Travelwise: the Journal of the BGTHA

BGTHA
The British Global and Travel Health Association

Promoting education and networking in global and travel health

www.bgtha.org
Travelwise 2, Autumn 2018
ISSN 174-4709

Editorial

This is the second edition of the newly formatted and combined 'Travelwise: the Journal of the BGTHA', and I have thoroughly enjoyed helping to review the variety of pieces received before publishing. Feedback from our first edition published online in June has been positive which is extremely encouraging as we move forward. As is timely, in this edition, tick borne diseases such as Lyme disease feature, as does FGM. Unfortunately, in June/July this is at the forefront of our minds for many of our long-term female child travellers.

As we come to the end of an extended heatwave, which has been well received by me and many others in the UK, the devastating effects of global warming have been experienced globally and affected many of our UK travellers. This serves as a reminder as to the importance of recommending travellers review Foreign Office guidance before travel and that our travel health consultations are tailored for the individual, their destination and activities. Extensive flooding in popular destinations such as India, Japan, China, Philippines and Sri Lanka have led to many deaths and loss of infrastructure and this greatly affects the tourist industry. Closer to home we have seen wild fires in Greece. The recent catastrophic earthquakes in Indonesia have also disrupted many tourists plans and subsequently travel health consultations should be the perfect opportunity to make sure travellers have adequate insurance to cover such disasters.

Both myself and my colleagues are very sad to see the departure of Adrienne Willcox the BGTHA Journal's co-editor and executive member of the BGTHA committee as she steps down for pastures new and all at the BGTHA wish her the best of luck in all her new endeavours. She will be greatly missed.

I would like to conclude with a request for any budding authors to please get in contact. We receive a fantastic range of items but are always looking for new pieces to publish and these range from researched reviews, referenced articles to top tips from inside the travel clinic. We welcome case studies and any travel tales you'd like to share. I am always free to discuss any prospective ideas you may have and share the author guidelines with anyone interested – so please do get in touch!

Becky Swadling
Co-editor

Contact Us

British Global and Travel Health Association

Administrator: Roger Morley
Email: info@bgtha.org
Telephone: 0845 003 9197
Postal Address: British Global and Travel Health Association
13 Burlington Street
Flat 5
Bath BA1 2SA

In the News

Medication and overseas travel

The Foreign Office is warning tourists of potential problems when taking medications abroad. Some common medicines are considered contraband in some countries. Medication containing pseudo-ephedrine, often included in decongestants, is outlawed in Japan. In Greece and United Arab Emirates, diazepam, tramadol, codeine and other commonly prescribed medicines are considered controlled drugs and banned from entry. Sleeping pills, anti-anxiety pills and strong painkillers also require a licence for importation by vacationers into Singapore. In India and Indonesia, medicines such as codeine, sleeping pills and treatments for ADHD are illegal. Over the counter (OTC) medicines such as cold and cough remedies are controlled substances in Qatar.

A Foreign Office survey found that only one in three people look up rules for taking prescribed medications when going abroad and only one in five do so for over-the-counter medicines. Some countries such as Costa Rica, only allow entry for medication needed for the length of the trip and a doctor's letter is required to confirm the amount necessitated. People who are on routine medication should confirm that the medicines are allowed legally into the country being visited and it is wise to check online whether prescription medicines and OTC medicines are acceptable at the destination.

Visits to the developing world

Figures from the Office for National Statistics show that visits to Sri Lanka have risen by more than a fifth with a similar boost to the United Arab Emirates since 2014. There have also been significant rises in visits to Pakistan, Nigeria and Japan. More British people are therefore being exposed to exotic and regional diseases.

Ocean Travel

According to a report from MarketWatch.com nearly 2 million British holidaymakers opted for a cruise holiday in 2017 and there has been a 6.63% annual growth in cruising worldwide. Ever bigger ships are being launched with the new Symphony of the Seas accommodating about 6500 passengers and five other big ships being launched this year to hold more than 30,000 passengers.

Infection in British waters

Surfers are three times more likely to have antibiotic resistant E. coli in the intestines than non-surfers a study has found. A team at the University of Exeter medical school took swabs from surfers and published data in the Journal of Environment International. They report that 9% of surfers were colonised by the resistant bacteria, compared with 4% non-surfers. It is believed that surfers swallow 10 times more sewage-contaminated water than sea swimmers. Surfers should be made aware of the risks involved in the pastime.

Vacationer's nutrition

Cruise ship passengers are well aware that they eat more and put on weight while on a cruise. Other holidaymakers however are less aware of the changes in their diet on holiday. A study of 1025 adults by OMRO Healthcare has interesting findings. Middle-aged people from the UK eat an extra 3504 calories a week when on holiday. In an average week, over-40s, ate 12,327 calories which rose to 15,876 when abroad. Average alcohol consumption also doubled from six units a week. The vacationer was also likely to spend less time physically exercising while away and 84% considered personal calorie and alcohol intake while at home, whereas only 4% keep this up while on holiday.

In the News

Travel health insurance

The financial ombudsman has reported rulings in three cases in which travel insurers had rejected claims of medical treatment for accidental injuries on the grounds that the customer had drunk excessively. The ombudsman found in favour of the consumer in two cases, ruling that the insurer had no convincing evidence that alcohol was a cause of the accident. The small print in policies have often been grey areas, and this ruling helps to clarify the situation, in regard to companies excluding claims because of alcohol intake. The ombudsman's conclusion is that if someone is honest about the fact they had a drink, it should not be assumed that they have been drinking to excess and that the drinking was necessarily a reason for the claim. It is up to insurers to assure that any exclusion applies, rather than for the customer to show that it does not. The definition of "excessive alcohol intake" still leaves room for manoeuvre however.

New plans set out by the travel health insurance regulators may make travel insurance policies cheaper. The financial conduct authority (FCA) has told price comparison websites that they must direct consumers away from expensive policies towards cheaper deals and special providers, for travellers with long-term health conditions. The regulator conducted a study that found that holidaymakers with illnesses, including cancer, diabetes and heart problems were struggling to find reasonable cover and many were paying over the odds for insurance. Others were cancelling trips. The FCA believe 15 million UK people are currently living with at least one long-term health condition, with the number predicted to increase and many of these travel abroad.

The Money and Mental Health Policy Institute has become concerned, when investigations showed that almost 45% of people with mental health problems never disclosed their illness to the travel health insurer. Those who do, face significantly higher premiums and limited cover. Premiums increased by between 200% and 500% for people who disclosed more severe mental health problems, with some insurers only offering cover excluding mental health conditions and 30% did not take out travel health insurance as a result. The insurance regulator has stepped in with plans to improve signposting to specialist insurers, but the charity is calling for reform in the travel health industry to ensure providers do not discriminate against those with mental health issues.

One in five Britons has been approached by cold-calling companies about making compensation claims for holiday sickness. ABTA which commissioned the poll; claims management firms are cold calling many people urging them to make false claims. There has been a six-fold rise in the number of claims made in the UK since 2013, despite sickness reports in resorts remaining stable and travellers from other countries not having the same issues. The most common approach was over the telephone or by text message and email.

Pastime activity exclusions are common on health insurance policies and covered in the small print where they are unread or ignored. The comparison site GoCompare analysing a thousand multi-trip travel policies found that almost half did not cover quad biking. Many excluded banana boating, jet skiing and horse-riding accidents, with some even not covering cycling. Many travellers indulge in these activities, assuming accident cover is in place, and they should read the small print with care. They should also go to www.NHS.uk and find the EHIC coverage for the destination.

Ticks and Lyme disease

A study from Bristol University reported in 'Ticks and Tickborne diseases' suggests that the substance Turmeric might stop infection causing Lyme disease. Researchers tested turmeric on ticks in the laboratory, in the wild and on dogs and found it did a better job than commercial insect repellents.

Oxygenators

Airline travellers with hypersensitivity conditions and those requiring low dose of oxygen on line, have been having problems with oxygen apparatus. Lightweight oxygen concentrators of G4 type were disallowed on a recent flight from Manchester, because only G3 version was on the approved list. The European Lung foundation says that there is no consistency between airlines and acceptance of oxygen concentrators. Potential passengers requiring this equipment should browse websites to confirm that the apparatus will be carried.

Air safety

According to Aviation Safety Network, 2017 was the safest year ever for commercial airline travel. There were no commercial passenger jet deaths last year.

In the News

Air Travel

Respiratory Infection researchers at Emory University (USA) in a study published in the Proceedings of the National Academy of Science, have reported on data on air passengers, modelling the likelihood of travellers catching a respiratory disease during a flight. With more than 3 billion airline passengers travelling annually, in-flight transmission of infectious diseases can be an important global concern, as was the case with SARS. The main transmission routes are respiratory droplets propelled short distances when the infected person coughs or sneezes.

Passengers and crew on transcontinental flights were observed during the influenza season. It was found that a sick member of cabin crew was likely to affect an average of 4.6 passengers per flight, with those sitting in the middle of a row of seats at greatest risk. A sick passenger was less of a threat to fellow travellers, infecting an average of less than one person per flight, as long as they sat more than a row of two seats away. Only sitting close to someone coughing and spluttering raised risk of infection. Anyone sitting within a row or two seats of a sick passenger had an 80% risk of picking up an infection.

Disabled travel

There have been many recent reports of disabled travellers being separated from their wheelchairs and wheelchairs being damaged in transit. The Department of Transport is currently considering measures to make flying less miserable for people with reduced mobility. The authorities have announced there will be a policy for wheelchairs to be taken to the doors of planes in future. At the moment, wheelchair users are forced to put the chairs in the hold with the risk of them being damaged and not delivered on arrival. Short haul flights do not tend to carry on board facilities for disabled passengers to move on the aircraft. Consideration has to be given to making travel more comfortable and less of a hassle for disabled travellers. The Department of Transport is discussing with the aviation industry plans to develop priority wheelchair storage on planes for quick access on arrival. Heathrow airport authorities have announced that from this summer they will make it policy for wheelchairs to be taken to the doors of planes.

Mid-air turbulence

A publication in Geophysical Research Letters Journal predicts increasing severe turbulence in aircraft in the future, with severe buffeting increasing up to 3 times in the next 20 years, as a result of global warming. Risk of mid-air injuries will rise. Passengers can expect to spend more time belted in their seats. On some popular routes such as transatlantic flights, severe turbulence will increase by 80% while over Europe it is set to worsen by 60-100%. The study by Reading University used a comprehensive mathematical model predicting long-term global conditions and it estimated that by 2050, the rate of in-flight injuries will have tripled in line with the increased incidence. Global warming is increasing turbulence by strengthening wind instabilities in the jetstream and making pockets of rough air stronger and more frequent.

Jetlag

Jetlag can have a marked effect on workers productivity. Research commissioned by travel search engine Kayak found that 29.6 million long-haul trips are taken each year, resulting in 53 million working days affected in the typical worker who estimated that they were only able to operate at 61% of the normal level of productivity when suffering from jetlag.

Sleeping modules

Airbus manufacturer is considering plans to turn plane cargo holds into sleeping and relaxation quarters for passengers. This would permit economy class flyers to temporarily swap cramped seating for beds and sofas during the flight. The modules could be interchanged with ordinary cargo containers. If this concept takes on, people would be released from cramped fixed position postures in airline seats and be able to stretch out and relax, with probable decrease in the number of deep venous thrombosis incidents.

In the News

Airline seats

Aircraft manufacturers are cutting seat pitch in economy from the industry standard of between 34 and 35 inches to just 32 and even less. Seating pitch may be a factor in development of deep vein thrombosis. On long haul flights, Quantas offers more than 31 inches while Virgin goes as low as 29 on its Atlantic A330. 'Which' magazine examined more than 30 carriers and Virgin and Thomas Cook were found to offer less than 30 inches on long haul flights. On short haul flights many airlines offer only 29 inches, including British Airways and EasyJet. Economy class passengers have lost 8 inches of legroom since the nineties. Boeing accept that seat pitch has been reduced by 3 inches on average for long haul flights but adds that seat pitch seat design and comfort has improved. There are also plans to install 10 abreast seat configuration which will add to congestion and discomfort.

Infectious diseases

WHO has advised that tourists should ensure they are vaccinated against measles after 41,000 children and adults on the continent of Europe were affected in the first six months of this year. Popular summer destinations, such as France, Greece and Italy recently have recorded more than a thousand measles cases each, including fatalities. Georgia, Russia, Serbia and Ukraine also experienced the same number of infections, with the Ukraine worst with more than 22,000 measles victims. Public Health England has advised that tourists should ensure that they are up-to-date with measles mumps and rubella vaccination before travelling to countries with outbreaks. WHO said that at least 95% immunisation coverage with two measles vaccinations a year is needed to stop the spread of measles.

Infestation

Bed bug populations went into decline in the eighties and nineties but have recently undergone an aggressive resurgence, with cases more than doubling in the UK during the past few years. A study by the University of Sheffield published in Scientific Reports has shown that the insects are drawn to dirty laundry and soiled clothing, which could be the method of hitchhiking between countries. Once a room is infested with bedbugs they can be very difficult to get rid of. The study shows that keeping dirty laundry in a sealed bag while staying in a hotel can reduce the chances of people taking bedbugs home with them.

Snow sports

Snowboarding and skiing are responsible for a substantial number of musculoskeletal injuries and a recent study at Brown University in Rhode Island has confirmed that, snowboarders are three times more likely than skiers to suffer an injury during a fall and are at greater risk of breaking arms and wrists. Snowboarding accounted for 4% of all snow related injuries in 1999 but now makes up 56% of all snow sport related injury.

Malaria

A drug-resistant strain of malaria has spread from Cambodia into southern regions of Vietnam. This strain has been detected in Thailand and Laos. Researchers at the tropical medicine research unit in Bangkok say the strain has become resistant to artemisinin and piperaquine. Researchers fear that if the drug resistant strain spreads to Africa, it could create a major crisis there. From this year, children in Kenya, Ghana, and Malawi will get the first doses of the RTS,S/AS01 vaccine developed by GSK pharmaceuticals. The launch of the vaccine is a landmark in the war against malaria however a single-dose vaccine is still the holy grail for researchers.

In the News

Diamox use in Athletes From the International Society of Travel Medicine ListServ

Diamox is banned by the World Anti-Doping Agency (WADA) because it is a mild diuretic. All diuretics are banned because they can alter urine drug concentrations. Diamox is not a performance enhancing drug at any altitude, and actually causes a decrease in maximum exercise performance.

Peter Hackett MD.

Diamox is on the WADA banned list for both in and out of competition. If you have a reason to use it for medical purposes, make sure the athlete applies for a "Therapeutic Use Exemption" certificate by the local anti-doping authority. Like Dr. Peter mentioned, although it is not performance enhancing, it is classified as a masking agent that alters concentrations of other doping agents.

Suvash Dawadi, MD.

Education Update for Community Pharmacists

NICE have produced new guidance called **Community Pharmacies: Promoting Health and Wellbeing**. Although it doesn't specifically mention travel health services, much of the content is highly relevant and is supportive of CPD and education for pharmacists who deliver travel health care.

The interactive flowchart is particularly useful as it quickly links the reader to other resources. The **Advice and Education** box links to:

- *Contraceptive services for under25s*, and such advice might be sought by young people heading off on holidays and gap years.
- *Antimicrobial stewardship* which of course has individual, national and global implications.

The Behavioural Support box links to:

- *Principles for selecting interventions and programmes aimed at individuals*, an understanding of which is essential to an effective travel health consultation.
- *Training in Behaviour Change Interventions* and NICE guidance *Behaviour change: general approaches (2007) NICE guideline PH6*.

You can find **Community pharmacies: promoting health and wellbeing (2018) NICE guideline NG102** at: https://www.nice.org.uk/guidance/ng102

Tales from the clinic: Things no one tells you when training to be a travel clinic nurse

1. You will soon get bored of bartering over the cost of vaccines, especially when you don't even have a say in the price and have already run over the appointment time by ten minutes.

2. You will hear repetitive phrases that will make you cringe and subsequently loathe the upcoming conversation:
   How much!!!??
   But my sister says vaccination is pointless!
   But my sister went to ... and didn't have anything, and she was fine.
   Do I really need it though?
   I'll just phone and check with my mum what she thinks I should have.

3. You will learn to love or at least tolerate cold tea and coffee (having microwaved it in-between every patient, hence making it too hot to drink in time before the next consultation). You will therefore adore the person who kindly thinks to make you a brew five minutes before the end of your consultation, so you can drink it fresh and hot for once.

4. Despite saying it repeatedly to yourself under your breath, and almost perfecting it; when it comes talking to a client or colleague you will never say schistosomiasis correctly. It just becomes that 'schisto-thingy' disease.

5. Six months down the line you will still be unsure how to correctly pronounce 'encephalitis' so you just alternate between 'enSephalitis' and 'enKefalitis' so at least 50 per cent of the time you are right.

6. You will be amazed at how much of all that important information you gave a client last week has simply been forgotten by the second visit. 'What am I having today again?'

7. Seeing a traveller going on a 'round the world' trip, booked in a 15 minute slot will make you die inside a little.

8. You will eventually notice that 'round the world' actually means 'I'm flying across a lot of the world but not getting off', i.e. it usually just means four countries in East Asia (Laos, Cambodia, Vietnam, Thailand) and two countries in South America (Peru and Bolivia, maybe Ecuador too), and sometimes Central America. The other continents usually don't get a look in. (Incidentally these big trips scare the bajeebees out of you when you're new but as soon as you have done a few you realise it's not that bad because basically everything is a high risk so you don't need to filter anything out or watch the client procrastinate with the low risk/high risk debate. You get to confidently say: "if you can afford it you should definitely consider it". End of discussion).

9. You will actually want to hug the sensible (rare) person that buys a medical kit.

10. You will dread having to explain yet again why there's a national vaccine shortage and they can't have it 'even though we're private.'

11. You will learn how to write an ICVP and think yeah that's pretty straightforward. Then you will repeatedly make mistakes the moment you have a family of four in front of you.

12. You will have a nightmare of a day working on your birthday when every vaccine record ends up dated with your birth year and not the current year. You cringe as another ICVP gets wasted...

13. Just as you think you finally know what you're doing, someone will walk in who's pregnant with an immunosuppressive condition you have never heard of and has no vaccine record, going to 'somewhere in Africa' for three months.

If you chuckle or nod at any of the above you must have nailed it so don't worry.

Alys Bunce
Travel Health Lead Nurse, Nomad.

Impossible Ethical Dilemmas in Rural Zambia

When applying for FY1 you face an exam consisting of multiple ethical dilemmas, such as "the drunk colleague" or the "underperforming colleague". In reality, as a junior doctor in UK, at the slightest whiff of a complex situation there are consultants, multidisciplinary teams (MDTs) and defence unions at hand. This was an aspect of work as a doctor which I had not considered prior to setting off to work in rural Zambia, after 3 years UK experience.

I quickly found myself feeling quite at home in the pretty ex-mission hospital, manning a medical ward and contributing to outpatient work. I did feel constantly aware of my inexperience, surrounded by equally inexperienced but well-meaning UK graduates. Most of my monthly budget seemed to be spent on mobile phone data, accessing UK guidelines and UpToDate to ensure I was practicing medicine at standards as close to UK standards as is feasible with a fraction of the resources. Within a month I had seen countless firsts: cerebral malaria, leprosy, TB meningitis, pellagra….and while this was challenging I felt it was the reason I had wanted this experience and I felt I was learning quickly.

There are numerous cases that stand out in my memory, however none as complex and challenging as Patient F. I first met this lovely girl in the outpatient department. With my limited Chichewa I ascertained that she was sore all over (a common complaint here which can mean from absolutely nothing to imminent death). With this girl, though, she was covered from head to toe in multiple purple/red lesions and patches, typical of Kaposi's Sarcoma (KS). It also transpired she was HIV positive and prescribed antiretrovirals, with variable compliance, which backed up the diagnosis.

She was admitted to the ward. The hospital policy was that, given the prevalence of Kaposi's Sarcoma, if the presentation was typical, then treatment is started without a biopsy. In my 7 months there we had a stock of doxorubicin and vincristine for about 5 months. This is when the dilemmas start. Problem 1 was explaining the diagnosis to her. Despite being 26 she had never heard of cancer, so via a translator I went down the route of explaining "abnormal cells" etc. Patricia (the Zambian nurse translating) felt that she understood but I wasn't so sure. Then as I was fixed in my UK ways I went about ensuring that she didn't have active infection prior to starting chemotherapy. Immediately this caused a problem. Her blood tests (results obviously obtained the next day) showed a white cell count of 23 (neutrophil predominant) and ESR184. The X-ray machine wasn't working but clinically she had crepitations at right base and a fever, therefore I postponed chemotherapy and treated her for pneumonia. After 5 days she had improved clinically and white cell count normalised so I asked her to go home and come back a week later to start chemotherapy (with slight anxiety that a language mix up would mean she never returned).

As planned she returned. She seemed jovial! She explained that she had been managing to take antiretrovirals consistently but also extremely happy as she realised she was pregnant! Pregnant! This filled me with horror! Delaying chemotherapy due to infection was simple but what was I meant to do about a pregnant 26 year old who needed and wanted chemotherapy but was delighted to be pregnant. I selfishly hoped she was wrong. She was pretty sick, maybe it was just amenorrhoea as a result of that. No, an ultrasound confirmed a viable pregnancy, approximately 12 weeks. I consulted the other doctors, knowing they wouldn't have encountered this. I spoke to a Zambian gynaecologist…."go ahead with the chemo" he said. But what about the risks to the baby I asked, the mum needed to at least be aware of this or wait? "No…go ahead" he said. I texted anyone I knew doing O&G, I read and I read. The staging of KS is related to; tumour extent (t0 cutaneous, t1 with lymphedema or visceral involvement) immune status (CD4 >200= I0) and systemic illness (B symptoms, infection, diarrhoea). Evidence regarding prognosis based on treatment with antiretroviral therapy (ART) alone or with chemotherapy and ART was lacking.

The overwhelming opinion was to treat her as if not pregnant. I really think it's important to involve patients in their decisions. How do you go about discussing this with a girl who I don't even know understands her diagnosis? I felt at home she would be armed with information. Information that would come from MDTs, expert opinions, experienced people. I had none of that! We went ahead with round 1 of chemotherapy. Then following discharge she didn't return! Whenever I am asked by friends about undertaking similar work it is this case and similar that come to mind. Make sure you are robust enough to deal with the ethics as well as the clinical skills.

Samantha Gaw,
Junior Hospital Doctor, Cheltnham

Case History: Travellers beware of a biting menace

A 24 year old English hill walker arrived for consultation one July day, en route home after climbing in the mountains above Glen Affric, Scotland. He had been camping by the loch-side and his tent had been invaded by swarms of voracious Highland midges. Travellers to the Highlands of West Scotland often leave with the impression that the country is under siege from the midge menace and he had suffered badly from their attacks. Midges are seasonal and are at their most active during the peak tourist and hillwalking season. Midges of various species begin to appear in Scotland around April and continue to be present until October. The worst biting problems begin in June when the infamous Highland biting midge starts to appear and remains active for about three months.

The climber had a red, very swollen face, with bites coalescing to cover all his exposed face, ears and neck. His legs and the back of his arms were peppered with red, angry wheals and papules. He complained of pain, an intense itch and had been scratching at his legs causing the skin to weep. He said he had climbed in the Andes and Himalayas and had never suffered bites like this from mosquitos or other insects. I diagnosed an allergic response to their bites and prescribed a soothing lotion and some antihistamine tablets, advising better protection and a different season if he returned. Chastened he took his departure, vowing not to return to the far north-west.

July is the worst biting month. The ideal habitat being uncultivated open land near water with plenty of shade. Midges like it warm but not too hot, so they tend to avoid the sun and disappear if there is wind. Reports suggest the season is getting longer, possibly a side-effect of global warming and a general increase in Scottish temperatures. If this trend continues, the midge menace will worsen.

The midge begins life in the summer and the reproduction process is responsible for biting behaviour. Once fertilised, the female's eggs cannot properly develop without a blood meal and they produce two generations per season, normally laid in moist soil, often by water. The larval midge emerges within a day or two and burrows into the ground. The adult midge emerges from the pupa, after which it has a lifespan of some 20 to 30 days. Not all species of midge bite – but the worst offender is the Highland biting midge C. impunctatus, but it is not a vector of disease in humans.[1]

Symptoms

Midges fly in swarms and multiple bites are likely with numerous attacks on exposed areas of skin such as the face, arms and legs. Some people react badly with a serious allergic reaction, even anaphylaxis. For most people, midge bites are merely very itchy and annoying. The bloodsucking female punctures the skin which forms the centre of an inflamed red weal and a papule. In some people this is little more than a small spot – for others it becomes a large blister, especially if the midge has been left to feed undisturbed for several minutes.

Prevention

There is no reliable way to stop midge bites. Various midge repellent products are available and often ineffective. Neem oil appears to have some deterrent value. The volatile oil from bog myrtle has been shown to have a repellent effect.[2] Arguably, the wearing of light coloured clothing, long trousers and a face veil attached to a brimmed hat can reduce exposure. Visitors could avoid exposure in the main biting season – July to October, and stay away from rivers and lochs.

Treatment

The following remedies may be tried:

- Calamine lotions
- Antihistamine tablets
- Adrenaline and corticosteroid may be necessary for anaphylactic reactions
- Antibiotic cream for infected lesions.

References:

1. Hendry G. (1989) Midges in Scotland. Aberdeen University Press.
2. Stuart A. and Evans A. (1999) The biting midge of the west highlands. Trav. Med. Inter. 17. 143:7.

Iain B. McIntosh

Journal Watch

Lyme Disease Vaccine Candidate VLA15 Advances Through Phase 1 Trials.

Emily Wolfson. Disease Daily. July 16 2018. http://www.healthmap.org

This article reports on the development of a new vaccine (VLA15) for Lyme Disease by Valneva that has successfully passed Phase 1 trails and is due to enter Phase 2 by the end of this year. It has been approved a fast track designation by the American Food and Drug Administration (FDA) due to the increasing severity and incidence of Lyme disease. The article describes the incidence and the pathology of Lyme disease. It summarises how the VLA15 vaccine works; by targeting the outer surface protein of Borrelia burgorfei (bacterium) and is effective against all six types of Lyme disease. It creates antibodies that prevent Borrelia from migrating from the tick to the human after a bite. The vaccine is likely to be administered as a three-dose schedule each given one month apart. It concludes with a review of the previously licensed vaccine that was withdrawn from the market in 2002 following unsubstantiated reports of severe adverse effects including chronic arthritis.

Comment

Although still a long way to go, if this vaccine succeeds in getting to market it will be very welcome for both travellers and people living in endemic areas. Lyme disease is considered the leading vector borne disease in the northern hemisphere causing debilitating chronic illness. There are approximately 1000 serologically confirmed cases in the UK each year according to NICE guidelines although PHE state the true number could be 3000. In Europe there have been more than 360,000 cases reported in the past two decades.

Journal Watch

Altitude sickness and acetazolamide.

Williamson J, Oakeshott P, Dallimore J. BMJ2018;361:k2153.

This paper in the BMJ's 10-Minute Consultation series deals with the case of a 25 year old man who plans to trek to Everest Base Camp (5545m) in Nepal for charity. He asks for a prescription for acetazolamide to prevent mountain sickness. The response to this scenario used data from the Wilderness Medical Society's consensus guidelines, recent meta-analyses and the Oxford Handbook of Expedition and Wilderness Medicine. It provides guidance on how to assess the level of risk for a traveller to high altitude and how and when to prescribe acetazolamide to prevent mountain sickness. The "What you need to know" text box, which provides a summary of the main points to be taken from this type of article, stresses the importance of slow ascent of ≤500metres per day, resting every third day and avoiding over-exertion in avoiding mountain sickness. It makes two further important points: that the most important treatment for altitude sickness is descent to a lower altitude; and that acetazolamide 125 mg twice a day can be given as prophylaxis.

Comment

This article provides a useful resumé of the use of acetazolamide as a prophylactic against mountain sickness for travel health advisers. It concurs largely with this writer's long held views on the use of acetazolamide, namely that its use should be considered for a) for those who have previously experienced acute mountain sickness, especially in spite of a cautious rate of ascent; b) for those flying directly into a high altitude airport without the opportunity to acclimatise gradually; and c) for those whose itinerary, by virtue of the local topography, prevents them from adhering to a safe rate of ascent.

Effect of statins in preventing hospitalizations for infections: A population study;

Policardo L, Seghieri G, Gualdani E, Franconi F; Pharmacoepidemiology and Drug Safety (May 2018)

By using administrative databases, the 5-year hospitalization rate due to bacterial infections in population living in Tuscany, Italy exposed to statin therapy (n = 52,049) was compared with that of a population of untreated individuals (n = 3 300 ,675), matched, accounting for all available covariates such as age, gender, previous hospitalizations for infections, cardiovascular events, previous co-morbidities, diabetes, as well as general practitioners' proactive behaviour of care delivery according to current guidelines. The authors found that unmatched individuals of each treatment-class had significantly more hospitalizations than controls, while matched treated people, apart from those in class 0% to 20%, had a decrease of hospitalizations, as large as the increase in prescribed drug. Statin effect in reducing hospitalizations translated into a number needed to treat (NNT) ranging across treatment strata from 102 to 54. They concluded that compliance to statin prescribed daily doses above the threshold 20% of DDD, along a 5-year follow-up, prevented hospitalizations due to infectious after adjusting for covariates able to modulate baseline risk of infections. The NNTs to avoid 1 hospitalization for infections resulted on average not too dissimilar from a value lying between the 95% CI of NNTs previously found for primary prevention of 1 incident coronary ischemic event (72 to 119).

Comment

This is an interesting finding which suggests that patients, including travellers, taking statins may be less liable to infection, though the types of infections investigated were not necessarily travel related. Is this yet another confirmation of the oft-quoted adage that everyone over the age of 50 should take statins? There are, however, much better reasons to prescribe statins than infection prevention!

Q&A Polio

Question

I hope you can help me to interpret the polio vaccination exit recommendations. I have a family going to Nigeria to visit their relatives. Mother needed Revaxis® vaccination. Her son and daughter aged 19 and 17 years old, last had Revaxis® two years ago. Her youngest child is nine years old and is up to date with his childhood immunisations. This means his next Revaxis is due when he is in class year 9. Given the spread of wild polio spread in African countries should the three children be vaccinated with another Revaxis now? We do not usually interrupt childhood immunisation if they are up to date but in this case is this necessary? Does this need to be given within 4 weeks of departure from UK? Is a printout from the computer sufficient or do we need to get special certificate of vaccination?

Answer

Let's look at mother first. You have just given her a dose of Revaxis® so no need for any further action as regards to polio prevention in her case.

The son and daughter aged 17 and 19 years both had a dose of Revaxis® two years ago so again they are now covered (a booster, if needed, can be given 10+ years after this last vaccination.)

The youngest child aged nine years: I assume this child did receive his primary course of polio-containing vaccine at two, three and four months of age (check this is documented), and his first booster at three years after the last dose (at the age of around three years and four months or soon after – this is the 'preschool booster'.) The second booster is due 10 years after the first booster, so this child is covered for this trip.

However, the above recommendations are only for protection of the individual traveller against polio infection.

BUT: under International Health Regulations (which are aimed at protecting public health and stopping the spread of a disease), there is also a certificate requirement. NaTHNaC state:

Travellers who intend to visit Nigeria for four weeks or more should be aware that proof of vaccination [an International Certificate of Vaccination or Prophylaxis (ICVP)], given four weeks to 12 months before departure, may be required on exit. Failure to produce this documentation may result in vaccination on departure, most likely with oral polio vaccine.[1]

So you should ensure that all the family have had a booster within four weeks to a year before their departure from Nigeria.

You must record this on the International Certificate of Vaccination or Prophylaxis (ICVP) card. Providing a traveller with a computer printout of their vaccinations cannot be considered as a certificate but it is good practice to also provide this record.

The polio situation is dynamic and guidelines may change so always check.

Reference:

1. National Travel Health Network and Centre (accessed 02 August 2018). https://travelhealthpro.org.uk/country/165/nigeria#Vaccine_recommendations

Dr George Kassianos

Q&A Shingles vaccination

Question

Can we give the shingles vaccine to patients taking anti-TNF (tumour necrosis factor) or similar therapy?

Answer

As regards to biological therapies, the live shingles vaccine is contraindicated in patients currently taking anti-TNF therapy. The vaccine can be given only after 12 months have elapsed from when the patient stopped the anti-TNF therapy. The prescriber in general practice or a travel clinic must observe the 12 month period after cessation of therapy. Of course, the hospital consultant can decide on a shorter period and advise you in writing.

Patients with rheumatoid arthritis, inflammatory bowel disease, psoriasis, glomerulonephritis on corticosteroids or other immunosuppressive drugs: if taking any of the following drugs, currently or in the last three months, they cannot receive the shingles vaccine:

- Prednisolone long-term: over 20 mg after 2 weeks and over 40mg after a week
- Non-biological oral immune modulating drugs:
  - Methotrexate over 2.5 mg per week (OK up to 2.5 mg)
  - Azathioprine over 3mg/kg/day (OK up to 3)
  - 6-mercaptopurine over 1.5mg/kg/day (OK up to 1.5)

Patients on prednisolone long-term that take 20mg or less per day can be vaccinated.

Patients on prednisolone long-term that take 20mg or less per day AND in combination with doses of non-biological oral immune modulating drugs at the safe doses given above can be vaccinated.

Patients on high doses of inhaled steroids can be vaccinated.

The Summary of Product Characteristics for individual medicines (https://www.medicines.org.uk/emc) and chapter 6 of the 'green Book' (https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book) are useful resources. If in doubt, liaise with the hospital consultant.

Dr George Kassianos

Travel Health Update

The past few months have seen a number of Travel Health related publications revised and updated. On 3rd July, the World Health Organisation (WHO) released their renewed list of **Yellow fever vaccination requirements and recommendations for 2018**.[1]

This year there are many changes including a newly defined risk area in Ecuador – Esmerelda province. Some countries have removed the mandatory requirement for an International Certificate of Vaccination Prophylaxis (ICVP), whilst others have now implemented this where there was not before. The minimum age for a Yellow Fever certificate has been lowered for many countries and there are many changes to recommendations relating to transit through a Yellow Fever endemic country. NaTHNaC[2] and Travax[3] promptly updated their websites with a summary of the changes and all the new requirements on each country page to aid the Travel Health Professional in their consultation.

Public Health England (PHE) have also published several chapter updates in the Green Book (Immunisation against infectious disease) which are summarised below:

Japanese Encephalitis chapter 20[4]**:** The licensed rapid schedule of 2 doses given on days 0 and 7 in persons age 18 to 64 years can now be used off license in children from age 2 months and adults over age 65 years. It should only be considered if there is insufficient time to complete the standard schedule of days 0 and 28 and takes a week after the second dose for immunity to develop. Booster recommendations have also been amended according to age groups and are much clearer to follow.

The Yellow Fever chapter 35[5] was updated in June in accordance with the recently amended chapter 6. It states that vaccination can be considered in persons with chronic inflammatory diseases who are on stable long-term low dose corticosteroid therapy either alone or in combination with other immunosuppressive drugs such as non-biological oral immune modulating drugs (e.g. methotrexate / azathioprine) depending on the dose. Specialist advice should be sought to determine immune status before vaccination in these groups. It can also be given to HIV positive individuals who are asymptomatic with a CD4 count that is greater than 200 and a suppressed viral load.

Rabies Chapter 27[6]: A new accelerated four dose course given on days 0, 3 and 7 and 1 year can be given if there is insufficient time to complete the 21 or 28-day course before travel. The fourth dose provides longer term protection. This schedule is welcome news for last minute travellers. A single booster after one year is advised for some travellers, but only if travelling again to a high-risk destination or partaking in high risk activities or away from reliable post exposure medical care.

There has also been a change in post exposure recommendations since the **PHE Rabies post-exposure treatment: management guidelines** were revised and published on 3 July[7]. PHE now classifies all cases as either amber, green or red and uses various data to substantiate the composite rabies risk including country risk, animal source, type of exposure. The new evidence-based recommendations state immunocompetent high-risk patients require just four doses of rabies vaccine given on days 0, 3, 7 and 21 and not 5 as per previous guidance. The schedule treatment differs for the immunocompromised. Public Health England **'Vaccine update: issue 282, rabies special edition**[8] provides an excellent and thorough summary of all the changes.

There have been some minor amendments to other chapters including Tetanus and Varicella which have had links added to guidance documents.

The Influenza chapter 19[9] was updated on 15th August and has an interesting change in guidance for administration of the vaccine to persons taking anticoagulants. 'There is a lack of evidence that the subcutaneous route of vaccination is any safer than the intramuscular route in people taking anticoagulants. The subcutaneous route can itself be associated with an increase in localised reactions and advises that for those whose INR is stable and below upper threshold of their therapeutic range should receive the vaccine intramuscularly.' One wonders if this is unique to Influenza due to adjuvants and small dose volume or if this will in the future roll across the board for all vaccines administered to anticoagulated patients.

References

1. WHO International Travel and Health. Vaccination requirements for international travellers by country – International Travel and Health – 2018. http://www.who.int/ith/en/

2. NaTHNaC. Travel Health Pro. Country requirements for an international Certificate Of Vaccination or Prophylaxis (ICVP): key changes for 2018. 10 July 2018. https://travelhealthpro.org.uk/news/332/country-requirements-for-an-international-certificate-of-vaccination-or-prophylaxis-icvp-key-changes-for-2018

3. TRAVAX: Updated Yellow Fever Certificate and Vaccination Requirements WHO 2018. Accessed 21 August 2018. http://www.travax.nhs.uk/news/news-record-page?newsid=22719

4. Public Health England. Chapter 20: Japanese Encephalitis. Immunisation against infectious disease. PHE,11 June 2018. Accessed online on 21 August 2018. https://www.gov.uk/government/publications/japanese-encephalitis-the-green-book-chapter-20

5. Public Health England. Chapter 35: Yellow Fever. Immunisation against infectious disease. PHE,14 June 2018. Accessed online on 21 August 2018. https://www.gov.uk/government/publications/yellow-fever-the-green-book-chapter-35

6. Public Health England. Chapter27. Rabies. Immunisation against infectious disease. PHE,10 July 2018. Accessed online on 21 August 2018. https://www.gov.uk/government/publications/rabies-the-green-book-chapter-27

7. Public Health England. 3 July 2018.Rabies post-exposure treatment: management guidelines https://www.gov.uk/government/publications/rabies-post-exposure-prophylaxis-management-guidelines

8. Public Health England. Vaccine update: issue 282, August 2018, rabies special edition. https://www.gov.uk/government/publications/vaccine-update-issue-282-august-2018-rabies-special-edition

9. Public Health England. Chapter 19 . Influenza. Immunisation against infectious disease. PHE,15 August 2018. Accessed online on 21 August 2018. https://www.gov.uk/government/publications/influenza-the-green-book-chapter-19

Becky Swadling RN DTM (RCSPG) AMFTM.

A personal reflection: Female Genital Mutilation (FGM): delivering advice by a white, non-Muslim male

In all aspects of healthcare, the professional responsibility of reporting any concerns lies with each individual doctor, nurse or pharmacist. In travel health there is a greater opportunity to find travellers with young girls going to WHO-reported countries of high risk. Often these visits are for several weeks and will involve meeting family based abroad.

The regular training process covers what should be discussed at each consultation for children travelling to the high-risk countries and the emphasis is inferred that most of these consultations will be done by female staff. So how does a white, non-Muslim male, in a consultation room raise the topic of discussing the issue, without treading over the delicate line that the patient may consider any questions of a racial or discriminatory nature?

Having experienced this several times as a solo practitioner in a travel consultation, this is how I have approached the situation. First, remembering it is a requirement to discuss this with any patient or parents in the risk group that may be identified travelling to a high-risk country for an extended period of time. Secondly is to highlight to the parent(s) that you are aware of their travel arrangements and that according to the WHO map the country is of high risk. At the same time, I suggest an explanation that if this did happen abroad, it is also considered a criminal offence in the U.K and I have a duty of care to make them aware of it.

The reaction to this advice will probably produce a response from which the practitioner can gauge if further questions need to be answered according their training. To avoid conflict, I will offer to provide the written NHS advice in their own language or use an interpreter or interpretation app such as Google translator. I have used this technique with single mothers, couples and parents without any negative reactions to date. What I do often get is support for ensuring consistency across their community. I may be a white, non-Muslim male however the sensitive areas of racism and inequality can be managed with understanding.

Derek Evans, BSc(Pharm), MRPharmS, MPSI, Independent Prescriber, Travel Health Specialist and Consultant

A Study and Evaluation of the Global Issues surrounding Female Genital Mutilation (FGM)

Introduction

"Are women human yet? If women were human, would we be a cash crop shipped from Thailand in containers into New York's brothels...? Would our genitals be sliced to 'cleanse' us...? When will women be human? When?"[1]

The aim of this article is to discuss the current global issues surrounding FGM, and to evaluate the prevention and protection strategies.

What is FGM?

Female genital mutilation (FGM), also known as female circumcision or 'cutting', is a procedure in which a young girl has part of her genitalia removed surgically. There are four different types of FGM (see Figure 1):

Type 1 (clitoridectomy) – partial or total removal of the clitoris.

Type 2 (excision) – partial or total removal of the clitoris and the labia minora, with or without removal of the labia majora.

Type 3 (infibulation) – narrowing of the vaginal opening with creation of a covering seal, formed by cutting and repositioning the labia minora and/or the labia majora.

Type 4 – All other harmful procedures to the female genitalia for non-medical purposes, including pricking, piercing, cutting, scraping or burning the area.[2]

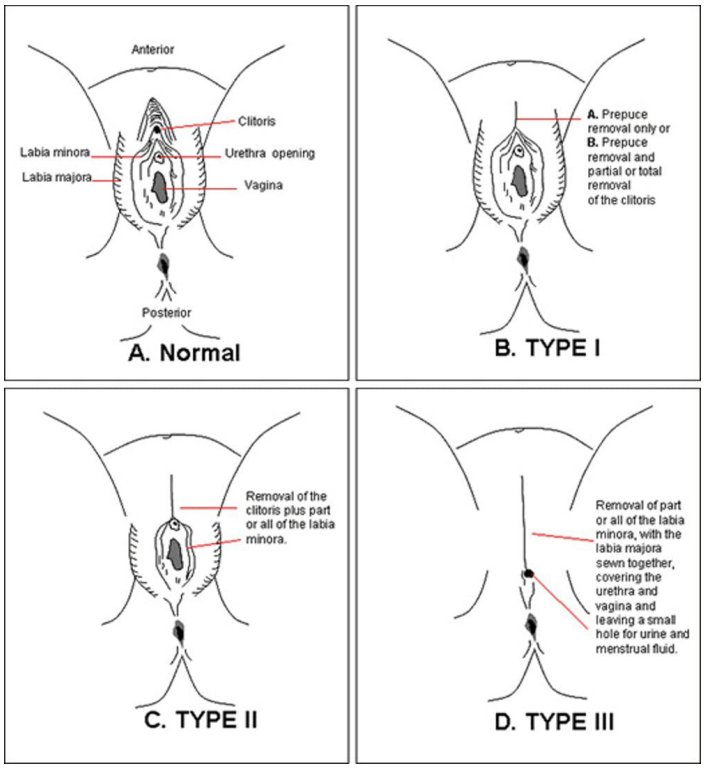


Figure 1: Types of FGM[3]

How is the procedure done?

Anesthetics are not normally used, and the genitalia is cut using knives, scissors, scalpels, glass and razor blades.[4] It is common for equipment to be shared and unlikely to be properly sterilized. Often girls don't know or understand what is going on and have to be restrained.

In Type 3 FGM the vagina is typically sewn up with wild thistle, leaving a small opening for menstrual blood and urine.[5] This technique is known as infibulation. To facilitate healing after infibulation, a girl's legs are often tied together, causing her to be completely trapped and immobile for a prolonged period of time. If a girl has been infibulated, the scar will be reopened by her husband on her wedding night either by using a knife or by forcing his way in.[6]

Cutting is often done by traditional birth attendants with no medical training, who have learned the technique from their mothers and grandmothers. These older women will have poor eyesight, and combined with unclean equipment this leads to many complications such as haemorrhage and infection.[7] In some countries FGM is carried out by medical professionals but this is much less common.

Why is FGM practiced?

Cultures that partake in FGM believe that cutting provides proof of virginity and therefore secures a girl's marriageability, giving her a better future. There is great pressure from family and community members for girls to have FGM done as it increases a girl's dowry, maintains family dignity and is a reminder of cultural identity. In 'Half the Sky' a midwife in Sudan states; "this is our culture, we all want it, why is it America's business?" She explains that she cuts girls at the request of mothers, and the girls thank her later in life.[5] The cost of FGM is one of the most expensive things a household will ever pay for and families see it as an essential investment, as without it their daughters will never make the marriage market.[6] Infibulation during Type 3 FGM is also done because of a belief it will protect daughters from being raped and maintain their honor to society. It also makes it possible to tell whether a girl is a virgin or not, and is a culturally accepted indicator of eligibility for marriage.[3]

Religion is a common excuse for the practice of FGM. Some Muslims say it is an obligatory part of their culture; however the procedure was around before Islam and is also practiced by Christians and followers of traditional African religions.[6] However there is no section in any religious text saying that FGM should be done.[4]

Removal of the clitoris reduces sex drive and pleasure for women during sex, and is therefore thought to make women less likely to be unfaithful or adulterous. Some cultures believe that removing the clitoris promotes cleanliness, as the clitoris 'poisons' the baby during childbirth.

"The prevailing wisdom in Somalia is that there are bad things between a girl's legs, part of our bodies that we are born with, yet are unclean…"[6]

The cutting of female genitals is thought to have first been done in Egypt around 2 thousand years ago, and occurred in some areas of Europe and America until the 19th century.[5] Typically, FGM is done before a girl is sexually active, so between birth and age 15. In Yemen, girls are cut within two weeks of birth however in Egypt it is done in the early teenage years.[5]

Where is the procedure done? See Figure 2

Data on FGM has been collected from 29 different countries, however FGM may actually be carried out in up to 42 countries.[8] It is known to occur mostly to girls in Africa, Asia and the Middle East.[4] UNICEF 2013 suggests 125 million girls have had FGM performed in Africa and the Middle East.[9] Approximately once every 10 seconds, female genital mutilation is performed somewhere in the world.[5] In African countries alone, an estimated three million girls are at risk of undergoing FGM every year.[2]

Refugees and asylum seekers have reintroduced FGM to the UK, with thousands of mothers who have been cut expecting their daughters to have the same experience.[3]

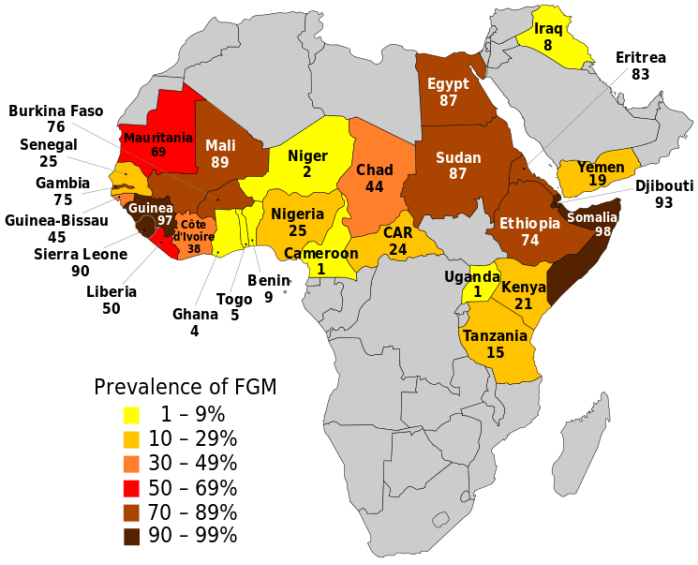


Figure 2: FGM Prevalence UNICEF 2016

Issues associated with FGM

Waris Dirie accounts her experience of FGM in her book 'Desert Flower', and remembers the death of her older sister due to excessive bleeding after she was cut. As a Somalian nomad, she recalls visiting towns and playing with little girls who, when she visited again, had disappeared.

"No one spoke the truth of their absence, or even spoke of them at all. They had died as a result of their mutilation – from bleeding to death, shock, infection, or tetanus. Considering the conditions in which the procedure is performed, that isn't surprising. What's surprising is that any of us survived."[6]

First and foremost there are health issues. There are no health benefits to FGM.[4] Instead, FGM leaves large numbers of women physically and psychologically damaged. Many girls die from FGM; however families often tell authorities that they died from malaria.[5] Scar tissue from FGM can cause death to a mother or her baby during childbirth as it increases the risk of obstructed labour and foetal distress.

The Royal College of Nursing subdivides the effects of FGM into immediate, intermediate and long-term complications (Table 1).[3]

Degree of complication	Effect on health
Immediate	▪ Hemorrhage, pain, shock ▪ Wound infections, sepsis, tetanus, vaginal fistulae, genital ulceration ▪ Bacterial and viral infections e.g. hepatitis and HIV as instruments reused and not sterilised ▪ Death
Intermediate	▪ Delayed healing ▪ Abscesses ▪ Vaginal scarring, obstructed menstrual flow ▪ Pelvic infections ▪ Obstruction to urinary flow ▪ Urinary tract infections (UTI's)
Long-term	▪ Post-Traumatic Stress Disorder (PTSD), flashbacks, trauma, depression, anxiety, self-harm ▪ Lack of trust in carers ▪ Vaginal closure due to scarring ▪ Epidermal cysts ▪ Neuromata ▪ Pain and chronic infection from obstructed menstrual flow ▪ Recurring UTI's and renal damage ▪ Painful intercourse ▪ Infertility ▪ Higher risk of HIV ▪ Perineal tears and vaginal fistulae during childbirth ▪ Postnatal wound infection ▪ Prolonged/obstructed labour due to tough scar tissue which can cause fetal distress, anoxia, and fetal death

Table compiled using information from RCN FGM report.[3]

Secondly there are legal issues. FGM has been made illegal in 18 African Nations and 12 industrialized countries, including the UK.[5] Strong support to abandon FGM can be found in international and regional human rights treaties and consensus documents.[10]

In the UK, FGM is a violation of The Human Rights Act 1998 Articles 3 and 8:

Article 3 – protection against inhuman or degrading treatment.
Article 8 – the right to respect for privacy and family life.

Furthermore, cutting girls under the age of 18 breaks laws surrounding child protection and is a serious safeguarding issue, of which anyone involved should be prosecuted.[8]

Existing Strategies to abolish FGM (UK)

It is a criminal offence to:

- perform FGM (including taking a child abroad for FGM)
- help a girl perform FGM on herself in or outside the UK
- help anyone perform FGM in the UK
- help anyone perform FGM outside the UK on a UK national or resident
- fail to protect a girl for whom you are responsible from FGM
- re-infibulate a woman following the birth of her baby, as this is seen as a form of FGM, within the WHO definition.[2]

Anyone who performs FGM can face up to 14 years in prison. Moreover, anyone found guilty of failing to protect a girl from FGM can face up to seven years in prison. These laws are enforced in England, Wales and Northern Ireland via the Prohibition of Female Circumcision Act (1985), Female Genital Mutilation Act (2003) and Serious Crime Act 2015. In Scotland, similar laws are enforced in the Prohibition of FGM Act (2005).[4]

In England and Wales, as of 31st October 2015, it is now mandatory to report cases of FGM on girls under 18 to the police.[3] Therefore, health visitors, midwives, school and community children's nurses have responsibility to ensure families know FGM is illegal and can act if a girl is believed to be at risk. This responsibility extends to all health professionals, including in the field of travel medicine.

In Sheffield, the family court recently granted police the right to issue protection orders and remove the passports of those at risk of being taken abroad to become victims of FGM, with eight of such orders being granted in Sheffield by November 2017.[11]

Risk factors and signs of FGM[12]

1. Girl aged 0–15 years.
2. Long summer holiday away to country of family's origin.
3. Girl becomes introverted, unable to focus on schoolwork.
4. Lack of effort and interest in academic studies.
5. Constant trips to the bathroom during the day.
6. Pain sitting down.

National Health Service (NHS) actions

To support girls in the UK that may be at risk of FGM, the NHS has put together a statement opposing FGM which can be downloaded online. The statement highlights the legal implications and detrimental health effects of the procedure.[4] An 'FGM Mandatory reporting duty' document has also been produced by NHS England, to give guidance on reporting FGM.[13] See Figure 3.

Support and Advice

Helplines support those who have had or are at risk of FGM. It is advised to call 999 if immediate danger of FGM is present, however in the case of a non-emergency, there is an NHS and National Society for the Prevention of Cruelty to Children (NSPCC) hotline dedicated to FGM.[8] Depending on the travel clinic setting, practitioners may be able to access their safeguarding manager or team and General Practitioners (GPs) should also be able to provide help and offer advice.

In recent years, many support groups and initiatives have been founded, involving police and practitioners, to raise community awareness of FGM. A successful example of this formula occurred in Bristol around 12 years ago, initiated by a local school nurse and a teacher. These women became aware of many people vulnerable to FGM in their area that weren't getting the correct support they deserved. They decided to collaborate, attended training on FGM in 2006, and later approached their local safeguarding children's board to develop guidelines for professionals to recognize and manage FGM.[3]

In 2013, the Official Intercollegiate FGM group was founded. This calls on healthcare, police, education and social work to implement strategies and safeguarding.[3]

Evaluation of existing strategies to abolish FGM in the UK

There are still many difficulties in implementing strategies to effectively stop FGM across the UK. It can be difficult to spot signs of FGM. Examinations are likely to be avoided by girls with FGM at all costs unless of a major health issue or childbirth. Often women affected by FGM will even avoid getting smear tests, so that their mutilation is not observed by the nurse doing the test.[3] Girls may be under tight control from their relatives, stopping them from having access to phones or the internet in order to call a helpline or download the statement opposing FGM. Even if the girl does manage to access the statement and show her family, it could have no effect and lead to punishment.[10]

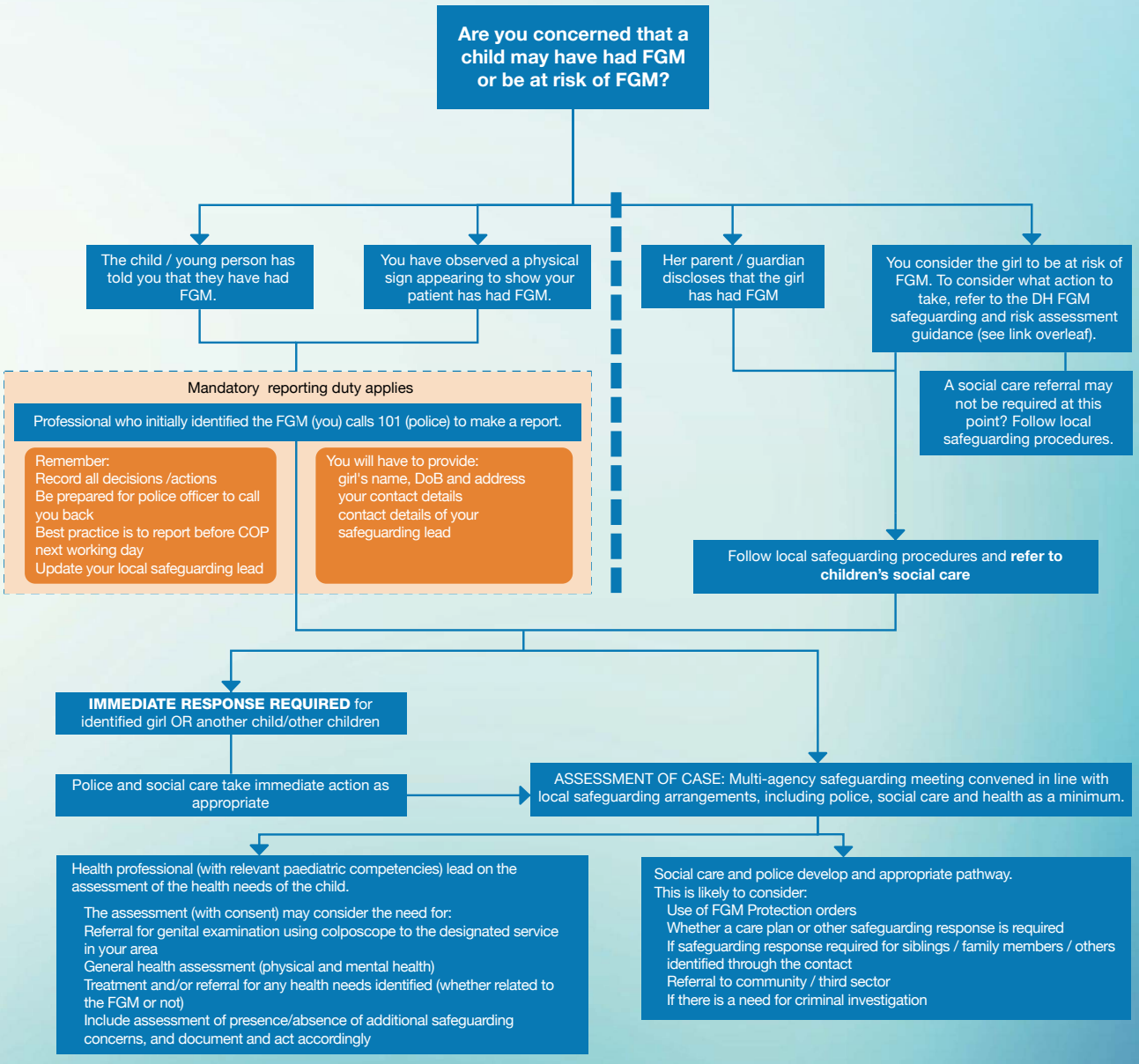
Furthermore, it is very difficult to build a strong law suit against the practice of FGM, often due to lack of evidence. FGM has been illegal for 30 years; however no-one has ever been convicted for the procedure, with approximately 6,000 new cases every year in England.[14]

Department of Health

NHS England

Female Genital Mutilation (FGM)

Mandatory reporting duty



If a girl appears to have been recently cut or you believe she is at imminent risk, act immediately – this may include phoning 999.

REMEMBER: Mandatory reporting is only one part of safeguarding against FGM and other abuse. **Always ask your local safeguarding lead if in doubt.**

Figure 3 NHS FGM Mandatory reporting duty[13]

"It's very hard to prosecute because you're asking a child to go into court and testify against their parents," FGM campaigner Hibo Wadere explains. "These parents aren't actually abusers in their mind, they think what they're doing is good for their daughters, so the children don't see this as child abuse."[15]

Because for many families FGM is embedded in their culture, they will take many risks in order to carry out the ancient tradition and any laws that are written will never be a real threat or deterrent.[15]

Existing strategies to abolish FGM (Non-UK)

Western campaigns against FGM began in the 1970s. Laws against FGM were passed in 18 African countries. Articles were written, and many meetings were held, however in the majority of countries where FGM is prevalent there has been no real change.[5] For example, in the 1960's Guinea ruled that FGM required the penalty of a life of hard labour, or if a girl died in 40 days after the procedure this resulted in the death sentence. Not one case has ever come to trial and today 99% of the population of Guinean women are cut.

In a documentary created by the International Federation of Obstetricians & Gynecologists (FIGO), the Magistrate of Djibouti states that education is the only way forward in the fight against FGM. He explains that laws are useless, as if everyone who was involved in FGM was prosecuted, the majority of Djibouti's population would currently be in prison.[7]

Tostan is a respectful organization that explains human rights and initiates discussion about health issues rather than lecturing, so that local people can formulate their own opinions on FGM. It was founded by Molly Melching from America, who had been living in Senegal since 1974 and was married to a Senegalese man with a daughter of their own.[5] Melching observed attempts by aid workers, who had no understanding of the community, attempt to abolish FGM and fail miserably. This was partly due to the fact that many Western campaigns included posters and television adverts, however the majority of Senegal's female population are illiterate and most families cannot afford a television. Tostan was launched in 1991, and provided three year classes for men and women covering democracy, human rights, problem-solving, hygiene, health and management skills.16 Additionally, Tostan organized group discussion regarding FGM with other villages where potential partners resided. This provided the opportunity for men and women to change their attitude on cutting, reassuring girls that they would get a husband in the future without mutilation.

Evaluation of existing strategies to abolish FGM (Non-UK)

Local projects such as Tostan have had a much bigger effect in decreasing rates of FGM. Project leadership is given to local people, who can be more authoritative and persuasive than foreigners in the surrounding community.[5] Over 2,600 villages in Senegal announced they had stopped cutting between 2002 and 2007.[5] Tostan's project was such a success, it became used in Senegal as a National model to stop FGM, and health officials across West Africa later adopted it on a regional scale. Tostan now works in Gambia, Guinea and Mauritania in West Africa, and Somalia and Djibouti in East Africa.[16] Tostan began to win international prizes, gaining financial support and recognition from the United Nations Children's Emergency Fund (UNICEF). Similar grassroots groups in Ethiopia and Somalia have also been successful, suggesting that the best results are obtained from 'bottom-then-up projects' involving local people and achievable goals rather than traditional aid projects.

Many resource-poor countries where FGM is practiced are rife with civil unrest, causing the government to have other priorities e.g. Somalia.[5] This makes it difficult to gain attention and support from the population, which are essential in making a National change. Furthermore, international workers are less likely to be willing to help in a dangerous environment.

Highly mobile communities are hard to educate e.g. Afar people in Ethiopia, as they are constantly on the move and will walk for weeks, stopping only to sleep and eat.[7] Tostan's method of a three-year teaching programme would be impossible, as there are no facilities or resources for three two-hour sessions each week, and teachers would have to follow the nomads in their journey across the country. Successful initiatives such as Tostan have identified that change must happen together. If a small group of women alone decided against FGM they would be branded unfeminine, and shamed for betraying their culture and causing their daughters to be spinsters. Instead, entire marriage groups must agree, an idea which Tostan has developed in their community initiatives.[5]

Future strategies (UK)

Children themselves are often completely unaware that they are in danger of FGM, with no understanding of the procedure or any of the risk factors.[14] Therefore, warning signs for FGM should be taught in all schools, so that girls whose families plan to take them back to their home country for a long holiday are aware of the possible intentions and can seek help. Guidance on FGM should be included in safeguarding training, so that all professionals who work closely with young girls know how to spot signs of FGM and are aware of the risk factors to prevent cases from happening. Further referral to local support services should be well-advertised and accessible in order for this strategy to be fully effective.[3]

Future strategies (Non-UK)

Although women ask to be circumcised, and insist on the same treatment for their daughters and granddaughters, the primary reason for wanting the procedure is to meet male expectation and become 'wife material'. Consequently, if male partners and community leaders changed their attitude about girls needing to be 'cleansed'

in order to marry, women would feel less pressure to be cut and FGM would decrease on a global scale.[7] In summary, education is the key to stopping FGM. Local and international projects should continue to inform and discuss with communities the health issues surrounding mutilation.

Conclusion

Female genital mutilation is internationally acknowledged as a major violation of human rights and a child protection issue which can cause grave mental and physical harm, including death. In the UK, many laws have been passed regarding FGM and multi-disciplinary support groups have been set up, with good results. In resource-poor countries, where FGM is a rite of passage for women, Western laws have had little effect. The best results in reducing FGM have come from grassroots projects involving local communities.

References

1. Title: Are women human? and other international dialogues. Page 112. Published: Harvard University Press Cambridge, MA 2007. Author: Catharine A. MacKinnon.

2. WHO website: FGM. Available from: http://www.who.int/reproductivehealth/topics/fgm/overview/en/ (Accessed 27/01/2018)

3. Female genital mutilation. An RCN resource for nursing and midwifery practice Available from: https://www.rcn.org.uk/professional-development/publications/pub-005447 (Accessed 25/01/2018)

4. NHS choices website: FGM. Available from: https://www.nhs.uk/conditions/female-genital-mutilation-fgm/ (Accessed 25/01/2018)

5. Half the Sky – How the Change the World. Chapter 13 (Pages 240-266). Published: Alfred A. Knopf, 2009. Authors: Nicholas D. Kristof and Sheryl Wudunn.

6. Desert flower – The extraordinary life of a desert nomad. Chapter 2 (Pages 24-36). Published: Virago press, 2001. Author: Waris Dirie.

7. 'The Cutting tradition' – film commissioned by International Federation of Obstetrics and Gynecologists (FIGO). Available from: https://www.youtube.com/watch?v=pUpToERm0q0 (Accessed 04/02/2018)

8. National Society for the Prevention of Cruelty to Children website (NSPCC): FGM. Available from: https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/female-genital-mutilation-fgm/signs-symptoms-and-effects/ (Accessed 25/01/2018)

9. UNICEF FGM Report – July 2013. Available from: https://www.unicef.org/media/files/UNICEF_FGM_report_July_2013_Hi_res.pdf (Accessed 03/02/2018). See 2016 updated map at: https://commons.wikimedia.org/wiki/File:FGM_prevalence_UNICEF_2016.svg (Accessed 02/08/2018).

10. Eliminating FGM – An Interagency Statement. United Nations. Available from: http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf (Accessed 05/02/2018)

11. Sheffield court grants protection over FGM risk – BBC news (17th November 2017). Available from: http://www.bbc.co.uk/news/topics/c40rjmqdq5wt/fgm (Accessed 04/02/2018)

12. Signs that a child may have already undergone FGM – NHS England. Available from: https://www.england.nhs.uk/north/wp-content/uploads/sites/5/2016/01/fgm-hp-guide.pdf (Accessed 04/02/2018)

13. FGM: mandatory reporting in healthcare. GOV.UK. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/525405/FGM_mandatory_reporting_map_A.pdf (Accessed 04/02/2018)

14. Lack of FGM convictions 'A UK scandal' – BBC news. 15th September 2016. Available from: http://www.bbc.co.uk/news/uk-37364079 (Accessed 03/02/2018)

15. The first ever FGM figures show nearly 6,000 new cases in England – BBC newsbeat. 21st July 2016. Available from: http://www.bbc.co.uk/newsbeat/article/36838870/the-first-ever-fgm-figures-show-nearly-6000-new-cases-in-england (Accessed 3/02/18)

16. Tostan website – FGM. Available from: https://www.tostan.org/areas-of-impact/cross-cutting-gender-social-norms/female-genital-cutting/ (Accessed 25/01/2018)

http://dx/doi/org/10.21864/jbgtha.2018.50

Isabel MacDonald
Medical Student, University of Glasgow.

Travelwise: the Journal of the British Global and Travel Health Association: Guidance for authors

Travelwise: the Journal of the BGTHA will consider for publication any material that is relevant to travel and global health.

Please read these guidelines carefully and check your submission meets their requirements to maximise your chance of successful publication. If you have any queries please contact the Editor during office hours, Monday to Friday:

Becky Swadling: **beckyswadling@gmail.com**
07980 925 811

Key message from the BGTHA:

We REALLY want to encourage new authors and practitioners with valuable experience to share!

The information below will help you to prepare a good piece but if in doubt, contact the Editor or send your work in anyway – editorial help is available!

Types of articles

Material should be identified by authors as:

Category	Description
Q&A	A short piece comprising a question posed by a practitioner or traveller (a couple of sentences) and an answer from you (approx. 200–300 words). Check that your answer is in accord with national recommendations, if appropriate.
How to...	Can you explain, as if to a colleague new to travel health, how to do something? E.g. injection techniques; manage a faint; record an incident; find/assess an injection site; reconstitute a vaccine; manage an unco-operative child, etc? Think of all those micro-skills you could share! Maximum 1,000 words.
Case study	Maximum 1,000 words describing a clinical case relating to travel medicine. It can be from pre-travel consultation; an episode during travel or describing the presentation and management of a returning traveller.
Review	*Review* with an abstract of not more than 300 words. Maximum 2,000 words of text not including references and abstract. Examples include literature reviews on a travel health subject, critical analyses, reviews of how to conduct travel health-related tasks such as assessment, imparting advice or education. Student Reviews – We welcome student reviews where the subject matter is relevant and relates to a student assignment from a UK University, re-written in a style to meet these guidelines.
In the News	Has something changed, been introduced or discontinued in travel health? Tell us about it in up to 500 words.
Journal Watch	Have you read a particularly interesting and important article relating to travel health? Please provide the reference, describe the content in 300 words and spend around 500 words discussing the implications or critiquing the topic.
Top Tips	A brief tip that would help another practitioner or traveller: universal plugs? Mooncups? Checks for dehydration? Up to 250 words.
Traveller's Tales	*In-country report*. Maximum 2,500 words. This describes local and/or traveller health and well-being issues in any country and can include descriptions of personal experience, projects, reports from an NGO etc.

Research papers	*Original article* with an abstract of not more than 300 words. These are usually items of primary research. Maximum 2,000 words of text not including references and abstract.
Education	Could you tell us about a study day, conference, course, book or website that has helped to further your knowledge – or is coming up this year?
Tales from the Travel Clinic	Has something funny or thought-provoking happened in your travel clinic? Tell us about it!
Miscellaneous	*Brief Communication or letter to the editor*, maximum 1,000 words. *Book reviews, conference reports, analyses of national guidelines, news reports* and similar short pieces are also welcomed.

Ethics

- *All submissions:* falsification or fabrication of data, plagiarism, including duplicate publication of the authors' own work without proper citation, and misappropriation of the work are all unacceptable practices.
- *Original research articles:* you must provide a statement to indicate appropriate ethical committee approval has been granted.
- *Anonymity* of individuals and places of work must be maintained in text and images unless accompanied by a statement that consent to identify has been obtained.
- *Conflict of interest:*
  Any financial interests or connections, direct or indirect, or other situations that might raise the question of bias in the work reported or the conclusions, implications or opinions stated – including pertinent commercial or other sources of funding for the individual author(s) or for the associated department(s) or organization(s), personal relationships, or direct academic competition – should be disclosed.

  If there are none, the disclosure should say: 'The authors have declared no conflicts of interest.' If one or a few authors have a conflict to disclose, further to that statement, there should be an additional statement for those remaining authors who do not have any, e.g. 'All remaining authors have declared no conflicts of interest.'
- *Acknowledging Travelwise:* the Journal of the BGTHA: Authors who wish to republish any manuscript printed in Travelwise: the Journal of the BGTHA should advise us of their intention and cite the Journal as first publishers.

Manuscript preparation

- *Title page.* Please copy and supply the following information:

Full Author name(s)	
Citation – (Highest degree only) for each author	
Title of Paper	
For non-research publications please provide a short description – one or two sentences describing the article. Research papers: please include full structured abstract up to 300 words.	
Contact details and organisation (including email) of the first (main) author.	

- *Layout*. Microsoft Word document, A4 size, any font accepted but suggest Calibri 11pt.
- *Diagrams, tables and figures.* Please supply separately from the Word document as pdf files. Images should be at the highest resolution (>300 dpi, or at least 1MB), ideally in JPEG file format (jpg). Ensure all are referenced appropriately if necessary and URLs are supplied if sourced from the web. State that permission has been received from the copyright holder (usually the publisher, not the author), for reproduction of other people's work. All tables and figures supplied as pdfs must also be cited in the Word document text and numbered in order of citation, e.g. Figure 1, Table 5.

- *Structure.* Make sure there is a logical structure to your submission, even if it is a short piece. Original research articles should normally contain an abstract, background, methods, results and conclusion. Most other longer submissions will require an introduction to state the main thrust of the topic, headings to provide a logical flow through the information, a conclusion to succinctly summarise the content, and perhaps to identify gaps in present knowledge and suggest future initiatives.

- *References.* All references must be cited by number in the text, tables, or figure legends. References should be numbered in the order of their occurrence in the manuscript. List all authors when there are four or fewer; otherwise, list the first three followed by 'et al.' The author is responsible for the accuracy of the references. Manuscripts accepted but not yet published should be designated 'in press'. Unpublished information in manuscripts submitted for publication should be cited in the text (not on the reference list) by name(s) of author(s) and 'personal communication' and should include the date of the communication.

- *References to journals* should include (in this order) authors' names with initials, article title, journal name, year, volume number, and inclusive page numbers.

  Example: Goodyer LI, Song J. Mosquito bite avoidance attitudes and behaviours on travellers at risk of malaria. Journal of Travel Medicine 2014: 21:33-39.

- *References to books* should include (in this order) authors' names with initials, chapter title, editors' name and initials, book title and edition, city, publisher, year of publication, and inclusive page numbers.

  Example: Goodyer LI. Travel Medical Kits in Keystone J, Freedman D, Kozarsky P, Connor B and Northdurft H. Travel Medicine, 3rd Ed. Elsevier Saunders 2012: *page numbers if appropriate.*

- *Internet references* are acceptable provided that they are official publications or comprise reliable, evidence-based information. The sequence is the same as for journals and books. The year should be the date the document was published online (if available). Include the full web address that takes you directly to the document, or as close as possible, and state the date that you accessed it.

  Example: Public Health England. Chapter 4: Immunisation procedures. Immunisation against infectious disease. PHE,2013. Accessed online on 8 February 2017. https://www.gov.uk/government/publications/immunisation-procedures-the-green-book-chapter-4

Submission

All articles must be sent as attachments by email to the Editor:

Becky Swadling: **beckyswadling@gmail.com**

Peer review

All submissions to the journal are initially reviewed by the Editor. At this stage manuscripts may be rejected without peer review if it is felt that they are not of high enough priority or not relevant to the Journal.

Research and longer papers are sent out for independent peer review. Based on the feedback from these reviewers and the Editor's judgment, a decision is given on the manuscript.

If a paper is not acceptable in its present form, we will pass on suggestions for revisions to the author.

Publication

Depending on the type of article, initial publication will be online at **http://www.bgtha.org/**

A CrossRef doi number will allow internet searches to identify research articles, increasing their influence.

A selection of articles is published in hard copy journal format each year.