importance of being earnest or why travel health matters
Nurse Group study day
Royal College of Physicians and Surgeons of Glasgow
www.rcpsg.ac.uk/travel-medicine/education-events-and-cpd.aspx

19 September 2015

Joint RCN/Travel Health Training
The highs and lows of travel
Royal College of Physicians, London
www.rcn.org.uk/TH15

8 October 2015

Faculty of Travel Medicine Annual Symposium & AGM
It's a disaster: Ebola and other emergencies
Royal College of Physicians and Surgeons of Glasgow
www.rcpsg.ac.uk/travel-medicine/education-events-and-cpd.aspx

13 November 2015

MASTA
Annual study day
Royal College of Physicians, London
www.masta.org
Email: **nicola.davison@masta.org**

1-4 June 2016

NECTM6
See back cover for details
www.nectm.com

Apps...

Videos, Blogs and Websites

New materials are being developed at an exciting pace, delivering health-related education in an engaging format for healthcare professionals and travellers alike. Jane Chiodini FFTM RCPS(Glasg) offers some of her current favourites.

TravWell A new app from the Centers for Disease Control and Prevention (CDC) has general advice on disease protection and lets you store documents and details of medication/immunisations—it even reminds you to take your malaria chemoprophylaxis. 'Can I Eat This?' is another CDC app that helps you select safer food and drink. Both are free and could prove entertaining, even for young children. See **wwwnc.cdc.gov/travel/page/apps-about**

It's OK to be Smart is both a blog (**www.itsokaytobesmart.com**) and YouTube show (**www.youtube.com/user/itsokaytobesmart**) presented by biologist Joe Hanson. 'Why vaccines work' explains it all in dynamic style. Or search for 'Ebola explained' and 'What's the deadliest animal in the world?' This approach to education is fun, but be warned: it can be addictive!

Brainscape, an app for geography, is a simple but effective tool that uses flash cards to improve your geographical knowledge–an essential skill in a travel health consultation. Register on the website (**www.brainscape.com**) and some topics are free. World geography with 12 decks and 1,046 cards costs $5.99 and is well worth it. A great way to pass the time on the bus or Tube!

Lizard Point Quizzes (**www.lizardpoint.com**) offer another fun way to improve your geographical knowledge. Having only managed to score 89% for UK major cities I think I can learn a lot from this one.

See updates on Jane's website: **www.janechiodini.co.uk**

From the Journals

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Padickakudi J O, Patel A, Baker E C, Brock R (2015) Fighting Ebola in Sierra Leone: the experience of frontline NHS workers Bulletin of The Royal College of Surgeons of England, 97(3) 131-133

Schlagenhauf P, Weld L, Goorhuis A, et al, for EuroTravNet (2015) Travel-associated infection presenting in Europe (2008—12): an analysis of EuroTravNet longitudinal, surveillance data, and evaluation of the effect of the pre-travel consultation. The Lancet Infectious Diseases 15(1) 55-64. **http://www.thelancet.com/journals/laninf/article/PIIS1473-3099(14)71000-X/fulltext**

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New publications

Sandra Grieve reports

WHO World Malaria Report 2014

I was privileged to represent the Royal College of Nursing at the global launch of this report. In the presence of HRH the Duke of York the event at Westminster was co-hosted by the All-Party Parliamentary Group on Malaria and Neglected Tropical Diseases (APPMG) and Malaria No More UK. It was presented by two global leaders in the malaria campaign—WHO Global Malaria Programme Director Pedro Alonso and Executive Secretary of the African Leaders Malaria Alliance, Joy Phumaphi. Each paid tribute to the significant role played by the UK in helping drive progress – from UK aid support to British businesses, scientists and researchers. The take-home message was: There is no room for complacency and much remains to do in the fight to eliminate malaria.

www.who.int/malaria/publications/world_malaria_report_2014/en

Malaria in 2014: an unprecedented opportunity at the dawn of a new era

The launch of the Malaria Report by the All-Party Parliamentary Group (APPG) on Malaria and Neglected Tropical Diseases, Malaria in 2014 highlighted the UK's work in supporting and strengthening health systems in countries where malaria is endemic and where neglected tropical diseases can be identified and treated.

www.appmg-malaria.org.uk

6TH NORTHERN EUROPEAN CONFERENCE ON TRAVEL MEDICINE

1ST — 4TH JUNE 2016
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