MT*b*

BULLETIN of the NETHERLANDS SOCIETY for TROPICAL MEDICINE and INTERNATIONAL HEALTH

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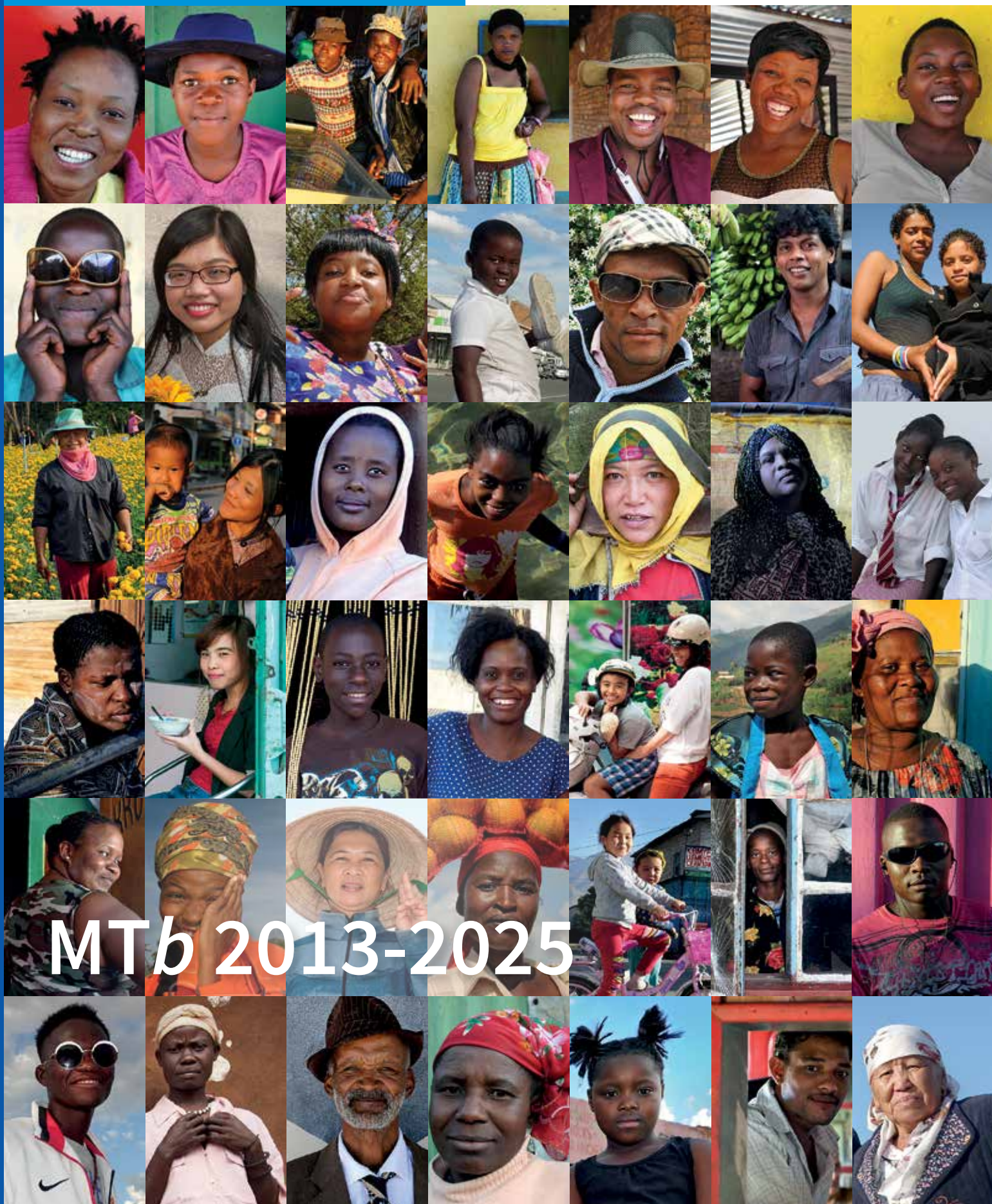


MT*b* 2013-2025

CONTENT

The finals, and the not-so-finals

This is the final editorial.

This is the final MT*b*.

This is the final quarterly published 'paper' Journal of the NVTG. But it is definitely not the end of our work.

Our ambition continues: to bring you a blend of science, first-hand reports from professionals in the field (young and seasoned), case reports, book reviews, and articles that explore new diagnostics, clinical strategies, and social approaches in global health. Our aim remains the same: to increase access to quality health care and to strive for health justice and equity, globally.

For this final edition of MT*b*, we also invited our editors-in-chief from the past twelve years to contribute something personal – from the heart. Some revisited columns they had previously written and others reflected on their career paths or spoke out on issues dear to them.

So, take a walk with us in this closing chapter – and take a step forward with us into a new beginning. One in which we will continue to present you with similar content in a new coat, a digital platform that offers the same rich content, now more accessible than ever to a broader audience. The new format gives us more flexibility to publish timely content on global health science, field reports, clinical cases and stories that matter.

Thank you, dear reader, for your continued support and interest. We welcome you to join us on our new and ever-exciting journey.

Esther Jurgens, Editor-in-Chief
Ed Zijlstra, Guest (co-) Editor-in-Chief

From Medicus Tropicus to Global Health Perspectives: a bird's eye view of sixty-two years

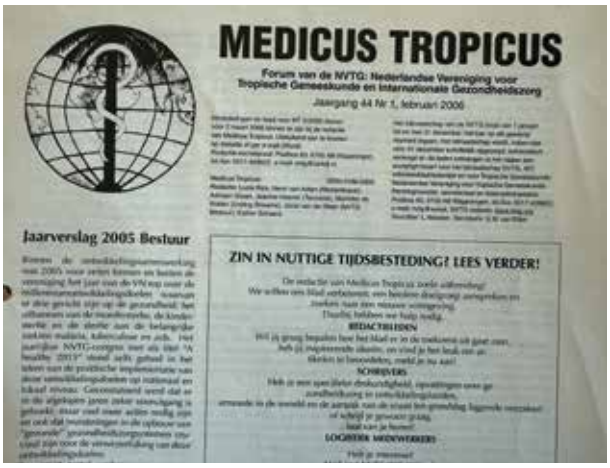
SAYING GOODBYE AND OPENING A NEW CHAPTER

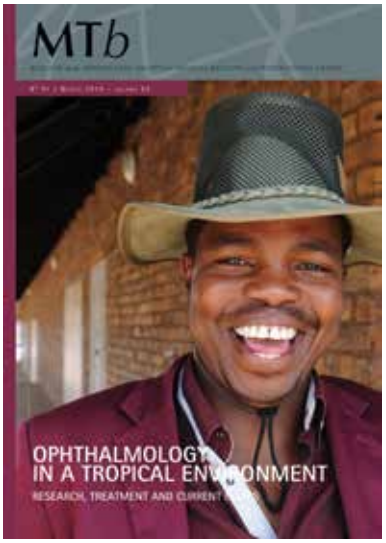
With pleasure I address a few opening words to mark this final edition of MT*b*.

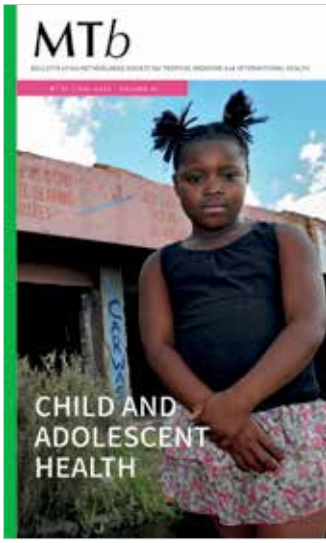
The Society, founded in 1907 by a small group of medical doctors, has come a long way. This moment – the transition to a new digital platform – coincides with another important milestone: a new chapter for the NVTG. From this year onward, we will go by a new name: the Netherlands Society for Global Health.

You have been part of this journey – one that we walked together and that began with the conversations sparked during the 2019 NVTG Symposium, Decolonising Global Health. Similar to the deliberate process that led to the renaming of our Society, the decision to transition the MT*b* Journal to a new medium was also taken with care. The shift to an online format was not taken lightly, but we recognised that the time was ripe as we saw the need to improve access, expand our readership, and provide more space to publish articles and perspectives that matter.

After months of preparations, the new platform is ready as this final edition of MT*b* goes to print. To our readers and contributors, I want to say, "Thank you". We are deeply grateful for your dedication and commitment throughout the years. And we are looking forward to your continued support as we step into this exciting new chapter.







Hanneke Dekker
Hanneke Dekker, Pediatrician, Physician Global Health
Chair of the NSGH (former NVTG)
Rijnstate Ziekenhuis, Arnhem

jhdekker.work@gmail.com

1963: THE BIRTH

The first edition of *Medicus Tropicus* was published in 1963, more than fifty years after the founding of the Netherlands Society for Tropical Medicine and International Health (NVTG). Initially, the magazine functioned primarily as a newsletter for the Tropical Working Group Committee (in Dutch: *Commissie Werkkring Tropen*, CWT) [1], a committee established to address the changing landscape for Dutch 'tropical doctors' in the wake of decolonisation.

Much like the CWT itself, the launch of *Medicus Tropicus* was foreshadowed by Prof. Oomen in his 1958 speech, in which he reflected on the shifting role and future of Dutch doctors following the decolonisation of Indonesia. [2] In its early years, *Medicus Tropicus* served as a contact publication, sharing news and updates from the Netherlands with those working abroad, particularly 'in the tropics'. It was meant to help maintain professional and personal ties between the Netherlands and its medical professionals overseas.

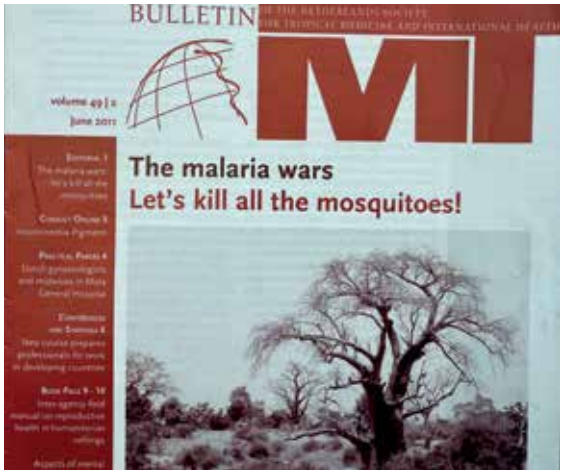
A few years after the magazine's inception, readers reaffirmed its mission: to serve Dutch medical professionals—whether working abroad or at home—and to possibly attract new members to the Society (NVTG). Having defined its audience and purpose, *Medicus Tropicus* was published on a bi-monthly basis.

Although closely linked to the CWT in its early years, the magazine's role evolved after the Commission was officially dissolved in 1973. [3] From that point on, *Medicus Tropicus* expanded its scope beyond its origins as a committee newsletter, gradually becoming a publication that represented the entire NVTG community.

1963 - 1970: THE ADOLESCENT YEARS

A positive side effect of *Medicus Tropicus* was that it helped attract new members to the NVTG. Membership grew significantly, from 222 members in 1962 to 751 by 1972. However, the abolition of the CWT and the gradual transformation of the magazine into a broader communication tool for the entire NVTG also triggered a moment of introspection: What should the role and status of *Medicus Tropicus* be in this new phase?

Despite its popularity among readers, active participation by NVTG members remained limited. Few showed interest in contributing content or joining the editorial board. This problem became more pressing when several long-standing editors expressed their desire to step down and make way for younger colleagues—though no successors had yet been identified. This raised an important question: Was the lack of involvement due to a generational disinterest, or was it a reflection on the magazine's format and content itself?



But as the saying goes, *never waste a good crisis*. The situation sparked a critical discussion about the future direction of *Medicus Tropicus*. Some argued that the magazine should move beyond internal updates and instead invest more energy in publishing engaging and relevant content. One proposed solution was to publish *Medicus Tropicus* as a supplement to the Tropical and Geographical Medicine (TGM) Journal—a publication that some believed should, in fact, become the official journal of the NVTG.

THE 1970S: TRANSFORMATION AND DEBATE

The proposed merger between *Medicus Tropicus* and the *Journal of Tropical and Geographical Medicine* (TGM) never materialised. For several reasons, the idea was abandoned—partly because TGM merged with *Acta Leidensia* and eventually, in 1996, became part of the European journal *Tropical Medicine & International Health* (TMIH).

Meanwhile, *Medicus Tropicus* underwent its own transformation. The magazine evolved into a platform for more substantial articles and – fittingly for the turbulent 1970s – a space for debate. These were years marked by heated discussions about the Netherlands' colonial legacy and the changing role of Dutch doctors in the emerging post-colonial democracies.

Under the leadership of a new editor-in-chief and with revised statutes, the nature of the magazine shifted. Members increasingly used the platform to reflect on current affairs and to question the role of Dutch health professionals in the field of international development. Not everyone welcomed this

new direction. Critics argued that the magazine should avoid polemics on colonial history and polarised discussions that, in their view, would not interest the broader membership.

Yet others believed firmly that such critical reflection was not only relevant but necessary. One comment in the magazine captured this spirit well:

"If there is criticism of medical development aid as a form of disguised colonialism, then we should be prepared to investigate whether our approach could have given rise to this accusation."

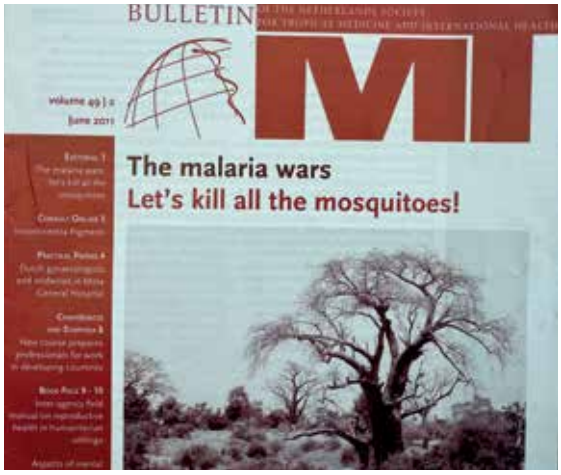
Ultimately, consensus emerged: *Medicus Tropicus* would remain the central forum of the NVTG—serving a dual purpose. It would continue to publish news from the NVTG Board, updates from working parties, training programme developments, and *International Health Alerts* [4], while also offering space for thought-provoking articles, commentary, and member contributions.

2007: A NEW LOOK AND A BROADER REACH

In 2007, *Medicus Tropicus* underwent a significant restyling, made possible through a subsidy from the NGO Cordaid. With the ambition to attract more contributions from international colleagues, it was decided to publish the magazine in English. At the same time, the editorial scope was broadened to include scientific articles, clinical case studies, and field reports – reflecting the growing diversity and complexity of global health work. A new name was introduced that honoured its legacy while signalling a fresh start: *MT, Bulletin of the NVTG*.

To expand its reach beyond the Society's membership, the magazine was also distributed in two pilot countries – Malawi and Tanzania. However, this international dissemination effort was short-lived. After one year, it was discontinued due to logistical challenges and high costs.

Three years after the launch of the newly styled magazine, an evaluation was conducted. Respondents appreciated the *MT Bulletin* for its readability, relevance, and editorial quality, affirming its value as both a professional publication and a platform for shared learning in international health.



2010 - 2025: THEMATIC ISSUES AND A NEW EDITORIAL STRATEGY

The evaluation of the *MT Bulletin* did not lead to major structural changes. Its main goal remained largely intact, as outlined in the *Editorial Statute of 2010*:

"To disseminate knowledge and information in the field of international health care and medicine in the tropics."

However, there were rumblings behind the scene. Editors felt that the magazine lacked focus, and in addition, attracting authors to provide articles was a tedious undertaking followed by a lengthy production process. More critically, the content of each issue tended to be a patchwork of unrelated articles, lacking a coherent thread. In itself, that would not necessarily be a problem, and could even be an advantage "as there would be something of interest for anyone". The lack of a common thread however led to a shift in editorial strategy: to produce thematic editions. This move allowed for deeper and more structured exploration of relevant themes in global health, approached from multiple perspectives.

Thematic issues soon proved to be a formula for success. Not only did it become easier to solicit contributions – as colleagues were now invited to write on specific, timely topics within their field – but the focused approach also improved planning and production efficiency. This new editorial direction brought renewed energy, a revitalised visual style, and a clearer identity to the publication.

Under a new name—still honouring its roots in the Society's history—some 44 editions were published between 2013 and 2025. These issues combined scientific insights with critical reflection, covering a wide array of topics within the field of global health including tropical medicine.

In line with these changes, and to accommodate the new quarterly publication frequency, it was decided that *International Health Alerts* would no longer appear in the print edition but would instead be published bimonthly on the NVTG website, enhancing both timeliness and accessibility.

LOOKING AHEAD TO A NEW PLATFORM: GLOBAL HEALTH PERSPECTIVES

Over the past two years, alongside the name change of the NVTG and the closer collaboration with both the knowledge centre (KCGH) and the training institute (OIGT), the editorial board has taken a critical look at MT*b*. It became clear that it was time for change.

To increase accessibility and allow for more frequent publication of articles, we've transitioned from a traditional paper magazine to a fully digital platform.

Why Global Health Perspectives? The term *Global Health* in our new title reflects our commitment to covering relevant topics across the entire global health spectrum. This includes, but is not limited to:

Infectious and non-communicable diseases; Comorbidities and mental health; Ethics in healthcare; Technological innovations and big data; Health systems and global health governance.

The word Perspectives represents our ambition to be a diverse and inclusive platform. As defined by the Cambridge Dictionary, perspective means "a particular way of considering something". Adding this noun makes our aim very clear: to offer a range of viewpoints, fresh insights, and solid evidence on urgent issues and dilemmas in our field.

WHAT STAYS, WHAT'S NEW?

Much like MT*b*, we will continue to publish articles within the broad scope of global health — now more frequently and more visibly. As part of the new structure, familiar categories remain, yet under a new heading:

- Consult online → under **Clinical cases**
- Letters from the field → under **Stories**
- Book reviews → under **Perspectives**

The thematic approach—so central to our editorial vision in recent years—will continue on the new platform under a fresh category: **Dossier**. One of the ongoing focal points will continue to be Migrants and Health (as published in December 2024), a theme that remains highly relevant and will be explored further in the coming months.

We believe that the transition to a fully digital format will significantly enhance both the visibility and accessibility of our work. With this step, we reaffirm our ambition to serve as an inclusive and low-threshold platform – a place where scientists, scholars, and practitioners can share insights, publish research, and engage in meaningful debate.

Our mission remains unchanged: to foster critical reflection and dialogue on the most pressing dilemmas and developments in global health today.

We warmly invite you to explore, contribute, and connect with us on the new platform.

Esther Jurgens, Medical Sociologist NSGH (former NVTG), Maastricht University

estherjurgens@xs4all.nl

**Note from the author: the historical overview in the first 3 parts draws on Leo van Bergen's book on the history of a hundred years NVTG, Netherlands Society for Tropical Medicine and International Health. His work provided valuable context on the history of the Society and the evolution of Medicus Tropicus throughout the past century of global engagement. See: Bergen, van L. (2007). Van koloniale geneeskunde tot internationale gezondheidszorg. Een geschiedenis van honderd jaar Nederlandse Vereniging voor Tropische Geneeskunde. Amsterdam 2007: Kit Publishers, NVTG*

Global Health Perspectives

1. The mission of CWT was to support Dutch medical doctors "in the practice of medicine in the tropics", a mission that was to be realised with the creation of new employment opportunities in the tropics for Dutch tropical doctors. In: Bergen van L. (2007)
2. Speech of H.A.P.C. Oomen in December 1958 on the changing position of the Dutch medical doctor abroad, and the future of the Dutch tropical doctor after the loss of Indonesia. He reflected on the "premature departure of many excellently suited doctors under the pressure of circumstances", but also on the question of whether the often curative training of the tropical doctors still matched the new demands that were made of them. This in view of the greater attention being paid to social-hygienic issues by the World Health Organisation (WHO) and various agencies of the United Nations that emerged from the rubble of the Second World War. In the speech, he also wondered how a new framework could be formed under the current circumstances, noting that the term 'tropical disease' did not actually exist. In: Bergen van L (2007).
3. Further reading on the function of CWT, the discussion on the role and position of Dutch doctors in decolonised countries, see Van Bergen L (2007).
4. IHA is a compilation of recently published journal articles or book reviews in the field of tropical medicine and public health in developing countries. It is published under the responsibility of the NVTG. and it aims to draw the attention of Dutch development workers and other interested readers to a broadly selected overview of recent publications in the above field. It appears six times a year in combination with *Medicus Tropicus* and is distributed among the members of the NVTG.

Medical Education in Global Health and Tropical Medicine

Ed Zijlstra served as editor-in-chief (ad interim) for three years, from 2020 to 2023.

It has been a pleasure to serve as a member of the MT*b* editorial board and editor-in-chief *ad interim*. I am most grateful to all my fellow editors and to all those who contributed to MT*b* for their commitment and expertise. The thematic approach proved to be attractive, and the digital library may serve as a source of reference.

I have selected Medical Education in Global Health and Tropical Medicine as the topic for this contribution as it offers an opportunity to compare, contrast and unify efforts in this field. From the Global South, I take the College of Medicine (now: Kamuzu University of Health Sciences [KUHeS]) in Malawi as an example, and from the Global North the training programme for Physician of Global Health and Tropical Medicine (PGHTM) in the Netherlands, now renamed Medical Doctor Global health (MD-GH).[1] What can we learn from the past and from each other?

MEDICAL EDUCATION IN MALAWI

The College of Medicine in Blantyre, Malawi, can be seen as a success story in medical education in Africa to which many partners contributed, including the Netherlands Support Program, funded by the Dutch Ministry of Foreign Affairs.[1, 2] Whereas in 1982 a delegation of the World Health Organization (WHO) and the Malawi Minister of Health agreed on establishing a medical school and decision to take this forward was made in 1986 by the former Head of State Dr Hastings Kamuzu Banda, it was not until 1991 that the school was actually established: the Malawi College of Medicine (CoM) in Blantyre, under the umbrella of the University of Malawi (UNIMA).[2, 3] The CoM adopted the format of a Bachelor of Medicine, Bachelor of Surgery (MBBS) programme. The first years followed a phased approach in which the first group of students who had completed their pre-clinical sciences in the United Kingdom, Australia or South Africa continued their clinical rotations (junior/senior clerkship and internship) in Malawi at the Queen Elizabeth Central Hospital (QECH), Blantyre. (Figure 1) In 1998, the first batch of students graduated who had been fully trained in Malawi.[1] The curriculum consisted of the classical format starting with two years of basic sciences; the third year focused on pathology, community health, and junior clerkships, with a research elective in year 4, and senior clerkships and the final MBBS exams in year 5. The curriculum was revised in 2008, with clinical teaching already integrated from year 1.

Figure 1a. The campus of the Kamuzu University of Health Sciences (KUHeS)

** Ed Zijlstra is Professor of Medicine and Former Head (1998-2009) of the Department of Medicine, College of Medicine (now: Kamuzu University for Health Sciences [KUHeS]) and was as such responsible for the undergraduate and postgraduate programme. He was chairman of the Concilium International Health and Tropical Medicine (Concilium Internationale Gezondheidszorg en Tropengeneeskunde) from 2015-2022 and chair of the Committee to review the Training Programme for Physicians Global Health and Tropical Medicine (CHOA) from 2018-2019.*

Figure 1b. The clinical wards of Queen Elizabeth Central Hospital; wards are often overcrowded with patients lying on the floor

The number of first-year students increased from initially 30 to 60 and later 100, with facilities both in Blantyre and Lilongwe.

After obtaining the MBBS, an internship of 15 months duration follows under the umbrella of the Ministry of Health, with clinical rotations in each of the major departments for 3 months. After this, the student may be registered with the Malawi Medical Council.[4]

The MBBS curriculum has always been community-oriented, and all students spend time every year in the CoM annex at Mangochi, along the shore of Lake Malawi for designated teaching. Quality of the teaching programmes is taken very seriously; every two years a curriculum review was organised for which national and international experts were invited. Second, for the final year examinations an external examiner was invited for each department to moderate the written paper and to attend the clinical examination sessions. The reports were discussed in the Board of Examiners meeting, and recommendations for improvement were formulated.

POSTGRADUATE TRAINING

After the first postgraduate programme in Public Health started in 2003, the clinical departments followed in 2004 and offered Master of Medicine (MMed) courses in Internal Medicine, Surgery,

Obstetrics and Gynaecology, Anaesthesia and Ophthalmology. These programmes consist of a part I and part II (two years each) as well as a dissertation. For the Department of Medicine, for example, during part I, the students work as registrars in the department supervised by senior staff. There is protected time for teaching. After passing the part I examination, part II followed, preferably in a country where the specialty is practised at the highest level. This is because the support services at CoM/QECH were not adequate to support clinical exposure. South Africa was in an excellent position, as it has the high level of care needed to provide a benchmark for the trainees, and a similar pathology as in Malawi as well as all other conditions relevant in high-income countries. Initially, these posts were funded by the National AIDS Commission (NAC), anticipating the need for specialists to deliver care for patients with HIV/AIDS.

STAFF DEVELOPMENT

In the first decade of the 21st century, the Netherlands Support Program from the Dutch Ministry of Foreign Affairs provided specialists in Internal Medicine, Obstetrics & Gynaecology, Surgery (including Orthopaedics) and Anaesthesiology to help with clinical teaching, as only few Malawian specialists were available. Twenty years after the start of the postgraduate programme, most members of staff are Malawian with subspecialists in plastic surgery, neurosurgery, respiratory medicine, neurology, haematology, pathology, endocrinology and renal medicine, among others.

A NEW UNIVERSITY

The Kamuzu University of Health Sciences (KUHeS) was established in 2021, in which the CoM and the Kamuzu College of Nursing (KCN) were amalgamated and became independent of the University of Malawi. This created more flexibility for expanding and budget control. KCN was established in 1983 and delivers a three-year university diploma followed by a one-year certificate in midwifery.[5] Other programmes in KUHeS include training for pharmacists, physiotherapists, and laboratory scientists.

REGIONAL TRAINING – INTERNAL MEDICINE AS AN EXAMPLE

The East, Central and Southern Africa College of Physicians (ECSACOP) was established in 2015 because of a shortage of internists in participating countries: Zimbabwe, Zambia, Kenya, Uganda, Tanzania and Malawi. For a population of 250 million, there are 1000 internists: a ratio of 1:250,000, whereas the WHO norm is 1:1000 population.

The ECSACOP provides a full-time training programme (fellowship) in carefully selected accredited training sites in each of the participating countries. The aim is to train locally, prevent unnecessary migration, benefit from each other's expertise, and aim for regional harmonisation; a Virtual Learning Environment (VLE) is created. There is an annual congress in which a ceremony is held for awarding the diplomas to those who have successfully completed the programme, thus qualifying for the title of Fellow of the East, Central and Southern Africa College of Physicians. (Figure 2) The programme is supported by the Royal College of Physicians of the United Kingdom (RCP) and the Africa office of WHO (WHO-AFRO). Currently, a debate is ongoing whether to keep the training limited to generalists in internal medicine or to proceed with subspecialties such as infectious diseases, renal medicine, endocrinology, etc.

Figure 2. ECSACOP graduates at the 2023 ceremony in Victoria Falls

Regional colleges that offer training in Africa

- COSECSA - College of Surgeons for East, Central and Southern Africa
- ECSACOG - East, Central and Southern College of Obstetrics and Gynaecology
- CANECSA - College of Anaesthesiologists of East, Central, and Southern Africa
- ECSAPACH - East, Central and Southern Africa College of Paediatrics and Child Health
- ECSACOP - East, Central and Southern Africa College of Physicians

RESEARCH

The CoM / KUHeS has always strongly promoted excellence in research and collaborates with partners such as in the Malawi-Liverpool-Welcome (MLW) programme and the Johns Hopkins Institute. Increasingly, research focuses on topics of direct relevance to public health and clinical care delivery such as malaria, HIV/AIDS and other infectious diseases. Increasingly, non-communicable diseases (NCDs) are also being addressed. Publications from Malawi abound in the medical literature. Research proposals need approval by the College of Medicine Research and Ethics Committee (COMREC). A Research Dissemination Conference is organised annually to provide a forum for (young) researchers to present their work.

In conclusion, setting up a medical school in Malawi was successful because of continuing political commitment, strong leadership - including a vision for the future - and varied international donor support.

THE TRAINING PROGRAMME FOR THE DUTCH PHYSICIAN IN GLOBAL HEALTH AND TROPICAL MEDICINE: A CRITICAL APPRAISAL

INTRODUCTION

The Netherlands Society of Global Health (NSGH) organises a unique training programme for Medical Doctor in Global Health (MD-GH).[A] The training programme was started in the 1950s,

	Duration	Content	Provider
Phase 1	12 months 12 months	Surgery or Paediatrics O&G	Dutch hospital accredited by RDMA
Phase 2	3 months	Course in Global Health and Tropical Medicine (NTC)2	Dutch hospital accredited by RDMA Royal Tropical Institute (KIT)
Phase 3	6 months	Global Health Residency	Hospital/organisation in LRS accredited by OIGT

Table 1. Structure of the PGHTM training programme as delivered by the Training Institute International Health and Tropical Medicine (OIGT). [6]

and in 2014 was recognised by the Royal Dutch Medical Association as a physician profile. It is a professional career step, not an added-on training. The programme prepares you to work as a medical doctor, advisor in public health, teacher or manager, or combinations. It consists of a mix of public health and clinical teaching and takes 2 years and 9 months to complete. (Table 1) It has a classical profile with core training in the Netherlands in accredited hospitals in surgery and O&G, both for 1 year; alternatively, a mother and child profile of O&G and paediatrics may be selected. This is followed by the mandatory Netherlands Tropical Course on Global health and Tropical Medicine (NTC) (3 months), which has a strong public health teaching component, covering disease control and prevention as well as health systems, finances, social and cultural issues, and ethics, among others.[A] There is also theoretical teaching in clinical subjects. There are 10 additional 1-day training courses in overarching topics (e.g., transcultural rehabilitation, ophthalmology, or dental pathology). After the NTC, a 6-month supervised global health residency follows in a low-resource setting (LRS) to consolidate what has been learned and to gain experience under supervision. This residency is not structured and may differ considerably among candidates.

A In this article, the former abbreviation of PGHTM will be used: Physician Global Health and Tropical Medicine for alignment with reports quoted in this paper.

B Now replaced by the Core Course in Public Health and Health Equity (CCPH-HE).

CHALLENGES: GAPS IN THE CURRICULUM, ASSESSMENT, ETHICAL CONSIDERATIONS AND OUTLOOK

GAPS IN THE CURRICULUM

The training profile of the PGHTM is seriously outdated, as it goes back to the 1980-90s. This pertains to the lack of formal clinical training in Internal Medicine (for all) and Paediatrics (for those in the classical profile). In LMICs, these specialties also include cardiology, respiratory medicine, neurology and palliative care, among other.

In 2020, the NSGH commissioned a curriculum review of whether the PGHTMs were adequately trained according to their own perspective as well as from the perspective of the host institute and/or international stakeholders. In the study by Isabelle Tiggelaar et al, *Graduates' perspectives on the Dutch post-graduate training in Global Health and Tropical Medicine: a qualitative study*, PGHTMs predominantly worked as clinicians; several were (also) involved in management or capacity building.[6] The clinical training programme adequately addressed general skills, but did not sufficiently prepare for locally encountered, often severe, pathology. While the generalist nature of the PGHTM training was appreciated by graduates, the programme would benefit from additional training on infectious diseases, non-communicable diseases (NCDs - normally the domain of Internal Medicine), and Paediatrics. It was not uncommon that gaps in the curriculum were addressed on the student's own initiative. These shortcomings led to feelings of a lack of competency and frustration and even burn-out; for some, it was a reason not to continue working in LRS.[6] Students would appreciate exposure to topics in the NTC earlier in the curriculum, while the total duration of the training programme should not be altered. Future outlook included a more prominent role as teacher, and teaching skills could receive more attention during the NTC. [6]

In the study by Jamilah Sherally et al, *The Dutch postgraduate training in global health and Tropical Medicine: international stakeholders' perspectives*, the theoretical knowledge of PGHTMs upon arrival was reported to be excellent; consolidation of skills and understanding of the local context were predominantly developed on the job.[7] More emphasis could be placed on NCDs, mental health, public health, development managerial skills and socio-cultural factors. The need for bilateral exchange and mutual ownership were emphasised.

THE CHANGING SCOPE OF TROPICAL MEDICINE AND GLOBAL HEALTH

While surgery and O&G have always played a major role (and still do so today), at the end of the 20th century, infectious diseases became a specialty in internal medicine and paediatrics. Previous optimism about, for example, infection treatment and control by antibiotics and control of malaria by chloroquine treatment and DDT spraying dissipated; malaria cases surged with high mortality particularly in children under the age of five years; antibiotic resistance emerged with force and continues to date. The HIV pandemic that started in the 1980s brought on a huge burden of infectious diseases. Initiated by Médecins Sans Frontières, Neglected Tropical Diseases (NTDs) were widely recognised as a serious neglected entity; this led to the establishment of the Drugs for Neglected Diseases *initiative* (Geneva, Switzerland) as there was a huge gap in research.[8] Major outbreaks of thus far unknown pathogens occurred as well as the return of forgotten infections. Antimicrobial resistance has become an increasing world-wide problem. This led to the concept of Emerging Diseases. (Table 2)

In 2011, the second meeting ever organised by the United Nations at the level of Heads of State was on NCDs (the first

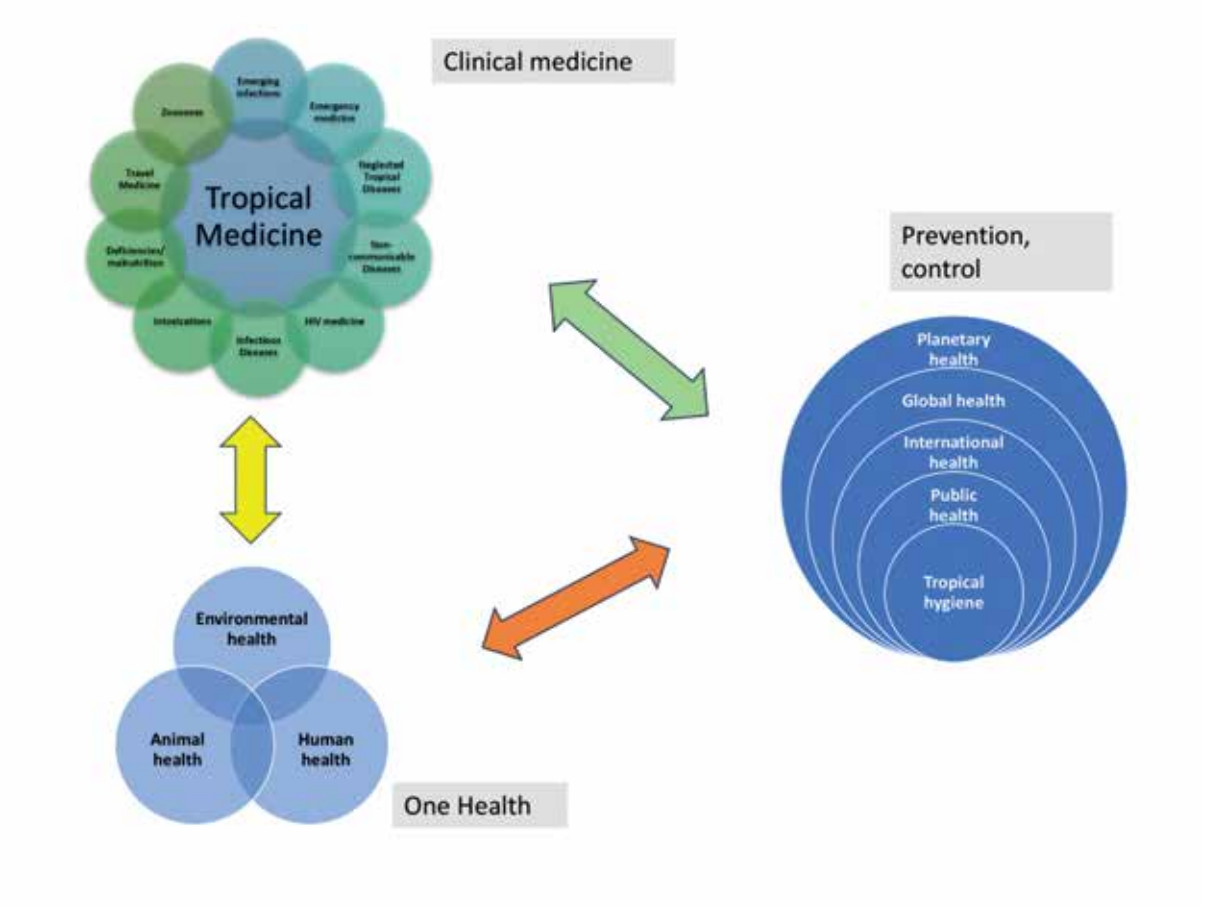


Figure 3. The three principal determinants of health in low resource settings

one in 2001 on HIV/AIDS). It is widely recognised that most deaths due to NCDs are in low- and middle-income countries. The NCDs have always been important in LMICs but have been seriously neglected/overshadowed by the HIV and tuberculosis epidemics. They include, among other, hypertension, diabetes mellitus (DM), asthma/COPD, cardiovascular disease and oncology. These are interrelated with other conditions; heart failure may be the result of acute rheumatic fever or HIV-related viral infections; cancer is common in HIV/AIDS and may include Kaposi's sarcoma (caused by human herpes virus [HHV-6]), cervical carcinoma (human papilloma virus [HPV]), or lymphomas (Epstein-Barr virus [EBV]). Hepatitis B and C cause liver cirrhosis while schistosomiasis causes periportal fibrosis. HIV increases the risk of stroke. The incidence of NCDs such as hypertension and DM increases with increasing obesity as the result of adopting western lifestyle and dietary habits, while DM may increase the risk of infections; an integrated approach is advocated.[9, 10]

The field of Tropical Medicine has expanded since Patrick Manson defined this specialty around 1900. While it included exotic diseases that occurred in warm climates and were associated with poverty, nowadays, it includes a spectrum of conditions and has a strong relationship with Global Health and One Health (Figure 3). Tropical Medicine may be considered as (Internal) Medicine in the tropics. Health workers who prepare for work in LRS should have knowledge about the different pathology compared to the Global North, and it may also vary per tropical region. For example, pathology and public health issues encountered in Thailand are different from those in Malawi or Ecuador. Knowledge about and adapting to a setting with different cultures, health systems and politics is essential. Tropical medicine should not be confused with or replaced by Global Health. While the concept of Global Health is valid, it seems a typical high-income country concept, and clinical medicine does not feature prominently; public health predominates as seems also to be the case in the PGHTM training.[11] Using Global Health and Tropical Medicine jointly (and jointly with One Health) adequately addresses differences as well as the overlap and is widely used, among others, to designate courses and scientific societies.

ASSESSMENT

Assessment relies heavily on awarding of Entrustable Professional Activities (EPAs) that are based on the CANMeds competencies. EPAs include professional activities or competencies entrusted by senior staff for trainees to perform activities without or with limited supervision once these competencies have been acquired. The Netherlands Association of Physicians (NIV), for example, has 4 compulsory EPAs (ward-based work, outpatient clinic,

consultations and on-call duties) reflecting 4 different patient populations and activities.[12] Acquiring EPAs should not be seen as a goal but as a means to support professional growth and to learn to work independently. Supervision is essential.[12]

Clearly the EPAs should be awarded by senior specialists in a setting of well-structured training such as the residencies in Surgery, O&G and Paediatrics. In the current training programme, EPAs for Internal Medicine (all trainees) and for those who do not do Paediatrics are awarded by the OIGT by proxy based on continuous quality assessment of the host institution.

ETHICAL CONSIDERATIONS

Taking Malawi as an example, graduates from the undergraduate programme do junior and senior clerkships (each 6 weeks) in all 4 main departments (Internal Medicine, Paediatrics, Surgery, O&G;) and sit for the final MBBS exam. This is followed by an internship of three months in the same departments in which they do clinical work under supervision, before being registered with the Malawi Medical Council. In comparison the PGHTM only have formal supervised clinical training in the two profiles and lack clinical skills and experience in subjects that are not covered. Despite this, they work as generalists covering and treating patients in all four major disciplines. This touches on professional ethics and should be discussed with the regulatory authorities in the Netherlands and the host country.

OUTLOOK

The current curriculum needs to be reviewed regarding training in clinical medicine:

1. The need for PGHTMs should become clear from the two studies quoted.

2. The emphasis of activities may shift from clinical work to teaching for which adequate skills are required.

3. All necessary skills needed should be provided in the training programme and not left to the initiative of the individual student (harmonisation).

4. The student should be adequately equipped and be self-confident (skills, remote support, etc) to avoid frustration and burn-out.

In the review of the PGHTM training programme, the following may be considered (see also ref [13])

1. CLINICAL TRAINING

a. All clinical training must take place in an accredited hospital setting.

b. It is essential that the PGHTM should have at least the same level of clinical exposure as the graduates from LRS and the CoM / KUHeS in Malawi in their junior and senior clerkship and internship; additional exposure at postgraduate level for 3-6 months may be needed. This would apply to all four major clinical specialties.

c. Keeping the current format of 2 years of clinical exposure would mean 4 attachments of 6 months each in an accredited hospital (*broad baseline training*).

d. The time allocated for training in Surgery and O&G in the current curriculum may not be necessary for everyone, particularly for those who will work in management or not in a low-resource setting, where it would seem a waste of time and resources. For most positions, limited training is sufficient, for example for Surgery in traumatology / emergency medicine as well as wound care, and for O&G obstetric emergencies. In many settings, ample expertise is available locally (consultants, experienced clinical officers) as well as options for rapid consultation (e.g. WhatsApp groups to that effect) and referral. In other remote settings, much more extended training is necessary to work independently. Early differentiation in a full or limited training may be considered (*differential or modular training*).

e. Training in Emergency Medicine should be compulsory (e.g. for 6 months) as the student would acquire quick and efficient diagnostic and management skills across all clinical specialities. It will provide triage skills and offers opportunities to train in traumatology, and all clinical emergencies as well as in additional skills such as drainage of ascites, pleural or pericardial fluid, performing bone marrow aspirates and ultrasound (*limited emergency medicine-based curriculum*).

f. An alternative and novel approach would be to make the entire clinical training Emergency Medicine based, in which the student would have a supernumerary appointment in the clinical departments to be able to follow up the patients admitted and to interact with the staff as well as to attend ward rounds, clinics and training sessions in each department (*extended emergency medicine-based curriculum*).

g. Another option would be differentiation in medical specialties (Internal Medicine and Paediatrics) and surgical specialties (Surgery and O&G) (*dual limited specialist training*).

h. Lastly, early differentiation may be considered in a single speciality e.g. O&G (*specialist training*). This would obviously mean the regular formal specialist training and will be outside the PGHTM programme, but with added-on training in Global Health and Tropical Medicine.

2. THE NETHERLANDS TROPICAL COURSE ON GLOBAL HEALTH AND TROPICAL MEDICINE (NTC)

The course has been replaced by the Core Course in Public Health and Health Equity (CCPH-HE); this course prepares "to systematically analyse and address complex public health issues, covering epidemiology, health system aspects, and broader social determinants of health. The course focuses on health equity in low-resource settings and high-resource settings with disadvantaged populations".[14]

a. A critical review is needed to compare this with other courses such as the Diploma and Masters' courses in Tropical Medicine and Hygiene courses such as in London,

Liverpool, Antwerp or Hamburg. Does the NTC / CCPH-HE provide the same standard or is it better to do a course abroad?

b. The course topics should be selected in close consultation with public health and clinical experts.

c. For clinical topics: theoretical exposure (lectures) can never replace clinical exposure or experience and cannot form the basis of EPAs.

d. Case-based sessions by experienced specialists contribute to a better understanding of severity and scope of the pathology that the student may encounter in the future; these should be placed early in the curriculum as an introduction to Global Health and Tropical Medicine.

e. The best teachers should be invited from the Netherlands or from abroad.

3. THE GLOBAL HEALTH RESIDENCY

a. The content of this attachment should be clear and standardised.

b. A student may select an accredited host institute according to what they can offer e.g. consolidation or advanced training, and/or experience in a certain specialty such as O&G or paediatrics, or a more generalist scope with well-defined supervised rotations in clinical departments.

c. The assessment by the host institute should clearly reflect the activities and performance in each subject according to what was expected.

d. The EPAs for infectious diseases and chronic diseases are awarded by the OIGT based on continuous quality assessments of the host institutes. Using this mechanism as a proxy for (hard) EPAs should be abandoned as it violates the meaning and purpose of awarding EPAs and may be misleading to regulatory authorities.

4. PROFESSIONAL AND PERSONAL SATISFACTION; WELL-BEING AND MENTAL HEALTH; CULTURAL ISSUES

a. In the study by Tiggelaar, most PGHTMs report a positive experience of their work in LRS. Others report frustration, feeling of incompetence / inadequate training and burn-out; all these are of serious concern and in part seem related to inadequate training. Professional and personal factors as well as the working environment all may play a role.[6] It should be clear where the PGHTMs can find support in case of mental or social problems.

b. Adapting to a different cultural environment is essential and this should have more emphasis in the curriculum. It is not only about humility, but about respect.[6, 7]

CONCLUSIONS

The medical education as offered by the CoM / KUHeS may be taken as an example of clinical exposure needed in this setting in all four major specialties, which should be matched in the PGHTM programme at least at the level of the internship and the first year of postgraduate exposure.

The PGHTM programme is unique and should continue to make a useful contribution to patient care and public health in low-resource settings, but only if its curriculum is credible and acceptable according to standards applicable to the host country. Recent insights will contribute to a thorough review of the curriculum (e.g. in the format of a curriculum conference) with the option for focussed training modules and appropriate assessment.

Eduard E Zijlstra, internist
Rotterdam Center for Tropical Medicine

e.e.zijlstra@roctm.com

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Disease	Year	Where *	Principal clinical features
HIV/Aids	Since the 1980s	Pandemic	Immunosuppression Multiple (opportunistic) infections * · Bacteraemia's · Sepsis · Respiratory infections including pneumocystis jerovici pneumonia (PjP) · Meningitis · Gastrointestinal infections including *S. typhi* and *non-typhi Salmonella* (NTS) · Tuberculosis, pulmonary and extra-pulmonary · Cerebral toxoplasmosis · Oesophageal candidiasis · Malaria Malignancies * · Kaposi's sarcoma · Cervical carcinoma · Lymphomas Neurological · Stroke · Polyneuropathies · Paraplegia
Covid-19 CoV-2	2019	Pandemic	Respiratory infection
MERS CoV	2013	Middle East (mainly Saudi Arabia); imported cases in Europe, Asia, USA	Respiratory infection
SARS CoV-1 (South Asia Respiratory Syndrome)	2002	South Asia (China)	Respiratory infection
Avian influenza H5N1 H7N9	1997 2012	World-wide China	Respiratory infection, systemic illness
Ebola	2014 2025	West Africa (Sierra Leone) Uganda	Haemorrhagic fever
Marburg Virus Disease	2024 2025	Rwanda Tanzania (?)	Haemorrhagic fever
Dengue	2013	Portugal, widespread	Fever, myalgia, headache, rash
Chikungunya	2007 2013	Italy Caribbean	Fever, poly-arthralgias, rash
Zika	1947 1960-1980s 2015 -2016	Detected in Uganda Asia Americas (Brazil)	Rash, conjunctivitis, arthralgia Congenital birth defects (microcephaly)
West Nile virus	2012	Europe, USA	Encephalitis
Q fever	2007-2010	Europe (Netherlands) USA, Asia	Fever, pneumonitis, hepatitis

Table 2. Examples of common infections, emerging infectious diseases outbreaks and pandemics since the 1980s and principal clinical features
** List not exhaustive*

A tribute to a 'Tropical Internist' - Ed Zijlstra

In a time when the world is changing rapidly, we have to say goodbye to a doctor who has dedicated much of his life to working for the good cause. Eduard Evert 'Ed' Zijlstra has officially retired as an editor of Medicus Tropicus *bulletin* (MT*b*). For thirteen consecutive years, Ed was a valuable and most certainly an indispensable contributor to the Editorial Board, in particular in upholding the quality standards of clinical contributions - articles, medical research, case reports - to the Journal. But who is Ed Zijlstra really? What else did he do besides MT*b*?

As a student attending his lectures during the Netherlands Course on Global Health and Tropical Medicine in 2014, one could hardly imagine what he did during his career. "An icon within the field of tropical infectious diseases", according to Martin Grobusch, Professor of Tropical Medicine at the Amsterdam University Medical Center. So perhaps it's time to dive into the past of E.E. Zijlstra.

Figure 1. The Zijlstra family en route in Luxor, Egypt

The best description of Ed would be a 'tropical internist', a medical specialisation not described in any curriculum. Ed, born in The Hague, studied in Rotterdam and started his specialisation in internal medicine at the former "Dijkzigt" hospital (now: Erasmus Medical Center). He was lucky, as back in those days it was already difficult to secure a training position. After spending time in Suriname (senior clerkship ObGyn) and Curaçao (military service), he decided to pursue a career in clinical tropical medicine. The MSc in Clinical Tropical Medicine in London marked the starting point of a lifelong dedication to those affected by diseases in tropical areas. To avoid just going on and on, we will divide his impressive career into three decades here by choosing a few highlights, each from a different decade: Sudan, Malawi, and the Drugs for Neglected Diseases *initiative* (DND*i*).

In 1989, he and his wife Helma started working in Sudan with Médecins Sans Frontières (MSF) during the Kala-azar epidemic, and became engaged in research with the Leishmania Research Group of the University of Khartoum. In 1995 he defended his PhD thesis "Kala-azar in the Sudan: Epidemiological and Clinical studies" at the University of Amsterdam.

The second decade started in 1999 in Malawi, the country that has a very special place in the heart of the entire Zijlstra family. Ed ran into an interesting vacancy in Malawi and convinced his wife Helma to come along with him to work on her specialisation, burn wounds. The deal was to go to Malawi, together with their two-year-old twins, for three years; it turned out to be ten years in the end. In a programme supported by the Dutch Ministry of Foreign Affairs, Ed became the Head of the Department of Medicine at the still young College of Medicine (established in 1991, and affiliated with the Queen Elizabeth Hospital, also in Blantyre). After a few years, in 2004, he was promoted to Professor of Medicine.

This was the time that the HIV epidemic was at its peak, with more than 70% of the inpatients being HIV positive, without access to ARVs, in a context where the authorities widely denied the existence of the virus. Besides teaching and doing research at what is now called the Kamuzu University of Health Sciences (KUHeS) (with a postgraduate programme that started in 2005), Ed invested a great amount of time in the improvement of the curriculum for the medical training programme. Over the years and to date, as Ed is still affiliated with the University as Professor of Medicine, he has taught many generations of medical students, with some of them now working as senior medical specialists, and others becoming professors or heads of departments themselves. All of this reflects Ed's continued dedication, which also makes him proud of their accomplishments in their personal careers. The journey back from Malawi to the Netherlands - by car, some 20,000 km in 3.5 months - was an unforgettable trip. Hard to repeat that now. (Figure 1)

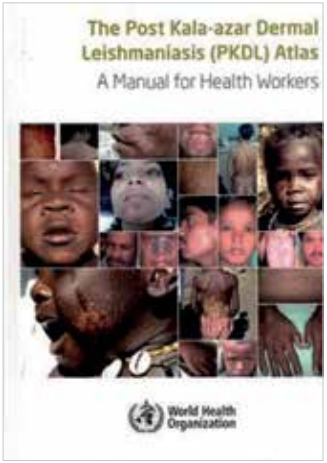

Figure 2. The PKDL atlas published by the WHO

His ambition to work in the field of tropical medicine continued in the third decade, during which he picked up his interest in Leishmaniasis, in particular Post-Kala-azar Dermal Leishmaniasis (PKDL): a skin condition that can arise after treatment of Kala-azar. (Figure 2) His interest in Leishmaniasis and in mycetoma was deepened through his work with the DND*i*: the Drugs for Neglected Diseases *initiative*, a non-profit research organisation founded by 5 partners (from government and research) with support of the World Health Organisation (WHO). [1] His work for DNDi was spread out over more than 13 years, from 2011 to 2024, a period in which a number of great advances were made in this particular clinical field, including WHO's official registration of mycetoma as a neglected tropical disease (NTD). Mycetoma, a devastating, slow growing infection (caused by fungi or bacteria) that destroys skin, muscle, and bone, can cause severe disabilities and stigma. It is one of the world's most neglected diseases. Adding the disease to the list of NTDs means

raising awareness (also among donors) and encouraging the development of new treatments. In this period, Ed also became Head of the Mycetoma programme and coordinated the first ever randomised clinical trial in mycetoma. It is also during this decade that Ed started contributing to MT*b*.

Ed is a prolific writer and author of more than 160 publications and three books. In the book *The Practice of Internal Medicine in the Tropics*, he presents 100 cases collected in Malawi that represent the entire spectrum of Tropical Medicine in LMICs. (Figure 3) It is a rolodex of pathology in the tropics, fully supported by a database of illustrative photos of extensive skin lesions and chest X-rays. Cases range from severe thrombopenia caused by an autoimmune reaction in HIV, to a massive abdominal ascites due to tuberculosis. There is truly no pathology that Ed has not seen. Ed has now retired from MTb, but he has not retired altogether. He continues teaching in the Netherlands and abroad. He still supports KUHeS with teaching and research, works on projects with PUM ((*Programme for Netherlands senior experts*), does consultancies for WHO, and continues to write papers and books. In the time left, he focuses on other passions like reading classical Greek and Roman literature, classical music, and his old-timer (and younger) cars. And finally, just between us, in the meantime, Ed will continue to cheer for his favourite soccer team in the south of Rotterdam.

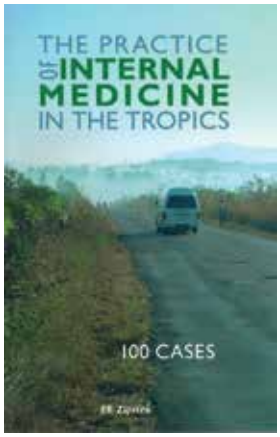

Figure 3. The 100 cases book

©
Jacob Van der Ende (former student of Ed Zijlstra)
Medical Doctor in Global Health, Quina Care

jacob.vanderende@quinacare.org

1. *The Oswaldo Cruz Foundation (Brazil), the India Council of Medical Research, the Kenyan Medical Research Institute (KEMRI), the Malaysian Ministry of Health, the Pasteur Institute (France) and the WHO Special Programme on Tropical Disease Research (WHO / TDR)*

The birth of MT*b* and a story with an unexpected revelation

Hans Wendte served as editor-in-chief for five years, from 2011 to 2015.

INTRODUCTION TO THE COLUMN BY HANS WENDTE

When I took over the position of editor-in-chief from Hans Borgstein, I was well- prepared. My role in MT*b* was closely entwined with that of Esther Jurgens. In our opinion, the existing Medicus Tropicus was inefficiently organised and not prepared for the future. Some questions had to be addressed urgently, like the independence of the editorial board, a lack of insight in the appreciation by our readers if any, the heavy burden of MT*b* on the budget, and the lack of contributions (papers). After two years of preparations and with the blessing of the board of the NVTG, I became editor in chief. We would surprise the readers with a bulletin of selected themes (idea of Esther) often prepared by a guest editor of one of the working groups. The new MT*b* was published quarterly, in English, in full colour, and was also available digitally. The graphic design studio - 'Mevrouw van Mulken' - did the restyling, and every issue had a cover photo by the photographer Hanneke de Vries. We kept the letters MT in the title as a compromise to comfort some distinguished NVTG members.

Since my own contributions to MT*b* in the years after I left were limited, it is my pleasure to contribute to the final issue with a column I wrote that was published in Emphasis, the Journal of MFAS (Medical Faculty Amsterdam Students, AMC), back in 2009. I wrote this column on the swine flu epidemic, illustrating the dynamic between disease, politics and economics.

This dynamic continues to play a role. Examples include the COVID pandemic, the rise of non-communicable diseases in low- and middle-income countries, and the recent measles outbreak in the USA. The occurrence of disease is determined by so much more than the biological pathophysiology alone. Please consider this column from 2009 as an additional illustration of this dynamic.

FOLLOWING JUDY TRUNNELL'S DEATH

Judy Trunnell, a teacher, was the first American citizen who passed away due to complications of an Influenza A H1N1 infection. On May 5th, 2009, she died, while 8 months pregnant.

Thankfully, the doctors were able to save her unborn child through a caesarean section. She left behind a husband, who, devastated, filed a lawsuit against Smithfield Foods. Smithfield is the largest pork producer in the world; in 2006 the company slaughtered 26,000,000 pigs globally. In the USA, Smithfield supplies a quarter of all pork, and McDonald's is a major customer.

The disease was named Swine Flu (initially), much to the dismay of the pork industry. Smithfield's stock price dropped dramatically, well below the Dow Jones Index average. Understandably so, as their pig farms in the village La Gloria, in Veracruz Mexico, were regarded as the source of the outbreak of this flu. Four-year-old Edgar Hernandez is thought to have been the first case. Fortunately, he survived.

Panic ensued at Smithfield, which didn't have the best reputation to begin with: bad for the animals, bad for its employees, and now a threat to humanity at large as well. Earlier, Smithfield's environmental practices were described by Felicity Lawrence in Eat Your Heart Out: Who Really Decides What Ends Up on Your Plate? (2008). In 1997, the company illegally dumped waste in the Pagan River in Virginia, and subsequently was fined 12.6 million US dollars. It concerned 4,700,000 gallons of faeces, heavy metals, antibiotics, hormones, etc., etc., which was also rotting in the lagoons and pools around the company's facility in Mexico. According to the Mexican newspaper La Jornada, clouds of flies multiplied there.

Panic ensued in Mexico as well. Politicians and businessmen feared major economic damage. Hotels closed their doors; the flu was coined the 'Mexican Flu' colloquially - an unjust label, leading the WHO to rename the flu H1N1. But it would always remain 'Mexican Flu' in people's minds.

Meanwhile, Smithfield tried to salvage its reputation. On May 17th, C. Larry Pope, Smithfield's CEO, proudly announced that health experts from the Mexican government had confirmed there was no flu virus present in Smithfield's pigs in La Gloria, a facility co-owned by AHMSA (Altos Hornos de México, a steel plant in Mexico). He also emphasised once again that the Centre for Disease Control and Prevention (CDC) in Atlanta and other scientific bodies had stated that one cannot contract flu through the consumption of pork or pork products. Nevertheless, he promised that Smithfield would take extraordinary measures to rigorously enforce global biosecurity procedures.

Smithfield's lawyers threatened legal action if Tracy Worcester's documentary Pig Business were to be aired. The documentary delves into the practices of Smithfield Foods, holding the company responsible for massive environmental pollution around its pig farms and for the health problems of local populations. It also critically examines the quality of our food and animal welfare. People living nearby are more likely to suffer from asthma, nausea and headaches. Local fishermen reported large fish die-offs nearby, which was already reported in the book Crimes Against Nature by Robert F. Kennedy Jr. [1] Worcester's film was produced in 2008, but by June 2009, still no one had dared to show the film. Smithfield claims that its contents do not reflect the current situation. Finally, the documentary was aired in a censored version.[2]

However, there certainly are concerns. Virologists at the CDC, through using genetic fingerprinting techniques, found that the virus strain was the same as the one first identified on industrial pig farms in North Carolina. Felicity Lawrence called it The Pig's Revenge in The Guardian (May 2, 2009).

I wish Judy Trunnell's husband much strength in his legal case.[3]

Dr. J.F. (Hans) Wendte
Retired lecturer Public Health, AMC, Amsterdam

hanswendte45@gmail.com

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2. Documentary available on: https://farmsnotfactories.org/pig-business
3. As of current publication date, no additional information was found on the outcome of Trunnell's legal case. It is unclear if Trunnell followed through with his suit against Smithfield Foods. See https://time.com/archive/6933522/h1n1-virus-the-first-legal-action-targets-a-pig-farm/

It's never too late to do a PhD

Even those without sight can see a haunting phantom drifting through our world called autocracy. Our work field is under siege; the World Food Programme and USAID have been erased by dictatorial authority. In the past, justice used to be a strong check on the abuses of power, but today, in the daily dazzle of distorted logic, we see autocracy dismantling justice at high speed. It's not just the future of our own work field, as international law and the most basic moral principles are at stake. Despite the Dutch government slashing 50% of the Development Cooperation budget, our work remains crucial: poverty, maternal mortality, tuberculosis, and HIV will not disappear by ignoring them. After critically assessing this onslaught, I anticipate that non-governmental organisations will soon develop significant new forms and modus operandi. Moreover, resilience is our trademark.

Figure 1. After the successful PhD defence. Photo by Angel Pinxten

In these gloomy days, I want to boost your morale and tickle your curiosity by arguing that it's never too late to do a PhD. Perhaps this is the right moment to deepen or redirect your career and start an academic adventure tour. Before delving deeper into my own research journey's why, how, and substance, I will first take you through some pivotal experiences in my 35-year international health career that prepared the ground for my recent PhD.

INFECTED

In 1990, I began my international health career at the Queen Elizabeth Central Hospital in Blantyre, Malawi. To become a competent 'tropical doctor', I completed an extensive 18-month rotation under the guidance of dedicated Dutch and international specialists. During this time, Prof. Anthony Harries introduced me to the clinical aspects of tuberculosis and HIV. He infected me with a lifelong scientific mindset through a joint study on the cost of antibiotic treatment. [1]

Later, as a district health officer in several Malawian district hospitals, I found myself overwhelmed by hospital management issues and especially by the tsunami of patients with HIV infection. We also had no treatment available yet in those days. This demanding environment left little room for research activities, but an inquisitive mindset helped win a big EU grant for the new Thyolo District Hospital.

CURIOSITY

In 2000, after nearly a decade in Malawi, I accepted the technical lead to revise and integrate the Indonesian national leprosy and tuberculosis specialist curricula in Makassar, Sulawesi. The Makassar National Leprosy and Tuberculosis Training Centre (PLKN) played a vital role in training young doctors, postgraduate specialists, and nurses. The diversity of training backgrounds highlighted the need to identify each professional's specific training requirements. In response, our curriculum team established several problem-based learning modules based on a strong set of core competencies. However, this top-down approach resulted in a relatively rigid, one-size-fits-all training structure.

During this traditional curriculum development process, I became curious whether building a training from the ground up using self-assessment and asking professionals about their actual learning needs would result in a more flexible training and learning process, better tailored to the specific context and needs of the various medical cadres.

TRAINING 15,000 MIDWIVES AND BEING THROWN UNDER THE BUS

To enhance family planning and lower maternal mortality, I worked from 2003 to 2006 for Johns Hopkins University as a senior quality & performance improvement advisor for the Indonesian USAID-funded reproductive & maternal health programme. Our training team proved that a self-assessment questionnaire could be particularly valuable in helping individual midwives, who often provide service without a supervisor or colleague to guide their performance, to define areas where they felt the need to improve

their service quality. Self-assessment also assisted the training team in determining, organising, and prioritising medical competences and customising training and learning to enhance the quality and performance of midwives' services.

In partnership with the Indonesian Midwifery Association and the Ministry of Health, this programme trained 15,000 private midwives and created a sustainable quality assurance system for "Quality Private Midwives" using a peer review approach based on self-assessment scales After this fruitful programme, it was evident that self-evaluation contributed to the qualified midwives' improved performance and quality in the "Bidan Delima". [2]

Nevertheless, we also found that some midwives produced inaccurate self-assessments, which raised the critical question of how accurate our self-assessment tools were. In 2005, US Republican politics kept liberal contractors like Johns Hopkins University out of the highly polarised reproductive health field (sounds familiar?). So, I never researched the validity and reliability of our self-assessment instruments for midwife competencies. In the end, I was thrown under the bus and needed to get a new job.

UNEXPECTED OPPORTUNITIES

From 2006 to 2011, Padjadjaran University in Bandung, Indonesia (UNPAD), Antwerp University (Belgium), Maastricht University, Radboud University, the Nijmegen Institute for Scientific Practitioners in Addiction (NISPA), and CORDAID formed an international consortium called IMPACT (Integrated Management for Prevention and Control and Treatment of HIV/AIDS). This consortium received a 5-year European Commission grant (Grand: Santé/2005/105-033) for the prevention, control, and treatment of HIV/AIDS and battling the combined HIV/IDU epidemic among intravenous drug users in West Java province (population: 40 million). Being the general manager (COP) of this academic partnership was an enormous honour and the capstone of my international health career.

Evidence of injected drug use, addiction treatment, and the resulting HIV issues was scarce in Indonesia and unavailable in Bandung, West Java. IMPACT aimed to establish an Addiction & HIV centre of excellence. As a result, we started baseline epidemiological studies and needs assessments to study and develop multidisciplinary approaches for tailoring evidence-based prevention to the development of combined HIV and Addiction prevention, care, and treatment programmes. My task was "getting the job done": facilitating multi-disciplinary research and implementing evidence-based treatment. This effort resulted in an additional spin-off of over 20 PhDs of young Indonesian (and some Dutch) scientists. At the end of the IMPACT programme, this new scientific knowledge formed the brick-and-mortar for the Indonesian postgraduate short course in addiction medicine (ISCAN), which, together with the construction of the addiction medicine training needs assessment self-assessment scale (AM-TNA), measuring self-perceived training needs in addiction medicine, offered an unexpected opportunity to start my PhD journey.

WHY

By the end of the IMPACT programme in 2011, the Indonesian addiction workforce was still too small and poorly trained, leading to a significant substance use disorder (SUD) treatment gap. We developed the Indonesian evidence-and-competence-based short course in addiction medicine (ISCAN) to address this treatment gap. From the health care provider's perspective, I explored a self-assessment approach (AM-TNA) during the training needs assessment process.

The AM-TNA scale can only be used as a valuable instrument for addiction medicine curriculum development and the assessment of training needs, training gaps or training progress if an evaluation of reliability and validity - critical requirements for any psychometric instrument - is well established. As a result, my research aim was focused and modest: to develop a valid and reliable self-assessment instrument to measure training needs, gaps, and progress in addiction competencies. My dissertation's primary focus is on the internal validity of the AM-TNA, and it leaves external validity and the effect of the combination of the AM-TNA with objective external assessment wide open for future exploration and discovery.

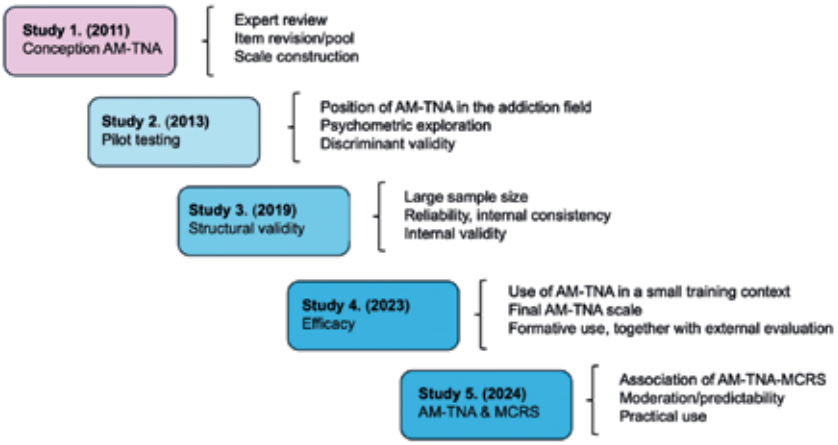

Figure 2: Validation process of the AM-TNA scale

HOW

The psychometric and practical value of the AM-TNA was gradually established in five studies, which evolved from each other. The first four studies have been published, and the last one has been approved but not yet published (April 2025). The first study showed that the AM-TNA could guide the ISCAN curriculum design. To our delight, the instrument also proved to have some initial psychometric value, despite the small sample size. This

result was only indicative though, given the small sample size (N=27). But it was a strong motivator for the following study. [3]

The second study tried to define the position of the AM-TNA scale in the bigger picture of the changing addiction paradigm shift. In this study, we could confirm the initial psychometric value. These first psychometric details of the AM-TNA scale were promising, but we considered the assessment scale still in its infancy. At that moment, we acknowledged that sample size was one of the biggest challenges in establishing the psychometric value of the AM-TNA scale. [4]

This issue was tackled in the third study by pooling data from four countries (Indonesia, Lithuania, Ireland and the Netherlands), resulting in a larger sample size (N=428) for the final in-depth validity and reliability study of the AM-TNA scale. Having now a well-established AM-TNA scale with excellent internal validity and reliability, curiosity took over again. Subsequently, we studied the efficacy of the scale in a small local training setting. [5]

In study number four, the AM-TNA measured increased addiction competence over four years in groups of psychiatry specialists in training; in our eyes, the instrument had matured. During this study, our focus turned to more practical assessment aspects, and we concluded the study with the advice to use the AM-TNA from the learning experience perspective and triangulate its results. [6]

In the final study, global ambitions took over, and we studied the association of physicians' stigmatising attitudes to people having SUD (as measured by the MCRS) and perceived training needs (as measured by the AM-TNA). We were able to confirm that the attitude of addiction professionals predicts training needs. Addiction knowledge, attitudes, and skills are intimately related, and our study confirmed that attitudes predict self-perceived SUD knowledge and skills training needs. [7]

LOOKING BACK

"Life is what happens when planning other things", said John Lennon. This proverb also applies to my PhD trajectory. I had abandoned the idea of ever getting a PhD for a long time – as I never found a good match between a challenging subject, a professor and me – until my conversation with Prof. Cornelis de Jong, visiting the IMPACT programme in Bandung Indonesia as a technical advisor for the development of an Indonesian short course in addiction medicine on 24 April 2010. That specific moment kicked off a decade-long journey of curiosity and learning.

First, conducting research on the validity of the self-assessment AM-TNA Scale by a free exploration of a topic in-depth, gaining a deeper understanding, answering questions that have not yet been asked and answered, and making a small but meaningful contribution to this specific though small part of medical education, was a great way to improve medical training practice and at the same time satisfy my curiosity and desire to learn.

Getting articles on medical training published in addiction journals proved challenging, especially during the COVID crisis. One article took over two years to get published: it took one editor 51 weeks to reject our submitted article, and another journal required over a year to start the review process. As a result, I learned to be patient, deal with rejection and frustration, and be persistent. I also learned that publishing my research in a specialised medical education journal was easier than in addiction journals.

As an external researcher ('buiten promovendus' in Dutch), I did everything to avoid becoming a lone maverick working in isolation. The technical-scientific and social support from my supervisors, colleagues, and peers in the Netherlands and abroad was essential during my PhD journey. The feedback from other 'struggling' PhD candidates during retreats, especially for improving academic writing and reasoning, proved very supportive. I love teaching, but this PhD journey, which ended on April 24 last year with a PhD thesis defence [8], added a lot of purpose and passion to my final career: training psychiatrists and addiction physicians in public health and medical leadership at the Dutch Addiction Medicine Specialists Course (MIAM/NOVA) in Nijmegen.

I loved this protracted research track and strongly advise my international health colleagues to consider a PhD track. For some, the passion will outweigh the struggle; for others, though, the challenges will overshadow the excitement. Discover for yourself if it's more fun or more of a burden for you. Give it a go, and start with a rough plan. Find a supportive senior professional, and try ONE article! If I can do it, you can do it as well!

RECENT DEVELOPMENTS

Last year, the Training Committee of the International Society of Addiction Medicine accepted the AM-TNA scale as the global benchmark to assess training gaps in over 44 countries: a memorable milestone in a decade-long research trajectory. [9]

W.J. (Lucas) Pinxten
Physician Global Health and Tropical Medicine, Radboud University Nijmegen

lpinxten@gmail.com

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Book review of “Ziener” by Adriaan Groen

In his latest and eighth book, Ziener (Visionary) by Adriaan takes a bold and refreshing departure from his previous works. While his earlier novels are more grounded in personal experiences and reality, this novel delves into a blend of psychological intrigue, the supernatural, and ethical dilemmas. Through an intricate and multi-layered storyline, Groen skilfully intertwines past and present, creating a compelling narrative that urges the reader to keep turning pages until the very end.

The story opens with Luc, a medical doctor and specialist in forensics, who finds himself at a crossroads following his own resuscitation after a severe cardiac episode. During his hospital stay and subsequent rehabilitation, Luc begins to experience a series of strange and unexplainable visions. These visions seem to connect to his time working at a mission hospital in rural Tanzania, raising the unsettling question of whether these are echoes of the past or warnings of an impending future. While struggling to ask for help, Luc confides in a few people close to him and eventually decides to go back to the mission hospital in Tanzania to potentially warn old colleagues. Still recovering, the journey is challenging and he is confronted with changes that have occurred over the years, personally and in his familiar surroundings. Will he make it on time to stop the possible future events?

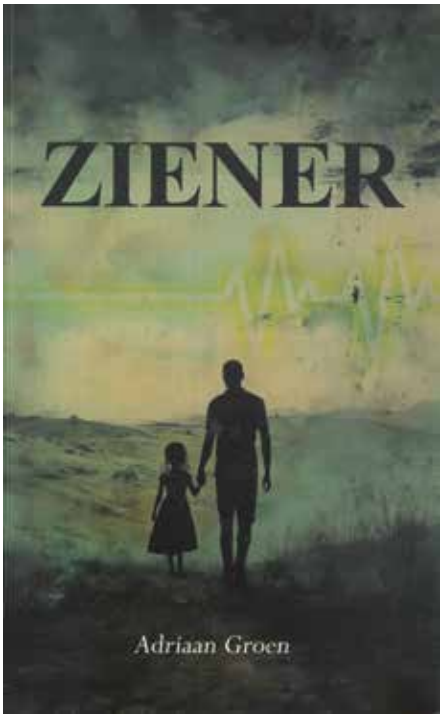
What stands out in Ziener is its exploration of profound themes beneath the surface of the thriller-like plot. Groen reflects on the emotional and psychological impact of life-altering events, touching on the complexities of guilt, the burden of knowledge, and the ethical challenges faced by medical professionals working in resource-limited settings. Luc’s internal struggles offer an introspective view of a man grappling with both his past and the weight of future possibilities.

Groen’s writing draws readers into Luc’s inner world while providing vivid descriptions of the Tanzanian setting. The novel’s pace balances moments of quiet introspection with more urgent and suspenseful scenes. This combination of reflective storytelling and urgent tension adds depth to the narrative, making Ziener a valuable addition to Groen’s body of work.

For long-time fans of Adriaan Groen, this book marks a subtle evolution in his storytelling style. New readers will find themselves drawn into the novel’s blend of psychological depth and narrative urgency. What is compelling about this story is that, in between the lines, it says a lot about life-changing events, the impact of blindness, the consequences of working as a tropical medicine doctor. and feelings of guilt. If you are a fan of Adriaan Groen’s books, this is a refreshing must-read!

Daily Krijnen
Medical Doctor in Global Health in training

dailykrijnen@gmail.com



ISBN: 9789463657150

And what have we learned from all this…?

Johannes Borgstein served as editor-in-chief for three years, from 2008 to 2011.

After many decades of development aid, one might have expected us to have picked up a thing or two ourselves. However, as Judith van de Kamp concludes in her PhD thesis Behind the smiles [1], the transfer of knowledge and information remains a one-way street, going in one direction, with little regard for cultural differences. "We in the West know what is best for the rest" has been the attitude, and we felt that other regions had very little to teach us. As the wealthiest, greediest and (in military terms)most violent section of the world, we had no need to be considerate. Unfortunately, it is becoming desperately clear that the Western lifestyle is unsustainable, and has been for some time. The economically challenged regions, as they have become known, may have cause to regret all the 'aid' they have received, while we may regret not having taken the interest to learn from them.

We have grown accustomed to the idea that science will bring continued progress and provide solutions to all of the world's problems. But science no longer seems up to the task, and is increasingly subservient to the inevitable financial interests that rule the world. For every solution science provides, it produces an equal and opposite set of problems that paradoxically often make things worse, especially in the long term.

This situation might perhaps encourage us to become a little more modest in transferring our views and practices, and even inspire us to take a closer look at older cultures and try to learn from what we see.

What are the lessons that are to be drawn from all this? For example, the true meaning of sustainability? It's not an electric car that merely moves the problems elsewhere but the ubiquitous bicycle, one of the truly great inventions, that uses and produces sustainable energy (unless the hill is very steep). And what about walking as a healthy mode of transport that may prevent cardiac problems and obesity. That a mud or adobe hut with a thatched roof is biodegradable and is in the end better for the environment than buildings made of concrete. That close family ties reduce mental illness, and that many symptomatic medications can be grown in your garden or window box, rather than expensively produced by a multinational pharmaceutical company. We must discover again that we are an integral part of nature, even though we seem to have lost the connection.

It is gradually becoming clear that we cannot survive without our entire ecology, no matter how much a few very wealthy individuals might desire to move on to the moon, Mars or even further afield. This dangerous distraction contributes to the idea that we have alternatives and that it is okay to wilfully destroy our home planet in the name of profit and avarice.

I once calculated that a single mission to Mars would cost the equivalent of 10,000 years of the Malawi health budget at its current level of very basic but free health care for 17 million individuals; and to put that into perspective, 10,000 years is approximately the time from the oldest recorded civilisations to the present day.

Individuals on the unimaginably inhospitable Martian environment will realise soon enough that they are a thousand times worse off than the school boy dragging his mosquito net along the shores of Lake Malawi to catch some small fish for his lunch, even taking into account the myriad tropical diseases – like malaria – as he is using his mosquito net in the wrong way; or schistosomiasis, which he is likely to encounter on the lake shore, or hookworm and ascaris; these parasites have complex and fascinating life cycles, which is clear evidence of the long interaction of individual organisms and species (think of the curious cycle of the bilharzia and malaria parasites).

Meanwhile, well-meaning billionaire philanthropists cause untold damage to fragile cultures and ecologies, imposing their limited imperfect theories by weight of finance.

But we could actually learn so much, and we may need to if the destruction of our only viable environment is to be halted.

We can learn that not everything is scientifically testable, that not all technological developments are desirable, and that mysteries are there to remain, for as Douglas Adams has written: "There is a theory which states that if ever anybody discovers exactly what the Universe is for and why it is here, it will instantly disappear and be replaced by something even more bizarre and inexplicable. There is another theory which states that this has already happened."

Could that be the surreal feeling we are all experiencing at the moment?

Johannes Borgstein
ENT Surgeon/Otologist Gibraltar Health Authority, St. Bernard's Hospital, Gibraltar

borgstein@gmail.com

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Twelve years of MT*b* (2013-2025) summarised in 12 points

Now that the era of Medicus Tropicus bulletin (MT*b*) is coming to an end, it seems appropriate to look back and summarise what MT*b* has offered the readership of the Netherlands Society of Tropical Medicine and International Health (NVTG), and all those who were interested in reading a 3-monthly update on current issues in Tropical Medicine and Public Health.

We have tried to summarise the organisation and the contents of MT*b* in 12 points, with highlights and trends.

THE EDITORIAL BOARD

The membership of the editorial board was entirely on a voluntary basis and open-ended depending on availability. The chair of the editorial board was the editor-in-chief:

- Lucie Blok († in 2022): 2005 - 2008
- Hans Borgstein: 2008 - 2011
- Hans Wendte: 2011 - 2015
- Leon Bijlmakers: 2015 - 2020
- Esther Jurgens and Ed Zijlstra (ad interim) 2020 - 2023
- Esther Jurgens: 2023 - 2025

The other members of the editorial board joined on their own initiative, or after having been introduced, or after responding to an advertisement. Over time, a considerable number of young doctors and other health professionals joined the editorial board; some stayed for a relatively short period of time as their still developing career took them to remote places and/or they needed to focus on other commitments; others contributed for a longer period, which caused stability. Overall, finding people who were interested posed challenges, although there were no doubt important benefits: editorship could help in developing writing skills under the supervision of senior members, and exposure to the most recent developments in Tropical Medicine and Global Health, as well as the social and professional network of the Editorial Board, could also bring benefits.

THE EDITORIAL TEAM

While the editing of the manuscripts was done by the editorial board (which was a time-consuming and elaborate task), the production process was supported by assistance from the secretariat and / or copy editors (Lies Laumans, Hanneke de Vries, José Hoppenbrouwer, Hein Dik Barentsen, Olaf van Muijden), and Language Editor (Eliezer Birnbaum); the design was provided by Mevrouw van Mulken™.

GENERAL PHILOSOPHY

From 2013, MT*b* adopted a thematic approach ranging from a clinical topic in the field of Tropical Medicine or a mainly Public Health oriented topic in the field of Global Health, to current issues such as climate and migrant health or cross-cutting issues such as Ethical issues in Global Health and Essential Medicines. Of the four issues in each year, the third issue was matched with the theme of the annual meeting of the NVTG that takes place in September.

While the title of each issue may suggest a uniform content and focus, in practice, if possible, each issue sought a balance between public health and clinical issues.

THE READERS

The readership consisted of members of the NVTG of whom many would be in training for Physicians Global Health and Tropical Medicine (now: Medical Doctors in Global Health), a unique hybrid of Clinical and Public Health training. Others would include anyone interested e.g. those who are retired and those outside the Netherlands.

THE TOPICS

New developments in Global Health and/or Tropical Medicine were addressed such as Covid-19, migrant health, brain drain, climate/planetary health, essential medicines (including fake medicines) and digital health. Remarkable issues were highlighted such as reverse technology in the treatment of burn injuries (MT*b* 2021-2 vol 59), or ethical dilemmas in global health - Training a 'lost generation in ethics: developing a training course for local public health practitioners in a postwar conflict' (MT*b* 2018-3 vol 57).

THE GUEST EDITOR

For reason of quality assurance, guest editors were invited as much as possible in order to have better access to expert input and to include articles on recent trends and developments. Whenever possible, contributions from the Global South were invited, often with remarkable success.

THE CASE REPORT

The case reports from Consult Online are among the contributions that form the backbone of MT*b*; the cases come from the field, mostly from the Physicians Global Health and Tropical Medicine (now: Medical Doctors in Global Health) who have completed the 2 year and 9 months training program, as provided by the Training Institute Global health and Tropical Medicine (OIGT) under auspices of the NVTG, and who work in a low-resource setting. Cases are presented to experts in the Netherlands for advice and written up for publication. Virtually all of them are gems in the field of tropical medicine and the Consult Online editors would do well to publish these cases in the future as a book.

THE OTHER COLLEAGUE

A relatively new introduction to content was the *Meet your colleagues in global health and tropical medicine*, in which colleagues were invited to discuss issues relating to their career, working environment, and contributions to Tropical Medicine and Global Health, for example: *Meet Klaas Marck, an advocate for Noma* by Maud Ariaans (MT*b* 2021-3).

THE BOOK REVIEW

Another new addition was the book review, highlighting new publications that in one way or another would be related to Tropical Medicine and Global Health. Among highlights are the hilarious

book Physician watch thyself by Pieter van den Hombergh (MT*b* 2022-4) and {everybody-should-read-this} The Power of Women by Dennis Mukwege.

WIDE DISTRIBUTION

MT*b* was made available free of charge in electronic format on the website of the NVTG; those who were interested could obtain a hard copy at a fee. Well before 2013, in 2007 with the introduction of a new layout and a new name (MT*Bulletin* of the NVTG), it was decided to publish the MT*b* in English for wider distribution, including partners in low- and middle-income countries.

THE NEW PLATFORM

Twelve years of MT*b* provides a wealth of information about virtually all aspects of Tropical Medicine and Global Health. All issues are available from the website of the NVTG; all previous issues of Medicus Tropicus have been scanned and will be available on the Platform: Global Health *Perspectives*.

ESTHER JURGENS

Last, but not least: Esther Jurgens has been the driving force behind MT*b* over the years, and still is, now that a new format will be introduced. Without her commitment, all this would not have been possible (Figure 1). Her contributions to the NVTG are not limited to MT*b* but include a wide range of service, support and advice in all aspects that are close to the aims and objectives of the Society.

I am confident that all those who have contributed to MT*b*, the readership of MT*b*, and members of the NVTG will join me in giving Esther a big hug and saying "THANK YOU!"

Figure 1. Esther Jurgens

©

Ed Zijlstra, internist
Rotterdam Center for Tropical Medicine

e.e.zijlstra@roctm.com

Table of Contents *

* Summary of topics over the years; variable for each issue as appropriate
** Association of Physicians International Health and Tropical Medicine (vereniging voor Arts Internationale Gezondheidszorg en Tropengeneeskunde in opleiding)

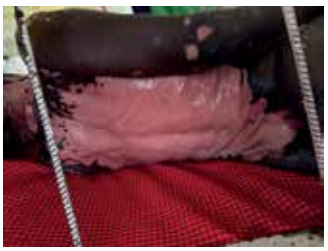
List of all 44 publications of MT*b*, published between 2013 - 2024: year of publication, title and broad category.

Year	Broad category
2024-2 Migrants and health	Migrant Health
2024-1 Otto Kranendonkfonds	General
2023-2 Planetary health	Climate
2023-1 Child and adolescent health	Child Health
2022-4 ONCOLOGY	Tropical Medicine
2022-3 Decolonising Global Health	Global Health
2022-2 Toxins and intoxications	Tropical Medicine
2022-1 Oral Health	Other specialties
2021-4 Climate Changemakers in health	Climate
2021-3 Orphan Diseases	Tropical Medicine
2021-2 High tech in low-resource settings	Research
2021-1 Global Surgery	Surgery
2020-4 Global Mental Health	Mental Health
2020-3 Global Health Research	Research
2020-2 COVID-19	Tropical Medicine
2020-1 Neglected Tropical Diseases part 1	Tropical Medicine
2019-4 Vaccination: achievements, challenges, prospects	Global Health
2019-3 Climate change and health	Climate
2019-2 Health Technology	Research
2019-1 Emergency Medicine	Tropical Medicine
2018-4 Towards an AIDS-free generation	Tropical Medicine
2018-3 Ethical Dilemmas in Global Health	Global Health
2018-2 Nutrition and Infectious Disease	Tropical Medicine
2018-1 Into the World	General
2017-4 Haematology	Tropical Medicine
2017-3 Safe Motherhood and Reproductive Health	Reproductive Health
2017-2 From Tropical Medicine to Global Health	Global Health
2017-1 The Devastating Effects of Conflict on Health	Global Health
2016 4 Medical Education	Education
2016 3 Migrant Health	Migrant health
2016 2 Child Health	Tropical Medicine
2016 1 Travel Medicine	Surgery
2015 4 Public Private Partnerships	Tropical Medicine
2015 3 Essential Medicine	Mental Health
2015 2 Migrant Health	Other specialities
2015 1 Emerging Infectious Diseases	Research
2014 4 Surgery and Orthopaedics	Global Health
2014 3 Noncommunicable Diseases	Reproductive Health
2014 2 Global Mental Health	Other specialities
2014 1 Ophthalmology	Tropical Medicine
2013 4 Science and Research	Surgery
2013 3 Urban Health	Tropical Medicine
2013 2 Sexual Health	Mental Health
2013 1 Dermatology	Other specialities

Toxic Epidermal Necrolysis: a Case Report

SETTING

Endulen Hospital is located in the Ngorongoro Conservation Area (NCA) of Tanzania. It has 70 beds. The hospital opened in 1976, and provides care in an area of approximately 8,300 km^2 where around 90,000 Masai people live.



CASE REPORT

Recently, a 72-year-old female patient was admitted with a suspected case of Toxic Epidermal Necrolysis (TEN) or Stevens-Johnson Syndrome (SJS), following the administration of ciprofloxacin. She received ciprofloxacin for the treatment of typhoid fever and was discharged after a short admission.

Upon readmission, five days after the last dose of ciprofloxacin, she presented with "sudden onset" blisters that had ruptured. Initial examination revealed that the affected skin closely resembled burn injuries (see attached figures). Approximately 45% of the total body surface area (TBSA) was involved, specifically the thorax, abdomen, neck, back, face (including membranes of eyes and mouth) and genitalia. The legs were mostly spared, and the capillary refill time was normal. All vital signs were normal, the initial full blood picture showed a white blood cell count of 5.8 x 10^9/ L, haemoglobin 13.5 g/ dL and platelets of 403 x 10^9/ L, HIV test was negative. Based on these findings, superficial partial-thickness burns were suspected. Eating was challenging since she had difficulty opening her mouth. Her urine output was around 25-30ml per hour, and she has not shown any signs of fever. She received treatment with daily cleaning and dressings, intravenous fluids, pain management, prednisolone and antibiotics (ampiclox). The differential diagnosis included suspected TEN / Stevens-Johnson syndrome, while Staphylococcal Scalded Skin Syndrome (SSSS) was considered less likely. Referral to a specialised centre for comprehensive testing (electrolytes, kidney function, etc.) and ICU care/burn unit in Mount Meru Hospital (Arusha) was planned. However, this was complicated by distance, costs and road conditions. Therefore, Consult Online was consulted for additional treatment recommendations.

QUESTIONS FOR THE DERMATOLOGISTS:

- How likely is our suspicion of TEN/SJS?
- What is the role of corticosteroids in the management of TEN/SJS?
- Is honey wound treatment sufficient, or would there be other recommended treatments? Any preference for antibiotics?
- What further steps should be taken in the treatment and care of this patient?
- What are the recommendations for nutritional support (nasogastric tube/ high-protein diet) due to potentially affected mucous membranes?

TOXIC EPIDERMAL NECROLYSIS

Toxic Epidermal Necrolysis (TEN) is a rare and potentially life-threatening muco-cutaneous disorder.[1] TEN results from extensive cell death at the dermal-epidermal junction and above, leading to significant areas of epidermis being separated from the dermis, which manifests as "scalded skin". The exposed skin can lead to considerable losses of electrolytes, albumin and water. Typical symptoms include extensive mucous membrane involvement, high fever, and intense "skin" pain. The onset of the disease is usually triggered by medications or their metabolites (antibiotics/antiviral, anti-epileptic and NSAIDs), or less frequently by infections, tumours, and vaccinations. TEN is more common in Asian and black people, females and elderly people (50-70 yrs of age). Drug-induced TEN is more common in adults, while infections are the main cause in children.

In low and middle income countries (LMIC), TEN is relatively common. It is relatively frequently observed in HIV patients due to the use of drugs such as nevirapine and sulfa-containing drugs (cotrimoxazole), which are recognised for their potential to cause TEN. Fansidar®, another sulfa-containing drug, used as an anti-malarial, is another well-known trigger.

The main treatment for TEN is supportive care until the skin heals, including fluid resuscitation, pain management, wound care, and nutritional support. Early management should focus on stopping the triggering drug and referring the patient to a burn unit or ICU. Taking these

steps within 24 hours of blister formation can reduce infection rates, shorten hospital stays, and improve survival.

ADVICE FROM THE DERMATOLOGIST, SURGEONS AND BURN CARE UNIT ROTTERDAM

Four specialists replied within three days. They all agreed on the diagnosis of TEN. Based on the pictures, the skin appears to be healing already. For obvious reasons, the causative drug ciprofloxacin must be stopped if not already done. The best treatment advice for TEN in LMIC is summarised in the case report by Mwageni et al.[2] The management of skin failure is most important. This means that hydration status, electrolyte and protein losses, and hypothermia should be monitored closely. Moreover, signs of bacterial infections must be checked regularly, since pneumonia (when bronchial epithelium is involved) and sepsis are the most life-threatening complications. Antibiotic treatment must be started only when a superinfection is suspected. Macrolides are preferential.

Wound care has to be done carefully by avoiding excessive touching: daily dressing with Vaseline® gauze or silver dressings if available. The authors used honey for some time with reasonable results.

The mucous membranes including the eyes, the mouth, the trachea, the bronchi and the genitals should be cared for. This includes daily use of ocular lubrication and hygienic mouthwashes.

Corticosteroids were advised with intravenous dexamethasone 1.5mg/kg for three days. The use of high doses early in the course of the disease may reduce morbidity and mortality. However, supporting evidence is still unavailable.

Potential albumin loss can be compensated for by high protein foods. One specialist also recommended starting her on high-dose vitamin D, if available. This is associated with better wound healing and less septic complications.

FOLLOW-UP

During her admission, the advice of the specialists was followed, but several challenges were encountered. There were multiple failures in placing cannulas due to the damaged skin and subsequently difficulties in keeping the patient hydrated. Daily dressings with Vaseline® and honey gauzes were performed. General hygiene measures were challenging to implement, and as a result, she was on preventative antibiotic treatment despite the absence of any signs of infection. Providing her with protein-rich nutrition was difficult because of the scarcity of nutritious food and insufficient funds. Moreover, the advised high dose of vitamin D was not available. On January 13, 2025, she was referred to the specialist hospital (Mount Meru Hospital) in Arusha. The family had raised enough money, and she was hemodynamically stable, with a good urine output and no signs of infection. Unfortunately, she passed away two days later. The exact cause remains unclear due to communication issues. The hospital, doctors, and nurses have been unreachable for days.

Anne de Boer
Medical Doctor in Global Health
Endulen Hospital, Tanzania

Ruth Gussenhoven
Medical Doctor in Global Health in training

consultonline@troie.nl

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This is not goodbye – just a new beginning

You have reached the final issue of MT*b*, but our story doesn't end here. It is time for a new chapter – and while the format is changing, we will continue our work, on a new platform, with the same spirit, depth and dedication.

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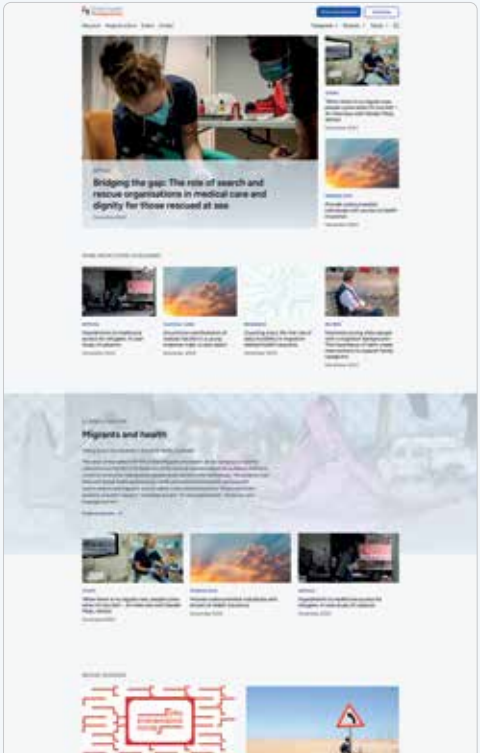

A personal reflection on my career-long ambition to make a meaningful contribution to global health

Leon Bijlmakers served as editor-in-chief for five years, from 2015 to 2020.

Looking back at the history of MT*b*, of which the first edition was published in 1993, one might become a little nostalgic. With more than 120 editions, spread over more than 30 volumes, I'd like to believe that *Medicus Tropicus bulletin*, later dubbed MT*b*, has served as a platform bridging a certain divide between health practitioners, researchers and policy makers. One of the most nagging recurring questions for the MT*b* editorial board was: who reads the articles that we publish and do they meet the needs of our readership? The willingness among many NVTG members and even professionals who were not members of NVTG to contribute articles for publication in MT*b* strengthened us in our belief that there was actually a need to be met. Even when it gradually became more difficult for to us to persuade potential authors to make a contribution in the form of a Research paper, Study review, Project brief, Guest editorial, Opinion letter, 'Letter from the tropics' or Book review, we kept thinking that global health professionals had many competing priorities that prevented them from writing, but not from reading. We were lucky that the working group TROIE (in Dutch: *Vereniging voor Artsen Internationale Gezondheidszorg en Tropengeneeskunde in opleiding* - www.troie.nl) never failed to contribute a case report in the section 'Consult Online'. And several of the Editorial Board members took on the responsibility to contribute Interview reports on a regular basis, or Book reviews that we deemed interesting for MT*b* readers.

Delivering a complete edition of usually 20 or 24 pages (occasionally 16 or 28 pages), was quite an undertaking. In three ways, MT*b* distinguished itself from scientific journals. First, we have always been a semi-scientific journal, never aiming to become a scientific indexed journal or pursuing an impact factor. However, we did experience competition to the extent that authors affiliated with academic institutions sometimes preferred to publish in medical or public health journals – most likely for reasons of prestige and/or pressure from funding agencies. Second, we rarely received articles at the authors' own initiative. Usually it was us, editorial board members, who identified candidate authors and then invited them to publish in MT*b*. Suffice to say that the acceptance rate was not always very high, and we sometimes doubted if we would manage to obtain sufficient publishable material and meet our own deadlines. Third, instead of engaging external experts for independent review of the submitted manuscripts, the Editorial board members themselves took care of the peer review process. In some cases, this involved a pretty intensive trajectory, as experienced clinical or global health practitioners are not necessarily good writers, as I argued in an interview published in MT*b* 2021/4.[1] Praise is therefore due to my predecessors, successors and fellow editorial board members who dedicated much time and effort to keeping MT*b* alive and thriving for such a long time. I also acknowledge the contributions of the language editor(s), designer (a long-term partner-in-crime), photographer (another such long-term partner), NVTG secretarial officers, and the NVTG board members (including the treasurer!). I have appreciated their commitment and flexibility.

In retrospect, having served as editor-in-chief has helped me personally in executing my duties since 2020 as editor of the European journal *Tropical Medicine and International Health* (TMIH). Let me now turn the page on nostalgia, which in my view is a somewhat tricky indulgence, especially for a society like NVTG – in 2025 renamed the *Netherlands Society for Global Health* – with its rich history spanning nearly 120 years. With the ever-changing global burden of disease patterns and persisting health inequities – within and between countries – despite

high promises of new health technologies, we cannot afford to dwell for too long on past achievements and memories.

Global health is everywhere, not only because public health threats easily spread across country borders and ethnocultural divides, but also because the demand for and supply of healthcare have become increasingly globalised. This is worrying, but it also presents opportunities for more meaningful intercountry collaboration to achieve common goals, and for worldwide expressions of solidarity and mutual respect. I would like to expand a bit on three aspects of my work as senior researcher at the IQ Health Science Department of Radboud University Medical Center (Radboudumc) - https://www.iqhealth.nl/over-ons.

1
One of the positive side-effects of the COVID-19 pandemic, in my view, has been the gradual recognition in the Netherlands and other high-income settings that there is a limit to what healthcare interventions can achieve, and that tough choices are sometimes required in allocating scarce resources. Many people have high expectations from innovations, but we cannot simply assume that there are technological solutions for any kind of health challenge. Even high-income countries face resource constraints, be it in terms of health budget, human resources or otherwise. Back in 2017, our Global Health Priorities (GHP) research group at Radboudumc organised the citizen forum '*Keuzes in de Zorg*' (Making tough choices in healthcare) which explored citizens' views in the Netherlands on, and support for, reimbursement of various types of healthcare interventions under standard health insurance. Based on in-depth deliberation around six cases and interactions with experts, we demonstrated that informed citizens are willing, and to a certain extent able, to make reasoned choices about the cost coverage of health services through public funding. They realise that choices are both necessary and possible.[2]

More recently, in Oct/Nov 2024, we organised another citizen forum, this time on the reimbursement of expensive medicines. At the request of the MAUG (Socially Affordable Costs of Medications) programme (in Dutch: *Maatschappelijk Aanvaardbare Uitgaven Geneesmiddelen* - www.maug.nl), executed by three national institutes in collaboration with the Ministry of Health, Welfare & Sports, we explored people's preferences and willingness to pay for forms of expensive medication, some of which have a very high budget impact, for a range of medical conditions. Our report and a 4-page *Citizens' opinion* titled "*Niet tegen elke prijs*" (*Not at any price*) will soon be made available in the public domain. The aim of MAUG is to inform a national framework for the establishment of prices and expenditure levels that Dutch society deems acceptable.

2
Much of the work of our GHP research group at Radboudumc centres around the universal health coverage (UHC) concept, a term introduced by the World Health Organisation more than two decades ago and adopted by many countries as a national aspiration. UHC means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. Ideally, it covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care.[3] The goals of UHC are typically defined by three dimensions: the health services covered by pooled funds, the target population that is actually covered, and the proportion of direct health costs covered by those funds (versus patients' out-of-pocket expenditure). Our GHP group is part of several global networks (e.g. *Health technology Assessment Internationa*l, HTAi, https://htai.org/, the *International Decision Support Initiative*, iDSI https://www.cgdev.org/topics/priority-setting). We advise government agencies in several countries and jointly undertake research on the composition and/or revision of their national health benefit packages, the institutionalisation of health technology assessment (HTA), and the institutionalisation of periodic health benefit package revision. Our advice involves not so much the content of those packages and the extent to which they are covered through social health insurance – both of which are national prerogatives – but rather the process through which benefit package recommendations, based on which the relevant authorities make their decisions, are developed. We put much emphasis on using a systematic approach, which we dubbed 'evidence-informed deliberative processes' (EDP). Stakeholder deliberation, legitimacy, fairness and transparency are key to EDPs. See for example this short video animation:

The use of evidence-informed deliberative processes (EDPs) - By research group Global health economics - Radboudumc (or https://www.radboudumc.nl/en/research/research-groups/global-health-economics/edps)and

Making Explicit Choices on the Path to UHC: Guide for Health Benefits Package Revision | Joint Learning Network (or https://www.jointlearningnetwork.org/wp-content/uploads/2022/12/Making-Explicit-choices.v4.pdf)

3
Among the global health research projects to which I contributed in my academic career are COST-Africa and SURG-Africa. See https://www.surgafrica.eu. Led by the Royal College of Surgeons in Ireland, these two EU-funded projects aimed to strengthen surgical systems that deliver safe, affordable and sustainable essential surgical services to rural populations in Malawi, Zambia and Tanzania. In collaboration with research institutes and surgical societies in these three countries, our consortium was quite productive in terms of journal publications and dissemination of policy options to national decision-makers. Our surgical systems research, rooted in health districts and district hospitals, which are the first point of surgical care for rural communities, have informed national scale-up plans to make safe emergency and elective surgery more accessible and affordable.[4] The application of insights, however, and the proper use of lessons learned that actually strengthen local surgical systems is less evident in my view, and this is not just a matter of resource limitations.[5]

4
Meanwhile, there has been a growing awareness, internationally but also in the Netherlands, of the need to address

sustainability issues in the delivery of healthcare. This arises from an increased understanding of the societal and public health consequences of the way in which healthcare is provided. Research has suggested, for example, that the climate footprint of the healthcare sector accounts for 4.4% of global net greenhouse gas emissions, with much higher per capita emissions in the 'global North', placing a disproportionate burden of the consequences on the 'global South'. Surgical practices generate a relatively large share of these emissions (estimated at 20-33%), part of which can be attributed to the use of disposable instruments, volatile anaesthetic gases, and pharmaceutical residues.[6] Waste reduction is considered a pivotal strategy to combat climate change, and several initiatives have sprung up to study and respond to the challenges at hand. The NWO-funded CAREFREE project, led by Maastricht University Medical Center, is one such initiative in the Netherlands. Started in January 2024, the project brings together practitioners and researchers from a range of disciplines and organisations. A short animation illustrates this nicely: https://www.youtube.com/watch?v=rqvzI68KnjU. The first publication involved a systematic review of the environmental, economic and clinical impacts of endoscopic surgical instrumentation.[6] Whereas it underscores the environmental benefits of reusables, and favours both reusable and reprocessed disposables for their economic advantages, it found insufficient evidence to warrant favouring one type over the other in instrument performance. I consider it a privilege to contribute multi-criteria decision analysis (MCDA) expertise to the CAREFREE project. It is expected to help research teams to undertake the necessary empirical evidence collection, and to eventually support clinicians, hospital managers and policy makers with priority setting and decision making in the field of surgery.

What the above three aspects have in common is that they illustrate how the triad of Health practice, Policy, and Research can be connected through *systems thinking* and *implementation science*. For deeper reflections on this, see for example Kwamie et al. and List et al.[7, 8] The cross-fertilisation of experiences from different contexts – encompassing high-, middle- and low-income countries – and engaging in teaching students and undertaking research with a view to addressing issues and concerns that are of global interest, is something that I find inspiring and rewarding. During the fifteen years that I was active internationally as a health systems consultant/advisor, after having lived and worked abroad in three different low-income countries, I did not succeed in really combining my work abroad with a professional role in the Netherlands. My transfer from consultancy to academia (in 2012) was not easy initially, but in hindsight, I believe that I managed to assume a role that satisfies my ambition to make a meaningful contribution to global health through teaching and research.

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Leon Bijlmakers
Assistant Professor Global Health Systems Research & Development, Radboud UMC, Nijmegen

Leon.Bijlmakers@radboudumc.nl

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Ethnicity and health in Suriname

My wife and I visited Suriname in April 2024 and contributed to undergraduate and postgraduate education in paediatrics, internal medicine and parasitology at the Academic Hospital in Paramaribo and the Anton de Kom Faculty of Medical Sciences. Suriname is a middle-income country with a population of 616,500 inhabitants, with mean age 33 years; it covers 164 square km and it has a GDP of 14,540 USD per capita. The population is a unique mix of people from various ethnic backgrounds, and people are invariably friendly and polite. The country has ample natural beauty in coastal areas, along the rivers, and in the interior the extensive forest that is continuous with the Amazon forest. The architecture in Paramaribo is famous for its wooden buildings.

Suriname became independent from the Netherlands in 1975, and I did my senior clerkship in obstetrics and gynaecology in the Diaconessenhuis Hospital in 1978. While I was already hooked on internal medicine, it did spark my interest in and commitment to pursuing a career in tropical medicine, with the challenges of working in resource-restricted settings, contributing to health care for those who need it most, and working with the diversity of pathology, both in a general (global) setting and more local settings such as Suriname.

ETHNIC GROUPS

The ethnic breakdown of the population of Suriname is summarized in Table 1. It is not surprising that the slave trade from Africa from the 16th century to its abolition in 1814 played a major role here; plantations were run to produce sugar, coffee and tea, among other products, and a strong and large labour force was needed. The suffering of those affected in this historically unsurpassed breach of human rights, degradation and humiliation is beyond imagination. After the abolition of slave trade, contract workers were brought in from Java and the Indian subcontinent and mixed with spontaneous immigrants such as Chinese, Europeans and other groups to form the typical Surinamese mixed culture. (Table 1). Some of the ethnic groups such as the Javanese, Hindustani, Chinese and Amerindians have largely preserved their ethnic identity.

The Jewish community deserves a special mention here as, in the context of the diaspora, a large Sephardic (Portuguese) Jewish community arrived from 1635, expecting better living conditions under a Protestant coloniser, and settled along the Surinam river in the so-called Jodensavanne (Jewish Savanna). A synagogue was built here in 1685. This isolated settlement of planters was very successful and essentially ran its own affairs in terms of administration, security and education. It was no surprise that, after World War II, the Jodensavanne was one of the options for founding a new Jewish state, which at last was established in Palestine and became Israel.

What are the implications of the ethnic diversity for health in Suriname? This has been the subject of research in, among other, the epidemiology of cardiovascular disease (hypertension, heart failure), diabetes mellitus, metabolic syndrome, infection (tuberculosis), and obstetrics. (Table 2)

IMPLICATIONS OF ETHNICITY FOR HEALTH - THE EXAMPLE OF HYPERTENSION

Among cardiovascular diseases, hypertension has higher prevalence among adults of African descent followed by those of Asian or Hispanic background, compared to Caucasians.[2] In Suriname, cardiovascular disease is the main cause of mortality in each ethnic group.[3] Historical data from 1973 indicate that in a sample of 243 people (40% of African and 43% of Asian ancestry) 40% had hypertension and 15% diabetes; 30% had ever smoked.[4]

More recent studies, carried out in Suriname, showed that prevalence of hypertension (26% in 5748 people examined) was in a similar range as in developing countries, while there was variation within ethnic groups. It was more common in Creoles, Hindustani, and Javanese while it was lowest among Amerindians, Maroons and Mixed.[5] Even more worryingly, half of those diagnosed with hypertension were not diagnosed previously, and only a quarter were treated effectively.[5] But it is not only awareness, prevalence, compliance, or drug availability that determine outcome efficacy. Amerindians have the highest efficacy of treatment and Maroons the lowest, suggesting a specific ethnic approach to treatment of hypertension that may include drug selection and determination of a cut-off point to start treatment.[5]

Health literacy is an independent risk factor for cardiovascular disease: individuals who are female have a low education level and those who live in a rural setting have the lowest health literacy. This needs to be taken into account when delivering health care.[6]

EXPLANATIONS VARY

Table 2 indicates that Hindustani have the highest risk of cardiovascular disease, including hypertension (together with Creoles and Javanese), ischaemic heart disease, diabetes mellitus, and metabolic syndrome. This is in line with data from Asia.

Another interesting finding is the difference in hypertension between creoles and maroons. While both are of African descent and share biological characteristics, creoles live predominantly in urban coastal areas (86%) with only 14% in rural areas, so they generally enjoy higher levels of education and income. Maroons have a similar geographical distribution but lower levels of income and education, suggesting that demographic, lifestyle, and anthropometric factors associated with living under urban conditions may be important (fast food, sedentary work, smoking).

Ethnic group	When arrived, from where	Number, occupation	Details	% *
Hindustani	1868-1916: recruited from British India	34,000 arrived, after abolition of slavery, worked on plantations	Largest population group in 2014	27%
Maroons	Runaway slaves (literally ''runaway cattle"), settled in the jungle	Founded their own communities in the jungle	Reinstated rites and traditions from Africa	22%
Creoles and Africans	1651-1825: brought by force and under cruel conditions from Africa	250,000 arrived	Forced to work on plantations as slaves	16%
Javanese	1890-1939: arrived from Java as contract labourers	33,000 worked in agriculture and cultivation of rice	Still live in closed communities on former plantations	14%
Mixed	All immigrants including also Haitians and Guyanese mixed with other ethnic groups	Widespread	Unique for Surinam: mixture of culture and folklore (festivities, food, music)	13%
Indigenous population (Amerindians)	Tribes: Trio, Wayana, Arowaks, Caraïbes	Live in deep jungle (traditional) or in coastal areas (partly westernized)	Original inhabitants	4%
Chinese	From 1953: contract labourers from Java; later free immigrants also from Macao, Hong Kong and Kanton	Urban areas Run shops and supermarkets	Large social influence	1%
Boeroes	From 1845; immigrants from the Netherlands	Ran plantations without slave labour	Successful in farming and obtaining high offices	<1%
Lebanese	From 1890	Total of 500; retail and textile shops		<1%
Brazilians	A suburb of Paramaribo is called "little Belem"	20,000 - 40,000	From 1990 ''garimpaieros" – gold diggers; live inland	<1%
Europeans	16th - 19th century; various nationalities, ran plantations	> 700 plantations in northern part	Aimed to run Surinam as colony for home country	<1%

Table 1. Breakdown of Surinamese population by ethnic group, principal characteristics, and percentage of total population. Source: Fort New Amsterdam, Commewijne District, Suriname
** % of total population* [1]

For tuberculosis, the high prevalence among Amerindians may reflect late presentation because of poor access to care; undiagnosed and untreated patients may facilitate spread in the community.

Yet other explanations need to be considered in the obstetric studies, where the difference in caesarean section rate may be explained by local hospital practices, while the high stillbirth rate among Maroons (only Haïti has a higher rate in the region) is still unexplained.

Also in obstetrics, ethnic differences exist that need clarification. For example, Maroons had the highest stillbirth rate and Javanese women the lowest; the caesarean section rate was 24% and highest in Hindustani women (32%) and lowest in Maroons (17%). [7]

THE NEED FOR ETHNIC PROFILING

In daily life, ethnic profiling makes us feel uneasy and often causes feelings of discrimination. However, it is important to understand what ethnic diversity means for health care delivery. Epidemiological research helps to understand where the differences in prevalence are and the underlying risk factors; from there targeted interventions may be initiated. Similarly, there may be a difference in response to treatment between ethnic groups for the same condition, within the region or globally; this may result in variable efficacy and adverse drug reactions. Pharmacogenomics is the study of how genes determine the response to drugs; this applies to individuals in the same population as well as on a global scale. There are many studies that report on these differences, for example between Asian, African or Latin-American populations, including those of mixed background.[8-11]
It follows that extrapolation of drug response from one population to another (region, ethnic group, minority) should be done with caution, and introduction of any new treatment should ideally be based on locally performed research.

It is important to note that the study of disease epidemiology among ethnic groups and the principles of pharmacogenomics form the basis of equity in health, and that more research is needed.[12]

Ed Zijlstra, internist
Rotterdam Center for Tropical Medicine

e.e.zijlstra@roctm.com

Health topic [ref]	How studied	Main Outcome	Interpretation
Hypertension [13]	5641 patients from Suriname Health study (SuHS)	Overall 26% Creoles, Hindustani, Javanese: most common Amerindians, Maroons, Mixed: lowest	Demographic, life style and anthropometric factors associated with living under urban conditions may be important (fast food, sedentary work, smoking)
Heart failure [14]	Cross-section of 889 admitted patients (Suriname Heart Failure Study - SUHF-I study)	Ischaemic Heart Disease · Asian - 52% · African descent - 12% Hypertensive Heart Disease · Asian - 11% · African descent - 39%	Risk factors are common: · hypertension (63%) · diabetes mellitus (39%) · smoking (17%)
Diabetes mellitus [15]	3393 patients from Suriname Health Study (SuHS)	Prevalence of · pre-diabetes - 7.4% · diabetes - 13% · Hindustani - 23% · Other ethnic groups - 4.7-14.2%	Association of BMI with pre-diabetes or diabetes, that occurred at lower BMI values in Creole and Hindustani people compared to Javanese and Mixed people.
Metabolic Syndrome [16]	2946 patients from Suriname Health Study (SuHS)	Prevalence · Overall - 39% · Hindustani - 53% · Maroons - 24%	Risk factors Female sex, low income, poor living conditions, marital status
Tuberculosis [17]	662 patients extracted from TB registry	Prevalence · Amerindians - 280/100,000 · Creole - 271/100,000 · Hindustani - 69/100,000	Risk factors · living in remote, rural areas with poor access to health services, low socio-economic status · living in urban areas, HIV infection (38% HIV+ve) · living in rural areas
Caesarean rate [7]	18290 births analysed from nationwide birth registry study	· Overall 24% · Hindustani - 32% · Maroons - 17%	May partly reflect ethnic distributions between hospitals
Stillbirth rate [7]		· Overall 15% · Maroons - 25/1000 births · Javanese - 6/1000 births	Stillbirth rate is second highest of the region, causes unknown

Table 2. Selected studies for various health topics that show variation between ethnic groups

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The puzzle of Wajir

These are dire times for those of us working in development cooperation—more dire still for millions of people who are the focus of our work. Since the onset of a new government in the United States—the beginning of the second Trump era in North American politics—the world has witnessed the consequences of treating development collaboration as a business proposition. It's a time for cleaning out the proverbial attic and discarding the so-called 'left-wing hobbies' of the elite, no matter the human cost. This mentality is not confined to the US but is spreading closer to home, in the Netherlands, across Europe in Germany, France, Belgium, and the UK, and elsewhere across the globe. With the stroke of a pen and at an alarmingly rapid pace, millions of lives are being endangered, and global partnerships are being jeopardized. How can we counteract the devastating effects of budget cuts in critical development areas and the destruction of academic and professional collaborations in global and planetary health?

In these stormy times, during the political coup d'état by a few manipulative men in world politics, I read Frank Terwindt's book *The Puzzle of Wajir*. It's an account of someone who walked the path of development work, starting in the 1980s. It offers an honest reflection of his experiences in a world that, back then, looked quite different from the one we know now. The book is an instructive reflection on his work as a public health consultant, dealing with critical issues in development collaboration. The title itself - *The Puzzle of Wajir* - is intriguing. What exactly was the puzzle, and what pieces needed to be connected?

This review is structured in two parts, and followed by an epilogue book review and introduction to evoke a dialogue. In Part I, the author Frank Terwindt introduces his motivation for writing the book, in which he masterfully intertwines personal growth with critical reflections on the dynamics of development work. In Part II, I will summarize some key crossroads discussed in the book, which we explored in an interview.

PART I: INTRODUCTION BY FRANK TERWINDT

"Although now retired, I am still fascinated by public health and the geopolitical context in which Development Cooperation (DC) is evolving. That's what inspired me to write my book. I wanted to share my reflections about this important but complex domain with my compatriots. Using examples from my work experience, I explain how public health is directly linked to global challenges, such as the widening gap between rich and poor, environmental damage, climate change, and migration.

The reader may initially be disappointed by the lack of straightforward success stories in my book. By that, I mean effective, efficient, suitable and lasting solutions. But that's the reality: the clichés about development cooperation, whether praising or condemning, do not take into account the many challenges these programmes face. Independent NGO projects and vertical programmes might report impressive results, but long-term, integrated development cooperation often encounters political conflicts, power games, and corruption. Despite this, I see development work as an ongoing learning process that is immensely valuable for all involved.

More than half a century ago, the Western world mostly engaged in missionary and humanitarian work, 'to save the poor.' Over time, we have learned that development cooperation can only yield lasting benefits for both parties if it is based on equivalent, respectful collaboration.

Recent developments in Dutch politics pose an acute threat to my country's commitment to partnering with poor nations. Not only has the new government replaced the term 'Development Cooperation' with the outdated term 'Development Aid,' but the national budget for this area has also been drastically reduced and is no longer linked to our gross national income. Furthermore,

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in line with neoliberal policies, it is intended that our international trade should benefit more from these development investments, while the co-financing of NGO work is being reduced by our government. Meanwhile, my country still continues to fulfil its commitments under the UN Sustainable Development Goals.

MT*b* of November 2024, focusing on Migrants and Health, reminded us of the goal of Universal Health Coverage: to enable access to healthcare services worldwide without causing financial hardship. Access to healthcare for migrants is still not guaranteed in the Netherlands, which seems symptomatic of our attitude toward immigrants. The government seems to think we can simply discourage refugees fleeing climate change, war, and poverty from crossing our borders. Reflecting on my time in these regions, I consider this policy naive and counterproductive. If we stop investing in development partnerships and lose contact with disadvantaged communities globally, I believe this will backfire on us. The world is too interconnected to ignore what happens in distant places. Our tradition of investing in development cooperation with poor countries has helped us understand global phenomena like migration.

In the epilogue of my book, I advocate for a less condescending and hypocritical Western approach to development cooperation for the benefit of our planet."

PART II: WHAT CAN WE LEARN?

Let's start at the beginning. I asked Frank Terwindt what motivated him to work in the field of public and global health for over three decades, and what continues to inspire him. For him, an interest in travel and a passion for justice were key motivations, along with his upbringing in a Catholic environment, and an uncle who served as a missionary priest in Congo. This broadened his perspective early on. In the first chapter, he questions whether he too can be considered "some sort of missionary" when he finds himself working for MSF in Mali. This reflection is nuanced and developed further throughout the book.

We continue by discussing the many assignments Frank undertook during his career. The table of contents provides a glimpse of this journey, reflecting his writing style and hinting at the content. Some chapters are titled "Letter from…" using his correspondence as a gateway to discuss his experiences in Yemen, Liberia, Benin, Congo, and Namibia. Other titles are more cryptic and evoke curiosity, such as "If it was an evil spirit I was supposed to know," "Health in God's name," "Strategy in a dangerous environment" and "Mongolia, quo vadis?" These intriguing titles lead into discussions about his work as a public health consultant, his travels, and the dilemmas he faced.

Of the many topics we discussed, I'll highlight some of the dilemmas Frank encountered—dilemmas that are still relevant today, especially in light of the current political climate and shifting dynamics on the global stage.

HUMANITARIAN WORK OR STRUCTURAL DEVELOPMENT?

In the chapter "From Humanitarian to Development", he discusses how, in 1986, what began as humanitarian assistance in Nepal evolved into a sustainable part of the country's health care system. Key elements? A political revolt, combined with a belief in community-based rehabilitation and preventive care. Frank contrasts this with his experiences working in Uganda, in the 1980s, in what was then considered 'The Pearl of Africa'. Rebels were fighting against dictator Obote, while MSF provided emergency medical care, staying neutral to continue its work. At one point, authorities banned the provision of medicines, fearing they might fall into the hands of rebels. As the situation worsened, MSF had to leave, and only Catholic missionaries continued their work. For Frank, working as a country coordinator, the work became increasingly challenging. He realised that leading in crisis situations required a different kind of mindset - you have to make decisions quickly, often with limited information. Besides emergency work, the teams were also facing public health issues, which led to differing opinions within the team about priorities and aid strategies. Some team members believed they should immediately deploy mobile units to the refugee camps, while others argued that it was more important to start with an assessment of the most urgent (health) needs. There were also tough questions around how to treat tuberculosis in a context where people are constantly on the move, fleeing violence and instability. It was then and there that Frank decided to shift his focus to public health—a vital field dedicated to improving and protecting the health of communities and populations both locally and globally and striving for equitable access to essential resources

DO THEY KNOW IT'S CHRISTMAS?

A few years after the world was being urged to donate money for the famine in Ethiopia – through the now highly controversial charity song [1] – Professor Maurice King stood before his students in Heidelberg, Germany and posed a provocative question: *What are we doing?* Are we simply providing aid to countries that, economically, cannot support their citizens? Is humanitarian aid nothing more than a band-aid—one that overlooks structural deficiencies and risks perpetuating suffering by failing to address root causes? King challenged the students to critically examine the role of the West in emergency and healthcare programmes in so-called "poor countries." Which countries are labelled poor, and why? Many of them are, in fact, rich in natural resources, which in many places cause conflict and rarely benefit the population, but rather a select few who control them. His words sent shockwaves through the room. *What is this? Do you see us as playing God? Don't we have a responsibility – a debt – to the countries we colonised?* For Frank, engaging with this dilemma was eye-opening. It marked the beginning of a lifelong interest in historical patterns and the importance of understanding problems within their full context. That reflection continues to this day, as we are faced with ongoing structural conflicts and the broader planetary crisis fuelled by climate change. One can only wonder how Maurice King would respond to today's dilemmas, where emergency aid is given instead of support for long-term development and systemic changes.

'SNAIL MAIL' AND THE 'THE GAME AND THE PLAYERS'

It's a strange feeling, reading the chapters on USAID, the World Bank and the World Health Organisation during a time when they all are under siege by the Trump administration—curtailed in funding and ridiculed for their missions by the billionaires and autocrats that are shaping global politics now. For Frank, his visit to the USAID offices in Liberia – tucked inside the massive concrete fortress of the U.S. Embassy – left him with mixed emotions. Entering the building and passing through tight security regulations was no small feat. Even something as simple as sending a letter to a colleague within that building could take ages, delivered at a pace that felt almost symbolic – 'by snail'. The staff inside often carried a quiet sense of apology for the heavy bureaucratic machinery they had to navigate each day. In many ways, the complexity of the building mirrored the complexity of development cooperation, the work on the ground itself: navigating layers of policies, politics and procedures, and full of contradictions.

The chapter *The game and the player*s continues along this line of thought. Reflecting on his own work and that of his colleagues – both in donor and recipient countries – Frank compared it to a stage play, where each participant knows his role, which, shaped over time by politics and competing interests, almost seem predetermined. A perhaps cynical observation follows, but one that seemed

to be true in a number of assignments he had worked on. For example, his experience in Mali, where he collaborated with the national team on strengthening the country's health system. Although all partners were genuinely committed to the shared goal, translating intentions into practice proved far more difficult. Cultural, political, and economic differences, divergent administrative systems and protocols, and external pressures (for example conflict or trade protection measures) often obstructed meaningful cooperation in many bilateral and multilateral aid efforts. Frank weighed the advantages and disadvantages of investing in smaller-scale initiatives, bypassing governmental systems – often bureaucratic and coloured by politics. While this approach may seem attractive, especially in the short term, he recalled the reasoning for evolving to the current day approach of collaboration and co-creation, grounded in mutual respect and equality.

HOW TO SOLVE THE PUZZLE OF WAJIR

Reading Terwindt's book and recalling both the success stories—like the establishment of the community care centres in Mali, which eventually became fully integrated into and run by the community—and the many challenges and dilemmas he faced along the way, I think about the many lessons to be learned. Our ability, or willingness, to learn them is often limited by the circumstances we work in, or by the need to swim against the current in an increasingly politicised environment. Funding cuts in development cooperation and the curtailing of academic research and international collaboration are just a few examples of how our work is continually being reshaped.

Yet, books like *The Puzzle of Wajir* are essential. They help us reflect critically on core issues in our field, like the business approach and the win-win paradigm, the revival of health initiatives *by and for the people*, the ethical complexities of social marketing strategies, and much more.

As Frank reflects on his long career in development cooperation, one thing becomes clear: the puzzles of global health and development are complex, interconnected, and never fully solved. His book offers valuable insights for anyone involved in or curious about this field –especially at a time when we are confronted with an increasingly turbulent political and environmental landscape. Whether you're a global health student or professional, or simply interested in understanding the particulars of development work, *The Puzzle of Wajir* is a compelling read.

The final chapters take a forward-looking turn, as Frank recalls *Lords of Poverty*, Graham Hancock's searing critique of the aid industry. Written in 1989, during the height of generous public spending on aid projects and the heyday of the World Bank and IMF's structural adjustment programmes, it exposed how these institutions pushed countries into sweeping reforms in exchange for loans, often with lasting and painful consequences.

So many of those lessons were already on the table back then. Why didn't we learn them? They were relevant then, and they remain just as relevant now. In the closing pages, Terwindt poses a deeply personal question: *if he had to choose between saving humanity or saving the planet, what would his choice be?*

You'll find his answer on the final page of the book.

Esther Jurgens, Medical Sociologist
NSGH (former NVTG), Maastricht University

estherjurgens@xs4all.nl

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Book review and issues for reflection

INTRODUCTION

In an earlier contact with Frank Terwindt, I offered some reflections on his book and started by stating that while some of my comments might seem critical in nature, in no way should these be taken as negative or condescending. I profoundly admire his initiative to summarize his career and all that he has experienced during his work as public health consultant. We need books and ''feedback" like this; why are these so scarce?

The book is well written, and I had no problem reading it twice to fully absorb and digest the contents and to be able to give feedback that, it should be mentioned, will be through the eyes of a clinician, be it with 30 years' experience of working in Africa and other areas, but with limited exposure to public health and emergency aid.

In general, given the wide range of missions to many countries in Africa and Asia, plotting the dates of visits on the maps could have been useful to understand developments and issues over time.

ISSUES ON THE COLONIAL PAST – A NUANCED OPINION IS NEEDED

What struck me most is the long account of missions that proved to be challenging and did not result in a satisfactory outcome, at least not in the long run. There are only a few success stories. Having said that, perhaps that summarizes the complexity of developmental collaboration. I do not think one can generalize this in stating that we, as developed countries, are exploiting our wealth to maintain our privileged position and that we should prioritize decolonization. This does not do credit to all who have committed themselves to the wellbeing of those living in low-resource settings for many years, driven by altruistic motivation. Here, support on a smaller scale may be more effective than larger scale support (read: governmental). In addition, developmental collaboration has been and should be

driven by mutual respect and focused bilateral collaboration seems to work best.

Indeed, not all that is wrong can be attributed to the colonial past. There are many examples of successful collaboration, certainly in the field of curative and preventive medicine, and many young individuals from the Global South have successfully been able to become senior specialists, researchers, policy makers and professors, being role models for their own younger generation. The current position of the Dutch government on developmental collaboration is reprehensible and short sighted; it breaks with a long-standing tradition of providing support in collaboration with partners in low- and middle-income countries (LMICs), based on solidarity and humanitarian principles. Education was among the issues that received support, and this provided, for example, an important and essential impulse to the success story in the development and maturation of the College of Medicine in Malawi, at the time the only public medical school in the country.

Not all LMICs are performing poorly; Namibia, Botswana, Zambia are examples in Africa of countries that are doing well with stable governments and responsible use of their natural resources. Similar examples can be found in Asia. Good governance is key and access to education is the basis of success with an open view on international collaboration for mutual benefit.

ISSUES FOR REFLECTION

It is regrettable that Frank Terwindt made no reference to the transfer of knowledge, sharing of experiences, and training of the younger generation; what lessons can the new generation of public health consultants learn from the book other than that developmental collaboration is fraught with difficulties and frustration?

I would also have liked to see a reference to One Health, especially in the context of climate change. In addition, regarding the shortage of essential medicines, I would have liked to see more about access, including generic medicines that could be made available through the WHO prequalified medicines mechanism. And, is research not an essential component of developing new ideas and vision for the future? More attention to the curative aspect of health care would have been useful, such as a critical appraisal of 1st,2nd and 3rd line health care; do we need more medical assistants, clinical officers, medical officers, or more specialists? What about Family Medicine?

If possible, there is nothing wrong with involving Dutch companies (this is now the philosophy of the NL government regarding developmental collaboration), but only if appropriate; this would only cover a fraction of the need. Sometimes you just need seed money for humanitarian support to help those affected and to get to the next, more stable, phase with structural support. Education and training are mostly provided by public institutions. Here, one also understands the barriers that Frank Terwindt has described in the predominantly horizontal approach; it would have been good to address the successes of vertical approaches such as in hiv/aids and tuberculosis. Of course, these approaches compete for staff and resources, but without UNAIDS (in fact a big vertical program), combating hiv/aids would not have been so successful in a relatively short period of time. Also here, the author could have added his vision for the future.

CONCLUSION

Notwithstanding the above, Frank Terwindt provides a major and important contribution to the debate on developmental collaboration and his experience is invaluable. Hopefully, this will inspire the younger generation and perhaps most of all, convince the NL government that they are on the wrong track and acting against the spirit of most of the Dutch public for whom compassion for those living in less favourable circumstances is a way of life.

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Ed Zijlstra, internist
Rotterdam Center for Tropical Medicine

e.e.zijlstra@roctm.com

A Journey Through Global Health: From 'Health for All' to contemporary global health challenges

Esther Jurgens serves as editor-in-chief (between 2020 and 2023, ad interim, together with Ed Zijlstra).

This edition of MT*b* centres around saying goodbye and reflecting. At the same time, we have a forward-looking perspective. That is also the spirit I want to bring to my contribution to the Speaker's Corner – a space reserved for the voices of recent editors-in-chief in this final edition of MT*b*. In my piece, I want to reflect on the sources of my inspiration and what continues to drive me: a deep belief in taking an interdisciplinary approach to tackle the complex issues and dilemmas we face in global health.

My academic background in medical sociology laid the foundations for the way I approach global health. From the very beginning of my studies and career, I realised how social scientists and medical professionals can – or rather need to – complement each other when it comes to addressing the concrete realities of global health. The solution is not the proverbial magical bullet – a vaccine, a new drug or a breakthrough treatment – as sometimes (ineffective) global responses to combatting the HIV/AIDS epidemic and the COVID-19 pandemic have shown. Medical innovations alone are not sufficient, as successful implementation equally depends on addressing the wider context and broader social and structural determinants, including discrimination, financial limitations or treatment adherence, and active engagement of communities in shaping sustainable health solutions.

In this column I want to tell the story of how these insights matured and developed throughout my professional work – working for UNICEF in Latin America and the Caribbean, consultancy work in global health, with Maastricht University and the NVTG. I chose three examples from my work over the past three decades of working in development assistance, with a particular focus on sexual and reproductive health and rights (SRHR). The three examples reflect my inspiration and approach – grounded in the firm belief in cross-fertilisation between disciplines, allowing quantitative and qualitative research to complement each other.

FIRST EXAMPLE: 'MEN AT RISK'

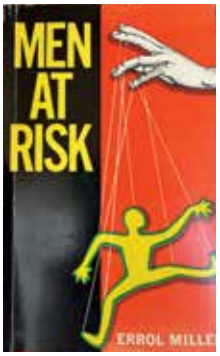
In the early 1990s, a year after world leaders endorsed the Convention of the Rights of the Child (CRC: a political charter, comparable with today's Sustainable Development Goals) – with the notable exception of the United States – I began working with UNICEF in Belize, Central America. At the time, our guiding principle was "Health for All by the Year 2000", a slogan that captured a somewhat hopeful momentum of the era because of increased immunisation – from 10% in the early 1980s to nearly 70% by the decade's end – almost eradicating polio and decreasing infant mortality levels, partly as a result of increased access to safe water and sanitation.

Due to the small size of the UNICEF office – mirroring the country's population of less than 200,000 – I was fortunate to be involved in a wide range of areas. As a recently graduated medical sociologist, I worked with the Medical Statistics Bureau to strengthen Belize's vital registration systems, from remote rural villages to the capital, by collecting data for UNICEF's situation analysis of children and women, and contributing to surveys on infant mortality and diarrhoeal diseases. It was also a time when the focus of international health began to shift toward adolescents – an age group long overlooked in health programmes. Another approach that took root in the early 1990s was the introduction of gender mainstreaming as a tool to promote gender equality across all levels.[1] Although the concept was already introduced at the 1985 Nairobi World Conference on Women, it took more than a decade to be formally adopted as a universal strategy for policy and programming.[2] This was no different for UNICEF. As a children's fund, its early perspective on women's needs was primarily shaped by their reproductive role – the "R" in Sexual and Reproductive Health and Rights (SRHR).

My work with the Women in Development Department within UNICEF, collaborating with NGOs and the Government Department of Women's Affairs, taught me many lessons, amongst others the persistent and far-reaching implications of gender imbalances in society. For example, addressing violence against women required a multi-faceted package of interventions. This included support for the passing of the Domestic Violence Bill, the provision of legal assistance and medical care to victims of violence (now referred to as 'survivors'), and the establishment of safe spaces for girls and women in need of protection. Yet I felt something was missing. If we are truly committed to breaking the cycle of violence, we must examine the underlying conditions that give rise to or sustain structural power imbalances and abuse. This means acknowledging and addressing the toll that gender inequality takes not only on women and girls, but also on boys and men—particularly through rigid stereotypes that uphold harmful forms of masculinity. Understanding gender equality merely as women's empowerment, or mentioning 'women and men' without considering their different lived realities is simply not enough. In addition, women and men are not homogenous groups. Addressing their needs meaningfully requires looking beyond and considering characteristics such as age, ethnicity, sexual orientation, and social status. From then on, my understanding of gender equality as an inclusive and multidimensional concept has only deepened. Yet we can't afford to become complacent. This holistic gender approach – carefully built up since the mid-1980s – is at risk. In the current political climate,

marked by the Trump administration's ban on terms of gender, gender identity and any reference to gender ideology is systematically being dismantled.

… back to the early 1990s, where I had the opportunity to meet Errol Miller, the Jamaican author of Men at risk, during his book tour in Belize. In this book, he explores changing gender dynamics in American and Caribbean societies, and addresses the often-contradictory nature of patriarchy and the ways in which masculinity and femininity are socially constructed and shaped over time within the Caribbean context. Insights like these, combined with my research and programming experience in the country, reaffirmed earlier notions on what it takes to develop effective programmes and policies – whether in health, education or beyond. What is required is a phase zero, in which we take time to genuinely try to look at the root, underlying, causes of health problems, and the context in which they occur. Failing to understand them makes our efforts superficial and, at worst, counterproductive.



In an effort to challenge traditional gender roles and expand employment opportunities for young girls in Belize, I proposed supporting a vocational training programme that would enable adolescent girls to enter non-traditional professions – such as mechanics and air-conditioning repair. It nearly failed, as UNICEF policies required funds to be channelled through government ministries, and stand-alone or so-called "isolated projects" were discouraged. Of course, I understood the rationale for this, though I doubted whether the Ministry of Education at the time would have prioritised such a progressive gender-equity initiative. Luckily, the programme got implemented.

SECOND EXAMPLE: VIACRUCIS DE LA MUERTE MATERNA

Despite my earlier idea to leave the UN behind, I found myself returning to UNICEF in 1999 – this time with the Regional Office for Latin America and Caribbean (TACRO). Once again, I worked within Social Monitoring and Evaluation, and what is now called the "Gender Unit". Assignments that reinforced my belief in cross-sectional and interdisciplinary approaches were the development of two regional position papers: one to adapt the globally formulated goals on the reduction of maternal mortality (MM) to the Latin American and Caribbean (LAC) context, and the other to shape a regional stance on adolescent health.

I'll focus here on the regional maternal mortality strategy, as it is a perfect example that shows the importance of combining medical and sociocultural perspectives when addressing the persistent reality of preventable maternal death. While regional maternal mortality averages in LAC were lower than in parts of Africa [3], they masked stark disparities between countries and within countries. My co-researcher on this project was a Cuban gynaecologist, and together we conducted fieldwork in several countries in the region. In Lima, Peru, she started with examining the state of the blood bank. While driving in our four-wheel drive to a remote health post in the Andean highlands of the country, I asked myself how on earth a pregnant woman would be able to walk to the centre for the recommended prenatal controls, let alone get there in time in case of an emergency. That the health centre lacked a quality-controlled stock of blood when in need of emergency obstetric care came as no surprise.

Still in the highlands, but in more urban areas, we encountered a different problem: the near-empty waiting rooms of a well-equipped maternal ward. Through discussions with local women, we learned that women were hesitant to use these services – not so much because of presumed medical care, but mostly because of cultural barriers: the white coats of the doctors, the birthing position, and the exclusion of traditional birth attendants (TBAs)[4] – who to them played an important role in emotional support. These were not just medical issues, but rather issues of cultural awareness and receiving culturally appropriate maternal health care.

These insights formed the foundation of a comprehensive regional strategy that recognised the full spectrum of factors influencing maternal health. Too often, the discourse around maternal mortality has focused exclusively on failures within the health care system—such as inadequate emergency obstetric care. As we wrote in the strategy: "There is no doubt that a great number of maternal deaths could have been prevented if these women had reached a health service in time and received obstetric care of respectable quality. But an analysis focused solely on the immediate, clinical causes of maternal mortality ignores the broader web of responsibility—one that includes not only the state, but also families, communities, and everyone involved in supporting a woman through pregnancy, childbirth and the postpartum period."[5]

In the strategy, we proposed an integrated approach and outlined the barriers to accessing at least the basic minimal standards of health care services: economic, geographical, and cultural barriers.[6] Through this lens, we presented case study analyses – including the illustrative "viacrucis" (cross-bearing) of Mrs. X – demonstrating how her death could have been prevented. It showed the need for action at all levels: emergency clinical responses, targeted interventions for high-risk groups, and, importantly, integrated and rights-based policies to address the fundamental causes of poor maternal health outcomes. Avoidable maternal deaths are not just failures of care; they are violations of human rights.

THIRD EXAMPLE: MUTUAL LEARNING, COLLABORATION, AND CURRICULUM DEVELOPMENT

The final set of examples reflects three

curriculum development initiatives – one in maternal health in Georgia, and the other two in climate change and health in Bangladesh. These projects reaffirmed the importance of mutual learning and interdisciplinary collaboration.

Central to our work in Georgia – a former Soviet republic, eager to reform its health care system, as it was still predominantly hospital-based and curative in orientation – was the repositioning of midwives within the maternal health system. The goal was to enhance their competences (by designing a midwifery curriculum at the University in Tbilisi) and to work on more systemic changes by granting them a more central role in prenatal and delivery care.[7] "You can write a curriculum in an evening", remarked our partner at Tbilisi State Medical University at the beginning of our three-year collaboration on designing a midwifery training programme. While drafting a curriculum may indeed be relatively quick, the transformation of the institutional, cultural, and professional context in which midwives operate – and enabling them to take on this central role – is a far more complex process, which takes much, much longer. In this programme, we also collaborated with a gynaecologist who had bought a previously state-owned hospital – taking advantage of the country's shift to market liberalisation and the introduction of private health care. This allowed him to introduce a new model of maternal care – elevating the role of midwives – and to implement a cross-subsidisation scheme that guaranteed access to quality care for pregnant women regardless of their financial means. The restructuring of professional roles, education and interprofessional collaboration – particularly across traditionally rigid boundaries between gynaecologists, midwives and nurses – were crucial elements to the success of the initiative.

Maastricht University, a pioneer in Problem Based Learning (PBL), was invited to serve as a technical partner in two Erasmus + programmes. [8] The first, the TRANS4M-PH programme [9] supported three universities in Dhaka, Bangladesh in redesigning nine (public) health courses. The second, the ongoing ACCESS4ALL programme, focuses on climate change & health education. It encourages students and young professionals to understand both the immediate and the root causes of climate change and to analyse how structural factors worsen its impact. In these curricula, the PBL approach enables students to develop a critical lens in order to dive deeper and to question dominant narratives and the myths, misconceptions and simplifications in many public debates on climate change. Students are invited to embrace complexity – to unravel the multi-causal nature of current day challenges in global health, like understanding the impact of climate change on health. This is the precursor to developing more nuanced and interdisciplinary approaches to address contemporary global health problems.

As with the midwifery initiative, implementing such change requires more than enthusiasm from a core group of colleagues. While the participating faculty quickly saw the benefits of the new approach, embedding these innovations into the wider academic ecosystem proves more challenging. Many institutions are still rooted in traditional modes of instruction and knowledge transmission. Transforming these mindsets will take time.

EPILOGUE

Finally, I return to my longstanding involvement with Medicus Tropicus, later MT, MT*b*, and now Global Health Perspectives. From the early days of my work with the NVTG, I contributed to the journal – first as an editor, later as editor-in-chief. In the early days, editorial work was relatively straightforward. The journal, then in Dutch, was a combination of news from the Society and articles. Over the years, and because of my work as policy advisor, I became a more and more stable factor in the editorial team, as I had been part of the journal's transformations over the past decades.

An essential theme throughout this journey has been, and still is, my commitment to bridging the gap between clinical medicine and public health, between the biomedical and the social sciences. The 2007 edition of the ECTMIH – hosted in the Netherlands by NVTG and partners – was illustrative, as we explicitly articulated the importance of cross-fertilisation between disciplines and professions. It's a spirit that continues to guide my work and thinking up to today.

Lastly, but certainly not least, I would like to thank all the colleagues with whom I've had the privilege of working. Not only was it fun and enjoyable to work with you, I also learned a lot.

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Esther Jurgens, Medical Sociologist
NSGH (former NVTG), Maastricht University

estherjurgens@xs4all.nl

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3. At that time the average rates in LAC were 189/100,000 live births, and the risk of death during pregnancy and live birth was 1 in 130 - with the highest rates in Bolivia, the Dominican Republic, Haiti, Honduras and Peru.
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6. The proposed framework for assessing and analysing maternal health included the need to address underlying factors (status of girls and women in society and women's vulnerability to poverty, among others); the intermediate causes (health and nutritional status of women, reproductive and maternal health rights, and knowledge, attitudes and behaviour that influence female health); and immediate causes (medical complications during pregnancy, childbirth, or postpartum).
7. Enhancing quality of care: Upgrading the knowledge and skills of midwives in Georgia (2008-2011). Implementing partners in Georgia: HERA XXI; Tbilisi State Medical University; Georgian Obstetricians and Gynaecologists Association. Implementing partners in the Netherlands: ETC Foundation; Rotterdam Academy of Midwifery; International Confederation of Midwives.
8. The Adapting Climate Change Education Skills and Sustainability for Advancing Locally-led Solutions (Access4All) Programme. Partners: James P Grant School of Public Health, BRAC University, Bangladesh; Independent University of Bangladesh; University of Liberal Arts, Bangladesh; Maastricht University, The Netherlands; Heidelberg Institute of Global Health, Heidelberg University, Germany. See: https://www.access4allhub.com.
9. The Transformative Competency-Based Public Health Education for Professional Employability in Bangladesh's Health Sector (TRANS4M-PH) Programme, running from 2019 – 2021. See: https://trans4mph.org

Neutral

I initially had a very different column in mind. As the title, I intended to use the green capital letters on the white OR board of the now-destroyed Al Awda Hospital in Gaza: "*We did all we could. Remember us*." Then, with the remaining 450 words we are allotted as columnists, I would list the names of all our murdered colleagues. First name, surname, and specialty. Until my words would run out, fully aware that the list would be nowhere near complete.

It would have been a gesture of solidarity, a tribute to the plea on the OR board in that surgical theatre and an attempt to transform the anonymous figures that flash across our screens into individuals again. It would have also been a call to action: for us, as medics, to speak out and to hold our governments to account. But I would have also chosen this unconventional format simply because I found myself at a loss for words. Every superlative describing the complete collapse of Gaza's healthcare system had already been used.

I never dared write that column. Friends warned me it was too politically charged and might undermine my neutrality as a doctor.

It got me thinking about our role as physicians in political discourse. This debate is not new. The eminent physician, pathologist, anthropologist, and politician Rudolf Virchow said it in 1848 already: "*Politics is nothing else but medicine on a large scale*." His words highlight a fundamental principle of public health: that illness and wellbeing reflect the successes and failures of society as a whole. Promoting health therefore demands political engagement. Virchow's convictions led to his dismissal from Berlin's Charité Hospital in 1849.

Yet he continued to advocate for safe drinking water and sanitation, for new hospitals, for childhood vaccinations, and for gymnastics classes for girls.

I am proud we have our own Virchows here in The Netherlands: fellow medical professionals who campaign against poverty, the tobacco lobby, loss of biodiversity, the food industry, and racism, for example. It takes courage, as political involvement by doctors has always evoked controversy. In the United States, for instance, medics were admonished to stick to their expertise when they spoke out against mounting gun violence and political gridlock over firearm regulation in 2018. "*Stay in your lane*," they were told.

In response, they launched the #thisismylane campaign, encouraging healthcare workers to speak up—even outside the traditional realm of medicine. I wholeheartedly join them, now more than ever. The entire population of Gaza is ill. We urgently need political action to help them heal.

Jamilah Sherally
Medical Doctor in Global Health
VU Amsterdam

jamilahsherally@gmail.com

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