Pre-Travel and On-site Medical Adherence and Compliance of Trekkers to Everest Base Camp

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Abstract: Trekkers to Nepal frequently succumb to a number of medical conditions, one of which is Acute Mountain Sickness (AMS). Many international trekkers do not familiarise themselves with tourist health care information prior to departure. Seeking out necessary health care information could be better managed by health care professionals and by the trekkers themselves before they leave home. Linking observance of pre-trip health advice sought to travel health outcomes, the study examines the healthcare information acquired among English speaking trekkers in the Nepalese Himalayas before departure on treks. Semi-structured in-depth interviews were carried out with twenty-eight participants. Each participant was interviewed either on a trek to Everest Base Camp, or after they had completed a trek and returned to Kathmandu. 17 females and 11 males ranging in ages from 20 to 70 years of age formed the participant cohort. The study was undertaken over a two-year timeframe while the author was in Nepal. Grounded Theory was used as the methodological approach to the data analysis. While older trekkers made visits to health care professionals, some younger travellers were less concerned about their health. Diarrhoea and food poisoning were common ailments hindering trekkers. Well known remedies for AMS – ‘go high, sleep low’ – ‘descent is the only cure’, were commonly cited as how best to deal with altitude sickness. Fewer than 50 percent of travellers confer with their GPs before leaving home. Of all medical conditions possible to contract, AMS was deemed the most important by all participants. Most mature-aged trekkers consulted with the doctors, while those under fifty appeared to see no need of any pre-trip medical consultation. All trekkers would be better served by consulting with a medical professional prior to departure. This then, provides a focus for both the tourism industry and the medical fraternity to achieve.

Keywords: Nepal; trekking age groups; mountaineering health; AMS; Diamox (Acetazolamid)


Introduction

 Authorities, travel agencies and the media sporadically release cautions about the subject of dangers linked to international tourism. Tourists are compelled to purchase traveller’s cheques, guide books and uncontaminated water, and to undergo inoculations as defence against many perils. As a matter of fact, questionnaires constantly document that wellbeing and health protection are notable matters for tourists holidaying overseas (Lepp & Gibson, 2003, p. 606; Poon & Adams, 2000). Nonetheless, direct research dealing with tourism and medication compliance and adherence is limited, in that, it has frequently only been investigated from within health-based research. This paper rectifies this anomaly through exploring these issues using a person-centred, social, inductive approach to trekkers in Nepal and their medication compliance and adherence arrangements. The single greatest
obstacle for tourism health care providers and the tourism health care trade has been convincing tourists to attend pre-travel health care guidance from a competent provider in a prudent manner. Preceding studies have found that only 44 percent of tourists went in search of medication assistance (Cossar et al., 2000; Leggat, et al., 2005, p. 30). Even though the percentage of global tourists who pursued pre-travel medication information and immunisation was comparable to the Cossar et al. (2000) and the Leggat et al. (2005)’s conclusions, there are no particular obligations for inoculation or malaria prophylaxis for Nepal (see http://www.traveldoctor.com.au/).

It is likely that global tourists had obtained travel health care advice for destinations other than Nepal, a possibility not examined in this study. As found in previous research (Cossar et al., 2000; Valerio et al., 2005, p. 30), the lack of pursuing travel health care advice by domestic travellers is not surprising. Nevertheless, some travellers from western and industrial global locations may be ignorant about specific risks (Valerio et al., 2005, p. 30) such as acute mountain sickness (AMS) (also known as altitude sickness) and malaria within Nepal. General Practitioners (GPs) were more likely to warn tourists regarding a variety of flight-related and geographical infection complications, possibly from their own tourism knowledge and experience. However, approximately two thirds of tourist health care clinics globally were typically offering information regarding schistosomiasis (parasite in the bowel) (Hill & Behrens, 1996; Seelan & Leggat, 2003). Previous studies have scrutinised health care information given regarding the topics of blood precautions, ecological ailments, cultural adaptation (Hill & Behrens, 1996; Seelan & Leggat, 2003), the perils of prohibited drug practices and defence against ultra violet radiation (Seelan & Leggat, 2003, p. 51; Usherwood & Usherwood, 1989). Many sources may be used in the delivery of tourist health care and medication advice and precautionary procedures. Facts regarding the hazards of a trekker’s journey objective and any detailed requests for travel health care and medication advice may be located from an assortment of data sources. These sources may include innumerable nationwide and globally advertised recommendations, other guides, audio visual promotions and electronic databases (Leggat & Seelan, 2003, p. 15).

This paper concentrates on how English-speaking trekkers to Nepal engaged in information seeking activities about trekking health and medications prior to their departure from their country of origin, whether such information was made readily available to them, and which organisations or health care facilities proffered the most comprehensive and up-to-date travel health information. The study aim is dealt with by first arriving at a perception of approaches for determining the importance of health advice before undertaking tourism. Second, differences in knowledge of risk and safety issues are explored. Recognising what facilitates or hinders access to pre-trip health and medication compliance and adherence knowledge for diverse groups of tourists has salient social connotations as it signifies an occasion not only to assess but also to respond to health knowledge transfer encountered by tourists. This in turn may justify modifications in the approach adopted by health care providers to ensure that tourists generally enjoy risk free, safe and healthy tourism.

Therefore, the current problem being addressed here is that many trekkers to Nepal do not seek or gain relevant and current information about the risks and danger involved in trekking to high altitude destinations. Of those who do, many remain in jeopardy through a lack of tacit knowledge being passed on to them. In some cases, general practitioners and health care providers are unaware or uninformed of the grave dangers this type of tourism presents. Thus, the objectives of this study are firstly, to examine the specific information acquired by trekkers to Nepal from their doctor or health care provider; and secondly, to examine how trekkers to Nepal deal with health problems they encounter on the trek.

Literature Review

Accessing trekking health advice pre-trip

Apart from Antarctica, only 2.5 percent of the world’s continents are situated above 3,000 metres; nonetheless, these elevations attract the traveller, trekker, mountaineer and climber, most of whom reside at sea-level (Rennie, 1976; Taylor, 2011). Acute types of altitude sickness strike at upper altitudes. High Altitude Cerebral Oedema
(HACE) arises in 1-2 percent of short-range trekkers between 3,000-5,000 metres and is typified by increasing brain dysfunction, ataxia, disorientation and abnormal conduct and can result in unconsciousness and loss of life. High Altitude Pulmonary Oedema (HAPE) transpires in two percent of mountaineers to 6,000 metres and is the most frequent origin of lethal acute mountain sickness (AMS). Indicators consist of rapidity of breathing, a cough and blood- spotted phlegm (https://www.traveldoctor.com.au/Page/Knowledge-Hub/Travel-Health-Fact-Sheets/Altitude-Sickness).

Additionally, according to Vardy et al. (2006), of all trekkers and mountaineers to Nepal, 10 percent succumb to AMS, HACE or HAPE at 3,000 to 4,000 metres; 15 percent at 4,000 to 4,500 metres; 51 percent at 4,500 to 5,000 metres; and, at over 5,000 metres, 84 percent. Due to the increasing understanding of altitude difficulties, contemporaneously there is only one fatality in Nepal for every 30,000 trekkers. But, even these casualties could be preventable if everybody knew how to react to AMS (Himalayan Rescue Association Nepal, 2013).

The concept of accessing tourist health travel and medication advice is of significance to medical sociologists as well as to other medical and health practitioners. Yet, within the realms of medical sociology, the specific area of research appears to be underexamined, and few social science projects that deal with tourism health issues are apparent in the wider literature. Nonetheless, it is apparent that tourists’ health issues and being informed about health risks and dangers while travelling are sites of intense interaction, but conversely, also sites of apathy and complete disregard, particularly by younger tourists. Consistent with Tissingh (2009), in a study of UK medical students, tourist health care is an increasing subdivision of medicine and has aspects that may make it appealing to potential doctors: convivial hours, interesting patients, stimulating pathology, beneficial research prospects and the adaptability for it to be linked with other specialisations. Regrettably, only a few doctors in training are conscious of it as a medical speciality and not many recognise what it really requires (Tissingh, 2009, p. 17).

In an Australian study of international tourists and the health care and medication advice they obtained pre-travel, Leggat et al. (2005, p. 30) found that wherever tourists have acquired tourist healthcare recommendations, research has indicated a first choice for seeing GPs reaching 65 percent, which is consistent with their conclusions for their research on global tourists to Australia. Even though other research has shown that global tourists frequently pursued information from travel agents (Cossar & Reid, 2004; Leggat et al., 2005, p. 30), few global tourists had been provided with tourist health care information or facts about local diseases or conditions. When travel agents do give information, there have been shortcomings observed in their familiarity with tourists’ health care concerns and in the health-related assistance they give to the tourists while they are travelling abroad (Grabowski & Behrens, 1996; Lobel et al., 1990; Leggat et al., 2005, p. 30).

Valerio et al. (2005) undertook a study with respect to high risk and low risk international travel from a Spanish perspective. They found that the delivery of tourist health care medicine in Spain is almost completely reliant on the bureaucratic services of Foreign Health (an official Spanish health service provider) or private health care providers. Still, sizeable municipalities did assign some tourist medicine services within preventative medicine or tropical medicine facilities, often, situated in third level hospitals. This model worked effectively for many years. However, since the mid 1990s, the continual expansion in population due to migration and tourism has had a negative effect. Presently these facilities are unable to sidestep widespread delays, particularly between May and July (the peak tourist season in Europe). This circumstance may be explicated to a certain extent by the absence of a triage approach; meaning that tourists can gain access to travel health medicine hubs irrespective of the potential risks of their respective journeys. Consequently, low risk tourists are frequently observed at a third level hospital in a similar fashion to those who embark on high risk tourism (Porter & Knill-Jones, 2004; Re & Gluckman, 2003; Thomson, 2002). In this case, the prospective gatekeeper function of the GP to concentrate on low risk health cases and to refer on high risk tourists is disregarded (Valerio et al., 2005, p. 327).

According to the UK-based project of Porter and Knill-Jones (2004), global tourism is becoming a customary experience for many, with progressively larger numbers of individuals undertaking additional excursions, increasingly to more isolated areas. They discovered that in 1949 there were approximately 26 million tourists internationally, of who 1.7 million were from the United Kingdom, but by 1990 this figure had increased to 429 million and 31.2 million respectively. By 1998 the overall number of global tourists was 625 million, and this number is anticipated to expand at an annual rate of approximately 4.3 percent for some time into the future (Porter & Knill-Jones, 2004, p. 347; WTO, 1999). Accordingly, it is reassuring that tourist health care medicine
as a focus has increased in scope and prominence. In the UK, the responsibility of delivering tourist health care information has been assumed significantly by the primary health care team, both for practical reasons (e.g. closeness of doctors to the patient and easy access to the patient’s health care documents) in addition to economic reasons (e.g. in England and Wales different fees can be obtained for providing inoculations). Primary health care teams appear content with this responsibility (Cossar & Reid, 2004; Porter & Knill-Jones, 2004, p. 347), while there are certain indications that the arrangement also benefits patients (Picot et al., 1993; Porter & Knill-Jones, 2004, p. 347).

The hazard of severe harm, or risk, is thought to be more serious for people when touring overseas (Bewes, 1993; Seelan & Leggat, 2003, p. 48). In Australia, the principal health conditions of returned Australian tourists recounted in a contemporary survey of travel insurance claims included respiratory (20%), musculoskeletal (17%), gastrointestinal (14%), ear, nose and throat (12%) and dental conditions (7.2%) (Leggat, 2002; Seelan & Leggat, 2003, p. 48). Fortuitously, few Australian tourists perish overseas and those that do perish usually prove to have had serious pre-existing ailments, such as heart conditions, or else were involved in disasters or some other misadventure (Prociv, 1995; Seelan & Leggat, 2003, p. 48). The research undertaken regarding the health of trekkers in the mountainous regions of the Nepalese Himalayas provides an insightful, if rudimentary, approach to the problem of pre-tour knowledge and medication and the quest to obtain astute advice and knowledge regarding trekking and health in the regions of Nepal. The next section sets out the research and methodological approach to the topic and explicates the data collection and methods undertaken for the research.

Methodology

The research was undertaken using a qualitative approach. The study focuses on English speaking trekkers in Nepal, and the health care advice they sought before departure from their home countries. The research that forms the basis of the work was undertaken over a two-year period. Nepal is a small country bordered by China (The Autonomous Region of Tibet) in the north and India in the south, east and west. It is a popular destination with young flashpackers journeying through Asia, while many older tourists and ‘repeat’ trekkers also travel to Nepal for both recreational and spiritual purposes.

The research was undertaken at many sites, and wherever trekkers congregate for rest periods or for overnight stays. Several interviews were conducted at the small hotel where the author stayed in Kathmandu. On the actual trek, many of the interviews were conducted at Lukla, the town at the beginning and end of the Everest Base Camp trek circuit. Many groups and trekking parties are often ‘stranded’ at Lukla, as it is notorious for inclement weather. As it eventuated, this meteorological circumstance proved conducive to collecting a great number of interviews for the research project. Both verbal and written permission to conduct the research was sought and obtained from the trekkers. All interviews were conducted in English. Ethics approval was applied for and granted from the author’s university. The owners of the hotel in Kathmandu and the trekking lodge in Lukla were happy to have interviews conducted on their premises.

A ‘snowballing’ and flexible technique was employed for the research project, where each participant would be interviewed and then would be asked if they knew of any other trekkers who they believed would be willing to partake in the research (see Ogan, 2007). Using this approach, ready access to participants was gained to complete the project. However, the limiting condition was the number of participants able to be interviewed (n=28) (Refer to Table 1). As open-ended in-depth interviews take a lot of time to complete, it is not always possible to interview everyone.

All participants in the project were assigned pseudonyms to preserve their anonymity, and to comply with the ethical requirements of the university. Each participant was also provided with an information sheet, informing them of the parameters of the research, and inviting them to participate in the research itself. Further, they signed Informed Consent forms which also advised that the interviews would be recorded. The form also served as a legal document that stated the signing participant was willing and able to take part in the research endeavour and to have the interview recorded, with a view to transcription later. Open ended, semi-structured interviews were undertaken with 28 participants. All participants came from many international points of departure, such
as: Europe, North America, Asia and Australasia. All participants spoke English. In some cases, English was not the first language of participants. The data was collected through face-to-face interviews with each participant at the research location. Each interview lasted up to sixty minutes. All interviews were recorded for transcription purposes. All the transcribed interviews were imported into NVivo. Thematic analysis was carried out on the interviews, using a hierarchical coding structure and subcategories for each node or theme (see Richards, 2009). Therefore, a grounded theory technique was employed as an inductive interpretative approach to ground the theory for the project in the data and thus concentrate on emerging categories or themes that the data itself provided (Charmaz, 2006). Grounded theory entails the compilation and analysis of data. The theory is ‘grounded’ in real data, which signifies the analysis and development of theories transpires after you have accumulated the data. It was pioneered by Glaser and Strauss in 1967 to legitimise qualitative investigation. Nonetheless, its usage is not constrained to qualitative investigations; it is a universal method that can be employed in many areas of research. Research is discontinued when you have reached theoretical saturation: the situation where you have appraised and scrutinised your data until you have expended all theories and revealed all data (http://www.statisticshowto.com/grounded-theory/).

The interview schedule, used as a guide, and consisting of eighteen questions, was asked of each participant. Standard demographic questions pertaining to age, gender, country of origin, and travel plans were asked initially. Other questions included inquiry about travel insurance, accessing health care services and medication before departure, awareness about vaccinations, and awareness about local diseases. Further questions were associated with written information about travel health concerns, documentation of vaccinations, and general health care while trekking in the Nepalese Himalayas and during the length of stay in Nepal. All the open-ended questions were developed through rigorous engagement with the literature (Bird, 2009; Charmaz, 2006; Lennie, 2006; Thorne, 2000) on global tourists and engagement with travel health care facilities prior to travel (Johnston et al., 2010; Cook, 2008; Turner, 2012). All participants approached were enthusiastic about their inclusion in the project.

Table 1. Demographics of English speaking trekkers in Nepal

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Age</th>
<th>Gender</th>
<th>First language</th>
<th>Trekking area</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>59</td>
<td>Female</td>
<td>English</td>
<td>Everest</td>
</tr>
<tr>
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<td>English</td>
<td>Everest</td>
</tr>
<tr>
<td>United States</td>
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<td>Male</td>
<td>English</td>
<td>Everest</td>
</tr>
<tr>
<td>Canada</td>
<td>34</td>
<td>Female</td>
<td>English</td>
<td>Everest</td>
</tr>
<tr>
<td>Canada</td>
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<td>Female</td>
<td>Spanish</td>
<td>Everest</td>
</tr>
<tr>
<td>Australia</td>
<td>38</td>
<td>Female</td>
<td>English</td>
<td>Everest</td>
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<tr>
<td>Australia</td>
<td>49</td>
<td>Female</td>
<td>English</td>
<td>Everest</td>
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<tr>
<td>United Kingdom</td>
<td>28</td>
<td>Male</td>
<td>English</td>
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<td>United States</td>
<td>59</td>
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<td>Australia</td>
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<tr>
<td>Canada</td>
<td>34</td>
<td>Male</td>
<td>English</td>
<td>Everest/Annapurna</td>
</tr>
<tr>
<td>Australia</td>
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<td>English</td>
<td>Everest</td>
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<td>47</td>
<td>Male</td>
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<td>Everest</td>
</tr>
<tr>
<td>Austria</td>
<td>27</td>
<td>Female</td>
<td>German</td>
<td>Everest</td>
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<tr>
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<tr>
<td>Switzerland</td>
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<td>Everest/Annapurna</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>53</td>
<td>Male</td>
<td>English</td>
<td>Everest</td>
</tr>
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According to Porter and Knill-Jones (2004), basic health care is characteristically a very disparate realm and it may consequently be expected that the elements of assistance differ extensively. When travel medicine was in its initial stages this may not have been noteworthy but with the escalating numbers of tourists, the accessibility of high-priced inoculations, and malaria chemoprophylaxis, the likely disparity in regulations becomes a central concern. Moreover, the appearance of diseases such as human immunodeficiency virus (HIV), the resurfacing of diseases such as tuberculosis, and the mounting challenge to malaria drugs increase apprehension (Porter & Knill-Jones, 2004, p. 347-348; Porter & Stanwell-Smith, 1992, p. 1323-1324). The data collected from the interviews forms the basis for the next section of the paper, which presents the findings of the research project.

Results

Seeking travel health information about trekking in Nepal

The participants in the research were interviewed individually, except for one interview, where two travelling companions related their joint experiences about pre-trip health and medication advice and how they dealt with any occurring illness and medications needed on the trek. As the overall sample is small, it cannot be extrapolated to the wider trekking population in Nepal. Rather, it can be used as a guide and a basis for further research. Each of the participants interviewed related their own individual experience of their trekking encounter. Countless numbers of tourists travel internationally each year. Obtaining current, factual, useful and accurate tourism health care advice is for many tourists, a personal choice. Some tourists are unaware of diseases and risks associated with tourism to particular countries (Leggat et al., 2005). Others are aware of the risks and hazards and prepare themselves pre-trip for both seen and unseen health eventualities that may occur during their tours (Boggild et al., 2007). Cautiously, it is approximated that up to thirty to fifty percent of tourists become unwell or hurt while on tour (Behrens, 1990; Seelan & Leggat, 2003, p. 48). One of the principal difficulties for health care providers and the tourism industry has been convincing tourists to engage with pre-tour health care advice from a reputable resource. One of the greatest significant influences in whether tourists pursue health care advice at all was the identified hazard and seriousness of tropical ailments (Seelan & Leggat, 2003, p. 48).

Specific information from doctor or health care provider

There has been limited research investigating the type of information offered by GPs and tourist health care clinics and whether printed information is provided (Seelan & Leggat, 2003, p. 48). When travelling overseas, and to developing countries, it is necessary to obtain relevant travel health information from qualified health practitioners. Many GPs and numerous travel health clinics provide tourists with up-to-date travel health advice, vaccinations for the many diseases they may encounter, prescriptions for medicines needed, and health alert warnings for the country/ies where the traveller has indicated they are going to travel. In this case, Nepal was the intended destination, and many of the tourists to that country attended either their local GP or a travel health
clinic to obtain information and health supplies, for the intended treks. As one Mexican woman, now living in Canada, who works for a Non-Government Organisation (NGO) recounted:

They gave me a pamphlet with a lot of information. Canada is very good at that you know, because a lot of Canadians when they travel abroad, to so-called Third World countries or developing countries [sic], they go through a lot of health issues. I’m a representative of one of them, because I’m really from Mexico, but I lived in Canada for many years, so I never really have health problems while living abroad. I’ve lived in a few countries like Brazil, Cuba, Mexico, of course, during the floods for six months in Bangladesh... Never really had a big problem, and so... Yeah, they offer you a lot of information... Lots of information, and they offer you all that, the repertoire of... you know medicines. But I don’t usually take anything (Female, Mexico, 30).

The notion of complacency is highlighted here. This young woman is aware of the risks of contracting infectious diseases and experiencing health problems while sojourning in a developing country but chooses to take no preventative measures or to have inoculations for such eventualities. There has been insufficient data made available regarding tourists’ acquiescence with recommendations afforded by GPs, practice managers and/or nurses (Leggat, 2000, p. 87). Indeed, one of the participants, an Australian woman, who had travelled extensively in Nepal, and had also been a trekking guide for many years, would attend a consultation with her GP and tell them what she needed for a trip to Nepal.

Usually I tell the doctor what I want [laughs]. Usually I advise people to go to their GP, and to access his book and see what is available with immunising at that time. Mostly it would be all the normal things that you have, your polio update, plus your tetanus, plus ahhhh... cholera and typhoid. I’ve always kept them up over the years, although they said it wasn’t necessary one time. It is necessary – cholera – in Nepal. Plus, your meningitis injection is important... and all different types of infectious meningitis, there’s the Japanese encephalitis one as well. But, I’ve never had the Japanese one, although, I’ve seen people with the Japanese one here. So, that is another one too. It is always necessary to keep up with all your injections, no matter if you went to Nepal or anywhere else, when you when to travel. So, that, even though there’s [sic] other strains of things. And you have Hep A, B and all that of course, because of food handling. I used to have the other one that was just before you left, but I think the Army took it all. I’ve forgotten what it was, a horse injection... (Female, Australia, 70).

This well seasoned, older tourist is acutely aware of the dangers of trekking without preparation. She is adept at knowing the health conditions in Nepal, as she has been a tourist and a trekking guide there for many years. Leggat et al. (2002) found that GPs in Australia generally obtained fundamental information from the tourists to customise travel health care advice for everyone. This material included tourists’ schedules, proposed living circumstances and pertinent previous medical and travel complaint history; topics thought significant when acquiring a pre-travel record (Leggat et al., 2002; Seelan & Leggat, 2003, p. 51).

Another trekker from the UK explained that he obtained his main travel health information from a local chemist. His narrative also indicates that it is not always necessary to access a GP or tourist health clinic for valuable tourist health advice.

I just said... I want something for diarrhoea, just in case, and the girl on the desk was amazing. She said, “Well, I’m not actually the pharmacist. I’ll phone him up because he has to tell you exactly how to take this medicine”. And the first thing he said to me was, “Get charcoal tablets as well”. So, he said not to take them within two hours of each other. So, that was really good information to have (Male, UK, 47).

This tourist and his approach to a pre-trip health care regimen show that there is more than one source of viable information regarding health when trekking, or when overseas, for that matter. Carter (1998) established in an analysis of health care as a recognised risk factor that whole regions could be specified as either hazardous or non-dangerous. Specifically, he found that North America and Europe are generally deemed to be risk free from contagious diseases, even though recent experiences may have contested this perception. Nevertheless, overall Europe was perceived as reasonably risk free with regards to health associated risks, even though tourists frequently consider Africa as a source of contagion, predominantly HIV. A connected analysis by Cossens and Gin (1994) mirrored these findings. They observed that health hazards emanating from a low-quality diet and water attributes are understood to be bigger in Asia and Africa than in Australasia and Europe (Lepp & Gibson, 2003, p. 608). This notion is further highlighted by another trekker who recounts her story of unexpected illness.
after dining at a reputable hotel.

I happened to eat a meal in a so called five-star restaurant the first night I was here and got very sick. Not only just diarrhoea but dysentery and [sic] parasitic and bacillic – both. And that’s through the first meal in a five-star restaurant hotel (Female, Australia, 63).

Hazards are to be found everywhere in foreign countries by tourists from the West. Eating or staying at a 5-star hotel does not actually guarantee immunity to any contagions or infections. According to Lawton and Page (1997, p. 95), for tourists, diarrhoea is the most conventional travel-related complaint and is principally linked with tourism to developing countries in tropical and sub-tropical zones (Williams, 2011). Incident levels may surpass 50 percent in some destinations and this complaint is brought about predominantly by consuming and/or ingesting unclean provisions or contaminated water. Several other more acute illnesses can also be gestated by consuming adulterated food or water and these include amoebic dysentery, bacillary dysentery, cholera, giardia, typhoid, viral gastroenteritis, worms and bilharzia or schistosomiasis (Bilharzia or schistosomiasis is a type of infection caused by parasites that live in fresh water, such as rivers or lakes, in subtropical and tropical regions worldwide) (Lawton & Page, 1997, p. 95). Indeed, a female trekker from Austria recounted the instructions her GP had provided her with concerning drinking the local water while trekking:

He told me what to do... just don’t drink the water. He also told me – it was interesting – to drink tea most of the time, if there’s not bottled water. He said, even if they wouldn’t boil it [the water] for long enough probably, there’s something in the tea that would kill a lot of germs... Yeah. Black tea. Something in the tea kills it [the germs] (Female, 27, Austria).

Reticence about consumption of impure water and other unsafe liquids is foremost in the thinking of Western tourists when travelling to less developed countries. As Lawton and Page suggested (1997, p. 91), the most customary complications confronted were gastroenteritis (Basnyat et al., 2001) and respiratory illness (Hackett & Roach, 2001). Consequently, health problems are progressively being acknowledged as an element to consider concerning risk management; and, as Wilks and Oldenburg (1995) contend, it is a dominant component in the provision of quality support to tourists (Baral et al., 2004). As well as seeking and obtaining accurate and specialist health information for trekking from suitably qualified health professionals, trekkers were then faced with dealing with health complications on the trail. This lead the trekkers to apply their knowledge and suitably prescribed medication for illnesses contracted while trekking. The next section details how the trekkers dealt with perils, dangers and infections on the trail.

**Dealing with health problems on the trek**

Many of the trekkers had concerns about Acute Mountain Sickness (AMS). AMS has several documented and well-known risk factors. Hou et al., (2004) found that many of the risk factors that indicated the contraction of AMS were: the ascent rate, the altitude attained, the sleeping altitude, and individual susceptibility (Hou et al., 2004, p. S54). Indeed, many of the trekkers had received conflicting information from their GPs and other sources about the use (and misuse) of the most commonly prescribed AMS drug - Diamox. Diamox (Acetazolamide) is the main treatment for AMS (Barry & Pollard, 2003; Ho & Siu, 2010, p. 33). Diamox improves the elimination of bicarbonates from the kidneys, which can re-acidify the blood. It also performs as a respiratory tonic particularly at night (Hackett & Roach, 1987; Ho & Siu, 2010, p. 33; Leaf & Goldfarb, 2007). The overall outcome of Diamox is to quicken the acclimatisation process. It can accelerate the process from between 24 to 48 hours and lessening it to between 12 to 24 hours. Diamox, however, is not an instantaneous treatment for AMS. The customary outcomes from its use are numbness, tingling and paresthesia (paresthesia is a sensation of tingling, tickling, prickling, pricking, or burning of a person’s skin with no apparent long-term physical effect). The manifestation of a paresthesia may be transient or chronic. The most familiar kind of paresthesia is the sensation known as “pins and needles” or of a limb “falling asleep” in hands, feet and lips and taste change (Ho & Siu, 2010, p. 33; Klocke, et al., 1998). The standard medication dosage of Diamox is 250-500mg daily. Individuals who cannot abide numbness and paresthesia can use a lesser dosage of 250mg; although the lowest possible effectual dosage is unclear. The only adverse reaction to Diamox is an allergic reaction to sulphurbased medications (Batchelor,
and medications not carried with them during a trek. This view reflects that of Basnyat Younger trekkers are full of complacency and possibly bravado, and this is reflected in their attitude to provisions (Female, Swiss, 55).

He said, "Do you mean I should walk by myself?", and I said, "Yes. That’s exactly what I mean". I was so angry I don’t want to get what you’ve got. I don’t know what you have, but I can clearly see that you are ill". And then he said, "No. You are old enough to think for yourself and to have at least an aspirin and a bandage". They always look...not only he [sic], but we were travelling with a group that had porters from the same company, and they were watching me too. So, he wasn’t the only bloke that was just giving the advice. So, it turned out being exactly as I read it in books or on the net (Male, Australia, 58).

Ever since being identified as an ailment, copious accounts about AMS in the medical literature have been issued. Broad community knowledge about AMS is also thought to have improved over the preceding 35 years (Basnyat et al., 1999; Dubowitz & Miller, 2001; Gaillard et al., 2004, p. 411; Hackett & Rennie, 1979). Despite these transformations, it is not identified if there is a greater recognition by average trekkers and if this improved knowledge supports a reduction in the occurrence of AMS; long-term data patterns of the prevalence of AMS are sparse (Gaillard et al., 2004, p. 411).

Many trekkers were very concerned and well informed about their own personal health issues and apprehensions or anxieties while trekking. As many trekkers travel in groups, and often with trekking companies, these groups are reluctant to allow ‘outsiders’ on the same trail to become a part of their inner circle. This may occur because they perceive that this may place a strain on the group and put them at risk of slowing the group down and delaying arrival at the destination goal, or perhaps they fear the risk of contracting an illness from an ‘outsider’ and again slowing down the group. Trekkers are very wary of this type of interaction because it can lead to a very costly and inconvenient emergency medical airlift out of the mountains. A Swiss woman travelling with her husband on a group trek found herself in this situation.

You know, I have seen many, not only young, people travelling without even an aspirin. And, when they are sick they, they... I don’t know what – “Can you give me an aspirin, can you give me this and that”, and I say “No. You are old enough to think for yourself and to have at least an aspirin and a bandage”. They always look to rely on other people. It’s not only young people. I’ve seen all this, seen that it is really stupid to travel alone. We have seen quite a few. Sometimes the way was like that [indicates slope], and like that [indicates again] and if you fall, no one would know there was anyone there. I told a young Finnish guy, “Listen, you are stupid”. He didn’t know where to go. Oh, he just hung with us and he was ill, and I said, “Listen I don’t want to see you close to us. If you want to follow us two hundred metres behind, OK. I don’t want to see you close to us, ‘cause we don’t want to get what you’ve got. I don’t know what you have, but I can clearly see that you are ill”. And then he said, “Do you mean I should walk by myself?”, and I said, “Yes. That’s exactly what I mean”. I was so angry (Female, Swiss, 55).

It is apparent then, that older trekkers plan carefully for their treks and for their health while trekking. Younger trekkers are full of complacency and possibly bravado, and this is reflected in their attitude to provisions and medications not carried with them during a trek. This view reflects that of Basnyat et al. (2001) who found
that illnesses and contagious infections at a high altitude frequently resemble those in bordering low-lying locations. Exposure to foreign agents, harsh environmental stressors, hypobaria, hypoxemia, immunomodulation, physiological acclimatisation, and inattentive actions can heighten vulnerability to disease causing bacteria or viruses. The eventual remedy may demand descent. Prevention is critical; both treatment and inoculation are vital. Plainly, more research needs to be undertaken on AMS illnesses to more fully comprehend their disease-causing processes and pattern of disease development and to advance remedy and avoidance (Basnyat et al., 2001, p. 1890-1891). In short, Boggild et al. (2007) observed that tourists and trekkers in Nepal are susceptible to a diversity of ecological dangers and their associated afflictions, incorporating AMS, wounds, lacerations and weather associated experiences. Issues freely linked with environment-associated disorders comprise of the male gender, an absence of pre-trip health advice and trekking for tourism; while AMS is linked to male gender, and trekking for tourism to later in life. The contrary link between environment associated disorders and pre-trip health advice probably suggests a lack of comprehension regarding the travellers, which is theoretically open to assistance. The growing acceptance of adventure tourism in developing nations being linked with the hazard of hypothetically life-threatening sicknesses requires a directed clarification for these people in a pre-travel situation (Boggild et al., 2007, p. 366-367).

Discussion and Conclusion

Tourists frequently attend consultations with their GPs before departing on trips overseas. Often involved in this occurrence is the acquisition of medications, appropriate inoculations and information on current health conditions and prevalent ailments to be avoided in the countries to be visited. As less than 50 percent of all intending Western tourists undertake the pre-trip consultation and inoculation sessions with their GPs (Cossar et al., 2000; Leggat et al., 2005), this research contends that trekkers in the Nepal Himalaya are risking their lives through poor engagement practices and a lack of pre-trip planning before undertaking the arduous pursuit of trekking in Nepal. However, many tourists to Nepal, especially those trekking for tourism, are at risk of AMS if they do not carry out preparations regarding this life-threatening condition before departure from their country of origin. As the participant sample is small, it is not proposed that the findings of the research are representative of all trekkers, English speaking or otherwise, throughout the Nepalese Himalayas. Indeed, the understanding of basic health care and of planning pre-trip for any eventualities while trekking may vary according to from those from countries where there are few high-altitude mountains, or where there are little opportunities to experience mountain tourism.

The research has shown through taking an inductive interpretative approach and grounding the theory for the project in the data collected, that many older trekkers to Nepal take their health care and risks associated with trekking in the Nepal Himalaya seriously. Conversely, many younger trekkers appear to have little or no apparent concern for their overall health while trekking in Nepal. Engagement with a health care professional before departure to a country such as Nepal for a trekking expedition amounts to personal choice. Many trekkers aged over fifty undertake risk and illness reducing behaviour, while many younger trekkers, it seems, do not. From the small participant sample examined here, it can be ascertained that many Western countries offer their populace informed and accurate pre-trip travel health information upon request. Moreover, many GPs do offer extensive advice regarding inoculations and diseases. The internet too, offers attention-worthy advice. Likewise, and according to the findings of the research, pharmacists are also adept at recommending accurate pre-trip health advice to trekkers. Anecdotally, the author has witnessed many younger-aged trekkers frequenting local pharmacists in Kathmandu to show them their ‘wounds’ and to obtain treatment. Many medically-based practitioners also gave suggestions regarding being wary about drinking local water. AMS was the biggest concern for most trekkers (including the author). If the symptoms of AMS are not clearly recognised and are shielded by the administration of Diamox, then life threatening illness, and in some cases death, will result. Many of the participants were aware of this but had met on the trail others who showed great disregard for any debilitating ailments.

Before commencing trekking in the Nepalese Himalayas tourists should become well informed about the risks and possible life-threatening situations they could encounter on the trail. Inoculations for major health ailments,
and the acquisition and administration of life-saving medications should also form part of the trekkers’ information and informed choice before departure from their home country. Many trekkers and mountaineers die in Nepal each year. An overarching approach to the pre-trip health and tourist wellbeing of those tourists to Nepal should become the joint focus of both the travel industry and the medical profession. With a view to overcoming the downfalls of access to, and provision of, accurate and potentially lifesaving information, joint research combining both medical and travel perspectives would be appropriate to expose trekkers attitudes to accessing and carrying out appropriate health care approaches to travel plans before their journeys begin. Interdisciplinary approaches can only serve to strengthen and inform those prepared to undertake the perils of trekking at a high altitude and the risk of contracting AMS. Further approaches to suitable and more informed considerations regarding better education of trekkers regarding their health needs may include mandatory information sessions and the active engagement of trekkers in their health needs and the risks pre-departure.

Finally, this research has contributed to the knowledge-area surrounding agency and free will of tourists and trekkers who travel to Nepal to experience high-altitude trekking in the Himalayas. Decisions pertaining to pre-trip inoculations, medications and travel health awareness were found to be important to the travel group of over fifty-year-olds; but, appeared unimportant to those of younger age-groups. This finding leads to implications from the results suggesting that compulsory health education before trekking in Nepal should be a mandatory regime. The limitations of this research were the number of participants able to be interviewed (n=28); and the fact that participants came from many international origins. All participants spoke English. But often, English was not their first language. It would be appropriate to undertake future research in this area jointly, from both medical and travel perspectives. This, in turn, would strengthen and inform those prepared to trek at a high altitude and risk contracting AMS. Further approaches regarding better education of trekkers should include mandatory information sessions about medications and AMS and educate trekkers about risks of AMS pre-departure.

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