

# MTb

BULLETIN of the NETHERLANDS SOCIETY for TROPICAL MEDICINE and INTERNATIONAL HEALTH

N° 01 / MARCH 2018 - VOLUME 56



**INTO THE WORLD**



# CONTENT

Editorial 2

## CAMPAIGN

Global health doctors: a view from abroad 3

The revised curriculum for the training of the Doctor Global Health and Tropical Medicine (AIGT) 6

Guest editor Heleen Koudijs introducing the 'why' and 'what' of the campaign Into the world 9

Goodwill alone is not enough 15

## CONSULT ONLINE

A patient with a painful thumb 16

## RESEARCH

Medical Journal of the Dutch Indies 1852-1942 – a rich source for research 18

Cover photo taken in Uganda

## INTO THE WORLD AND BACK



Some of you may have missed the launch of the book *Into the World* last December. But it must have been much more difficult *not to have noticed* how the media and others

have picked up on the underlying message of the book and the campaign. NVTG and the AIGT training institute are calling on the Dutch government for structural financial support to the training programme for global health doctors. As support for their appeal grows, not only from within the ranks of the NVTG but also from a wider circle, the call is gaining in strength.

The editorial board of *MTb* decided to contribute to the debate by providing some background on the ongoing campaign. We invited Heleen Koudijs to be our guest editor and present us with this background information. She selected interviews with global health doctors and endorsements from various stakeholders in the Netherlands for *MTb*. Support from overseas is also included in this edition, with the contribution of Richard Smith – former editor of *BMJ* – who outlines the four and perhaps even five wins that are at stake with the future of the AIGT training programme.

*Global health is fashionable* noted Jeffrey Koplan as early as 2009.<sup>[1]</sup> He was right and he still is; over the past decade, global health has conquered a solid place on many agendas. The Dutch Ministry of Health (VWS in Dutch) is in the process of formulating a global health strategy, thereby following the example of Germany, Sweden and the United Kingdom, among others. Two years ago, the Netherlands Organisation for Scientific Research (NWO), developed a global health research agenda as part of the Dutch Science Agenda for inclusive global development.

Public and private parties are recognising the *global aspects* of health, empha-

sizing the need to define shared opportunities and threats in cross-border health, and developing a joint response.

The *Into the World* campaign places the spotlight on the role of medical doctors in global health. Rightly so, given the historical ties of NVTG with the training programme and the fact that many of its members are medical doctors. However, one of the beauties of the concept of global health is its comprehensive and multidisciplinary approach to health. "Good health" does not depend on good access to medical care only but is a consequence of other factors, recapped in the discussion on the crucial role of social determinants of human development and health. Obviously, addressing these determinants is not in the hands of medical doctors only. Koplan formulates this as follows: '*It [Global Health] has driven the establishment or restructuring of several academic programmes, is supported by governments as a crucial component of foreign policy, and has become a major philanthropic target.*'

The Netherlands has a lot to offer in the field of global health, be it through health service provision, research, product development, teaching, advocacy, trade, or foreign policy. It has been fun for us to put together this edition of *MTb*. We hope you will enjoy reading it.

ESTHER JURGENS, LEON BIJLMAKERS

1. Koplan J. Towards a common definition of global health. *Lancet* 2009; 373: 1993-95

# Into the world

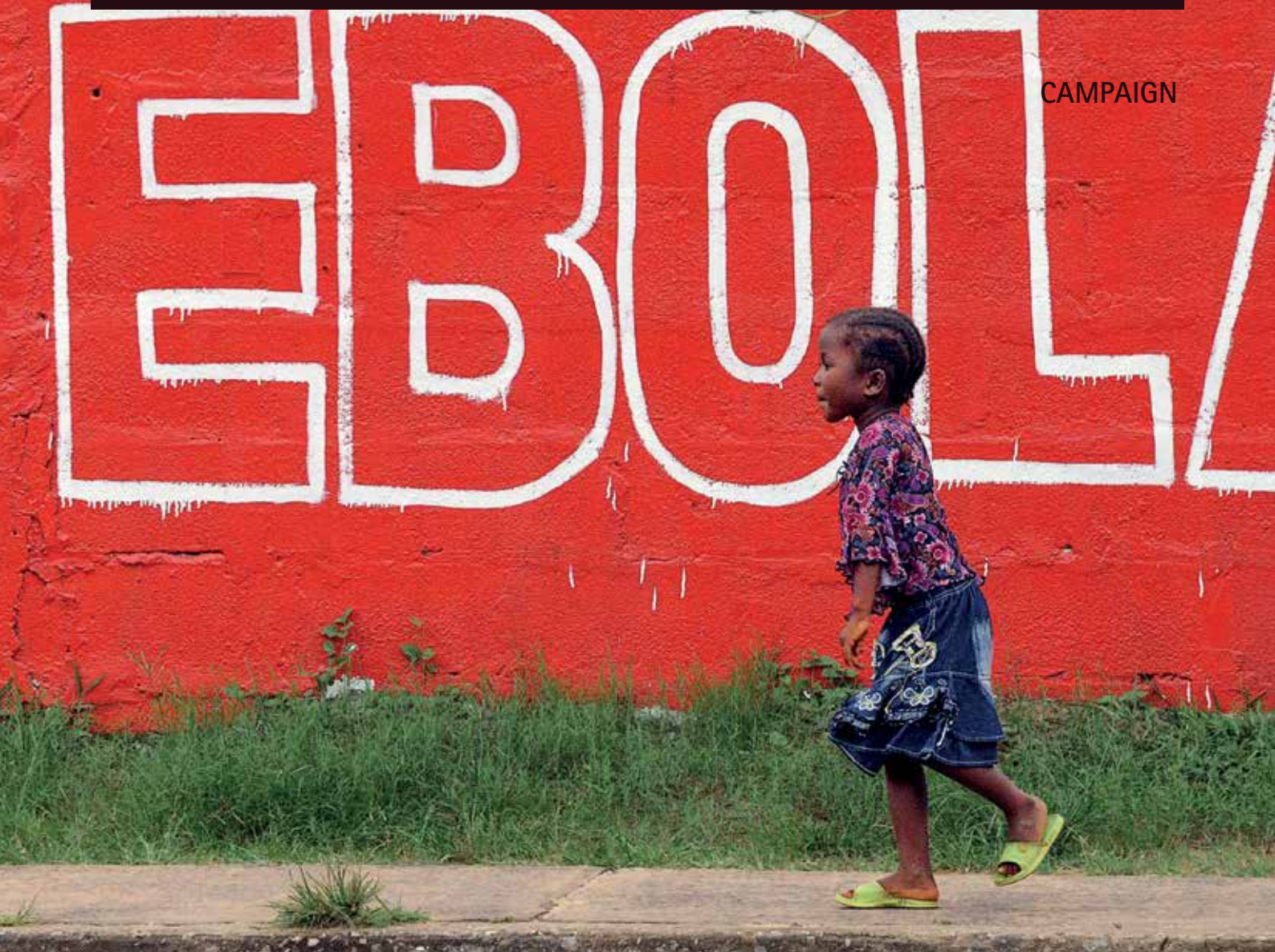


PHOTO CAMPAIGN INTO THE WORLD

## Global health doctors: a view from abroad

**I**n the December 28, 2017 issue of BMJ, Richard Smith published a blog in which he makes a case for sustaining the global health doctors training programme in the Netherlands.<sup>[1]</sup> The training programme is not new to him as he taught on the global doctors programme twice a year for about six years. In this blog, *Celebrating the Dutch global health doctors programme*, he presents the career paths of some of these global health doctors. By doing so, he aims to present to a wider public the characteristics of this new breed of medical doctors – doctors specialised in tropical medicine

who in their daily work in low- and middle-income countries had to deal with every aspect of healthcare, not only clinical work but also drug supply, finances, relating to government, and working with the community.

In his blog, Smith illustrates how these doctors – upon returning to the Netherlands – apply these specific skills and knowledge to their day-to-day work in the Dutch health care context. He also describes the competencies that global health doctors develop during their training and by working in low-income countries. These include an understanding and appreciation of the big picture, realisation of how privileged we are in Europe, flexibility,

appreciation of better/more sustainable health systems and models of care, and recognition of the importance of community, to name just a few. He concludes his blog by adding a fifth win that might convince the government to finance the training programme, namely *‘that the Dutch global health doctor programme is unique and something for the Netherlands to celebrate with pride. It’s a gift from them to the poor world and to themselves’*. Curious about the four other wins? Read about them in Smith’s contribution to the book *Into the World: ‘It’s time for the North to learn from the South’*, reprinted on the next pages.

*Esther Jurgens*



## Richard Smith

is chair of the board of trustees of icddr, b (formerly the International Centre for Diarrhoeal Disease Research, Bangladesh), and until 2015 he was the director of the United Health Chronic Disease Initiative, an initiative that resulted in eleven centres in low- and middle-income countries (LMICs) that work to combat chronic disease. He is an adjunct professor at Imperial College Institute of Global Health Innovation. From 1979 to 2004 he worked at the BMJ and was the editor of the journal and chief executive of the BMJ Publishing Group from 1991 until he left. He regularly publishes a blog in the online Journal.

### IT IS TIME FOR THE NORTH TO LEARN FROM THE SOUTH BY RICHARD SMITH<sup>[2]</sup>

In 2006 Lord Crisp stepped down as chief executive of England's National Health Service (NHS) and went to Africa to see how the NHS could help African health systems. His radical conclusion was that Britain and other high-income countries had more to learn from low-income countries than the other way round. He reported his conclusions in a government report, *Global Health partnerships*<sup>[3]</sup>, and a highly readable book *Turning the World Upside Down*<sup>[4]</sup>. His conclusions mean that health care workers from high-income countries who spend time working in low-income countries may learn much that will benefit health systems in high-income countries – in addition to developing a set of attitudes and skills that are useful anywhere.

### TURNING THE WORLD UPSIDE DOWN

Central to Crisp's argument is the

observation that health systems in high-income countries are not sustainable. The United States is already spending more than eighteen percent of its huge gross domestic product on health care, with poor results, and expenditure continues to rise inexorably. The same rise is seen in other high-income countries, and the main drivers are not aging of the population and increasing non-communicable disease (NCD), although these contribute, but the fact the cost of most new health technologies increases faster than inflation. Health care systems in high-income countries are dominated by hospitals and specialists and concentrate on treating people with established disease rather than creating health and preventing disease. They suffer from 'supply-induced demand,' whereby hospitals fill up, often with patients who may benefit little from the care, and specialists offer an ever-increasing array of treatments, many of which are expensive but add only small benefit. These health systems were developed when patients had mainly acute conditions, but now patients with long-term conditions predominate. Changing these expensive health systems is politically difficult, not least because of large vested interests, but health systems in low-income countries have a chance to do better.

They shouldn't slavishly follow the path set by high-income countries but should create more sustainable systems, and at least some are doing so. I worked with eleven centres in low and middle-income countries doing research, developing capacity, and advising governments in relation to NCD, and we imagined a system that would be better suited than those in high-income countries for preventing and managing the chronic conditions that dominate in high-income countries and already account for most of the health burden in low and middle-income countries.<sup>[5]</sup> There should be an emphasis on public health, prevention, and primary care, avoid-

ing what Crisp calls 'the hegemony of clinical medicine.' Much of care can be standardised and put into protocols that can be delivered predominantly by community health workers, who are often much closer to the people they work with than health professionals. Health care in high-income countries has developed a model where health care is something that is 'done' to people by doctors, whereas a more effective model puts the patients in charge. Crisp observes that in high-income countries good health has come to mean doctors, hospitals, and technical treatments, but organisations like BRAC in Bangladesh remind us of the importance of community, family, lifestyles, culture, and behavioural and social factors. Ethiopia is trying to build a system based on health not disease. As well as teaching high-income countries about how to build sustainable health systems, low and middle-income countries also produce innovations that can reduce rather than increase costs. Examples include health workers trained in India specifically to do cataracts who can do dozens in a day; oral rehydration therapy (the standard treatment for childhood diarrhoea) developed in Bangladesh; PACK (Practical Application of Care Kit) developed in South Africa that allows nurses to deliver primary health care<sup>[6]</sup>; and the use of mobile phones to deliver health care. Innovations may be in technology, systems, policies, how staff are employed, financing, governance, and leadership.

### ATTITUDES AND SKILLS LEARNT IN LOW- AND MIDDLE-INCOME COUNTRIES

Many doctors and other health professionals working in health systems in high-income countries are unaware of how their health systems, which are admittedly complex, work; nor do they see 'the big picture' which shows that only about ten percent of 'health' is accounted for by 'health care.' Those who work in health systems in low-income countries almost inevitably

develop an understanding of the whole system and the big picture. They also come to recognise the privileges of those in high-income countries and when back in high-income countries are less likely to complain and more likely to work to make optimal use of what is available. They recognise the tension between giving high cost care to the few and more moderate care to the many – and are more comfortable with accepting the necessity of prioritising. They can make a little go a long way. Those who work in low-income countries learn to be flexible and adaptable: they have to. They develop a 'can do' attitude that will serve them well not just in the work but also in their lives. They are more likely to be effective leaders as they have to lead when there are few others to do so; but at the same time they may become better team players and followers. They learn to work effectively in different cultures, a skill that becomes increasingly important as high-income countries become more multicultural.



#### BENEFITS FROM THE DUTCH SYSTEM OF TRAINING HEALTH WORKERS IN GLOBAL HEALTH

The Dutch have been far sighted in developing a system of training health workers in global health and have produced what I describe as 'a quadruple win.' Which I explain below. I taught about non-communicable disease on the Netherlands Course on Global Health and Tropical Medicine at KIT for some seven years, travelling twice a year from London, and I've been greatly impressed with the young health workers, most of them doctors, whom I've met.

The first win is to the young people themselves. Millennials, as they are called, want meaning and purpose from their work. Everybody wants meaning and purpose from their work, but millennials want them

so badly that they will put them ahead of money, status, and career progression. Little or nothing provides more meaning and purpose than working as a health worker and a leader with populations in low- and middle-income countries with people who have little or no access to health care. In contrast, young doctors in the UK and the US – and perhaps in the Netherlands – can find themselves disillusioned working in highly complex health systems in high-income countries with little scope to make much of a difference.

The second win is to people in low- and middle-income countries who benefit from the skills and leadership of the young health workers. Many of the young doctors I've met have worked and plan to work with Médecins Sans Frontières in difficult circumstances with people with desperate needs. There is also the benefit to Europeans that by helping people in desperate circumstances the health workers make it less likely that those desperate people will start on the hazardous journey of trying to cross illegally into Europe.

The third win is to the Dutch health system – because most of the young health workers return to work in the Netherlands. They have learnt about how to extract maximum value from health systems, and they have developed leadership skills, resilience, and can-do attitudes that mean that they are better able than health workers who have never worked in low and middle-income countries to rise to the challenges that are growing every day in health systems in high-income countries like the Netherlands.

The fourth win is again to the health workers themselves. Working in the often difficult circumstances

of low- and middle-income countries gives people a robustness and resilience that makes it much less likely that they will 'burn out' in the stresses of health systems in the Netherlands and other high-income countries. These young health workers may well still be working in 2080 and are likely to have to work into their seventies. It makes a great deal of sense for them to work for five to ten years (or even longer) in low- and middle-income countries.

#### CONCLUSIONS

Surgeons in Britain used to boast of having a "Been to Africa Degree," by which they meant that they had done a great deal of operating in Africa – often doing operations that they would not be qualified to do in Britain. They no doubt did learn – but it may sometimes have been at the expense of Africans. Now, as Lord Crisp has recognised, doctors and other health workers who work in low-income countries can not only learn much that will make them more effective professionals but they can also learn much that can help create sustainable health systems in their own countries. They, the countries where they work, the Dutch health system, and the Netherlands as a whole all benefit. It's hard to think of an investment with a better return.

#### REFERENCES

1. <https://blogs.bmj.com/bmj/2017/12/28/richard-smith-celebrating-the-dutch-global-health-doctors-programme/>
2. Into the world. Experiences and views of medical doctors Global Health and Tropical Medicine, Uitgeverij Boekschap and the authors, 2017, p. 142-145. ISBN/EAN: 978-9490357-21-4
3. Crisp N. Global Health Partnerships. London: Central Office for Information, 2007. file:///C:/User/Richard/Downloads/Global%20health%20partnerships%20-%20Crisp%202007.pdf
4. Crisp N. Turning the World Upside Down: the Search for Global Health in the 21st Century. London: RSM Press, 2010.
5. UnitedHealth, National Heart, Lung, and Blood Institute Centers of Excellence. Global response to non-communicable disease. BMJ. 2011;342:d3823. doi: 10.1136/bmj.d3823.
6. Fairall L, Bateman E, Cornick R, et al Innovating to improve primary care in less developed countries: towards a global model BMJ Innovations Published Online First: 23 July 2015. doi: 10.1136/bmjinnov-2015-000045.



# The revised curriculum for the training of the Doctor Global Health and Tropical Medicine (AIGT)

The Doctor Global Health and Tropical Medicine (AIGT in Dutch: Arts Internationale Gezondheidszorg en Tropengeneeskunde) curriculum has evolved from the 'tropical doctor' training that had developed over several decades into a more structured and regulated training programme. It used to comprise clinical rotations in surgery and obstetrics & gynaecology, or paediatrics and obstetrics & gynaecology, ending with the Diploma course in Tropical Medicine at the Royal Tropical Institute (KIT). Financial pressure on the programme caused by new financing mechanisms in the Dutch health care system, combined with some quality issues within the programme, motivated the Netherlands Society of Tropical Medicine and International Health (NVTG) to seek formal accreditation of the 'tropical doctor' training programme with the Medical Specialties Council (CGS, College Geneeskundige Specialisten). It was thought that this accreditation would facilitate financing to secure continuity of the programme and improve its quality. To meet the criteria for accreditation, some adjustments had to be made to the programme. Most notably this was the addition of a 6-month training period in a hospital in a low and middle income country (LMIC) setting (Figure 1). Furthermore, the curriculum had to be redesigned in order to meet the standards set out by the CGS. Accreditation was awarded in 2012.

## ORGANIZATION

The accreditation triggered a revision of the organisational structure of the training programme. The OIGT training institute (Opleidingsinstituut Internationale Gezondheidszorg en Tropengeneeskunde) was created under an independent foundation in which the NVTG is represented in order to secure a smooth running of the programme and compliance with CGS regulations. The committee that used to organise the training programme on behalf of the NVTG was renamed the CIGT.



Figure 1. Schedule of the AIGT training programme

The OIGT is responsible for the organization, daily operation and quality of the training programme. The CIGT advises the OIGT on any related issues.

Currently, the training programme takes place in 25 hospitals in the Netherlands involving 35 trainers and an average of 25 residents who enrol in the AIGT training programme each year.

## REVIEW OF THE CURRICULUM

In June 2016, the Registration Committee of Medical Specialists (RGS, Registratiecommissie Geneeskundig Specialisten) decided to renew the accreditation of the OIGT training institute for a duration of 5 years until 2021. The Committee at the same time recommended that the current curriculum,

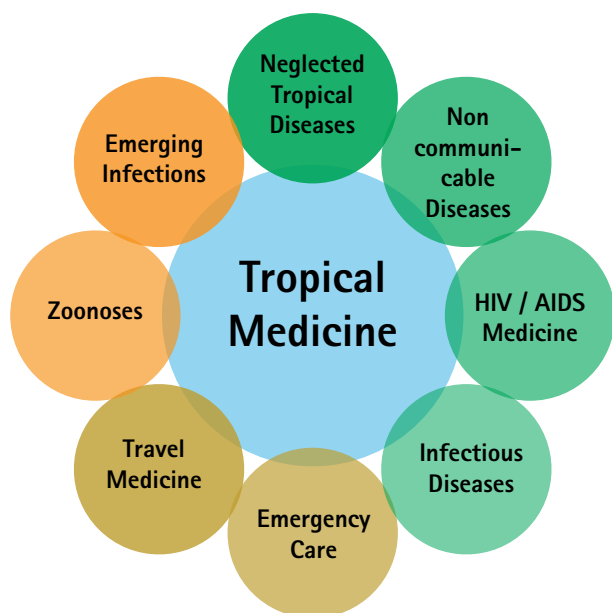


Figure 2. Broadening and deepening of Tropical Medicine anno 2017 (from ref. 1)

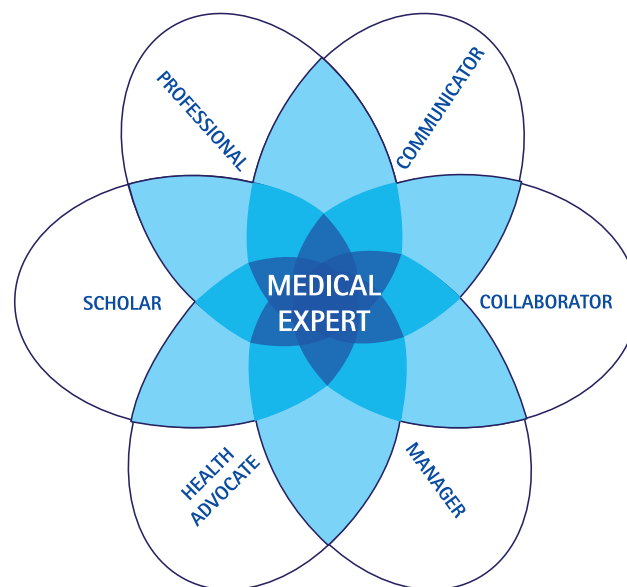


Figure 3. The seven CanMEDS roles

which was written in 2010/2011, be revised to make it more practical with clear descriptions of the two training profiles (surgery and obstetrics & gynaecology; mother & child health). The revised curriculum will be submitted to the CGS by 1 July 2018.

The NVTG has asked the CIGT to form an ad hoc committee to review the current curriculum (CHOA: committee to review the curriculum for AIGT). CHOA consists of representatives of OIGT, AIGT trainees, qualified AIGTs, surgery, paediatrics, obstetrics & gynaecology, and CIGT. At its first meeting in May 2017, CHOA decided to carry out a full review of the curriculum, taking into account the recommendations of the RGS. The curriculum needs to be simpler and more practical and flexible, based on competencies that are clearly described and that can be assessed. Better alignment with local curricula in training hospitals is also needed.

## THE REVISED CURRICULUM

### GENERAL DESCRIPTION OF AIGT

The dual character of training aimed at working in a tropical environment / LMIC setting as an AIGT and the value of the training and experience gained abroad after returning to the

Netherlands is emphasized. This is in full alignment with the concept of global health in which the continuum of curative and preventive care is described in all societies, and which is also influenced by political, socio-economic factors and climate change. In the Netherlands, this is abundantly illustrated in relation to an increasingly multicultural society due to migration. Because of this background, diseases are encountered that used to be in the realm of travel medicine among travellers such as malaria, schistosomiasis and others. In addition, the spectrum of tropical medicine has changed over the years. For example, non-communicable diseases are becoming increasingly relevant such as diabetes and hypertension (Figure 2). Because of training received and experience gained in LMICs, the AIGT is uniquely qualified to address such conditions in vulnerable populations, while taking into account the cultural aspects of disease, and can therefore contribute to the quality of health care in the Netherlands after returning as well.

### COMPETENCIES

While in the current version of the curriculum the CanMEDS ("Canadian Medical Education Directives for Specialists") roles framework was used to derive competencies (Figure 3), it was felt that these mainly focus on the doctor as

medical expert whereas the spectrum of AIGT competencies is much wider.

The special character of the AIGT should be emphasized, as it is a unique hybrid of curative medicine and public health, and in both areas the AIGT should develop leadership skills (Figure 4). In the new curriculum these are now called *areas of expertise*.

In the revised curriculum, each area of expertise starts with a general description, followed by a description of specific CanMEDS competencies in a general and in an international context.

### CONTENT OF THE CURRICULUM

The content of the current curriculum is captured in themes that elaborated extensively on all aspects of the field and are worked out according to the CanMEDS competencies. While the result was very comprehensive, some overlap could not be avoided. For this reason, in the new curriculum, the number of themes will be limited. Furthermore, Entrusted Professional Activities (EPA's) are identified that relate to these new themes. These EPA's allow an assessment of whether the candidate has mastered the relevant activity typical for an AIGT and can be entrusted to perform these unsupervised. Reorganising the content in this way should give

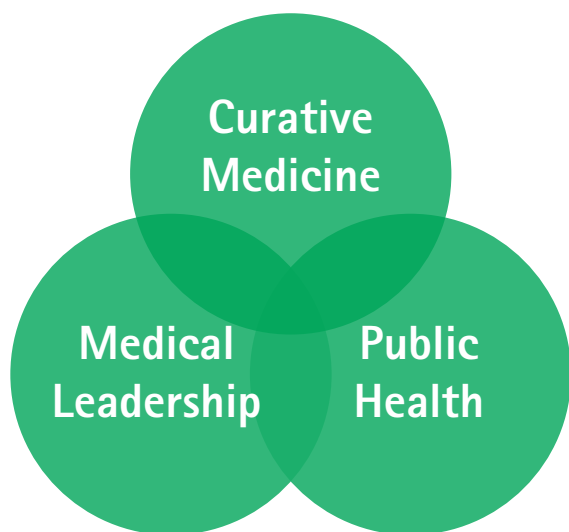


Figure 4. The AIGT curriculum - three areas of expertise

supervisors more direction and guidance during the training of the residents in Global Health and Tropical Medicine.

These adaptations will hopefully provide more practical guidance to the supervisors in the training institutions. They also seek to give a better foundation for the description and practical implementation of the two different profiles of the curriculum.

## CONCLUSION

The new curriculum that is under development is a next step in further improving the training programme for Medical Doctors in Global Health and Tropical Medicine. It is in line with new insights on how professional training is taking shape in the Netherlands and describes the programme content in terms of newly defined EPAs. Besides acknowledging all the good of the first official curriculum for AIGT, it hopes to provide more practical guidance for supervisors in the training institutions.



ED ZIJLSTRA - CHAIR OF COMMITTEE TO REVIEW THE CURRICULUM FOR AIGT (CHOA)

E.E.ZIJLSTRA@ROCTM.COM

BAREND GERRETSEN - DIRECTOR OF TRAINING INSTITUTE IN GLOBAL HEALTH AND TROPICAL MEDICINE (OIGT)

BGERRETSEN@OIGT.NL

## REFERENCE

1. Zijlstra E.E. From Global Health to Tropical Medicine? *Medicus Tropicus* bulletin 2017; 55: 3-6.

## COLOPHON

MT Bulletin of the Netherlands Society for Tropical Medicine and International Health

ISSN 0166-9303

CHIEF EDITOR

Leon Bijlmakers

EDITORIAL BOARD

Jan Auke Dijkstra - Nicole Fiolet -  
Esther Jurgens - Annefleur Langedijk  
- Josephine van de Maat - Andrea van  
Meurs - Ed Zijlstra

LANGUAGE EDITING

Eliezer Birnbaum

COVER PHOTO

Hanneke de Vries

DESIGN

Mevrouw van Mulken

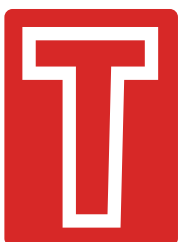
© NVTG 2018





## GUEST EDITOR HELEEN KOUDIJS introducing the 'why' and 'what' of the campaign INTO THE WORLD

PHOTO FREDRIKE ROOZEN - SLIEKER



his edition of *MTb* breaks with tradition. Instead of highlighting a particular field in global health as we normally do, the Editorial Board invited Heleen Koudijs (Medical Doctor Global Health in training) to be our guest editor. Heleen is one

of the driving forces behind the Into the World project – the campaign aimed at public support for the training programme for medical doctors in Global Health and Tropical Medicine, an *accredited programme* that is endangered because of a *lack of a sustainable funding base*.



Heleen explains:

“The Netherlands has a long history of doctors practicing tropical medicine. The training programme on international health and tropical medicine – going back to the 1960s – gradually grew in professionalism, eventually resulting in its formal accreditation in 2012 by the Medical Specialties Council (‘College Geneeskundige Specialismen’). Accreditation however has so far not resulted in a sustainable financing base. In 2015, the former Minister of Health, Edith Schippers, decided not to provide government funding. She argued that trained doctors in global health and tropical medicine (Medical Doctors Global Health, *AIGT in Dutch*) would not contribute to the Dutch health care system, thus could not be funded from the same budget as the other medical specialisations. [See for background on the request to the Ministry of Health also the interview with Matthijs Botman elsewhere in this edition of MTb.]

Some two years ago, Matthijs Botman and Barend Gerretsen – together with Uitgeverij Boekschap and some enthusiastic NVTG members – started a project aiming to raise awareness for the work of global health doctors, explaining to a wider audience the profile of the Global Health doctors and outlining their work and contribution to the health system in the Netherlands and in low- and middle-income countries. The core of this project was the publication of a book containing the stories of twelve global health doctors and five vision articles.

It didn’t end there. The book was just the start of the wider social media campaign that was carried forward by a team consisting of global health doctors in training and medical students. We actively started to collect stories and posted them on the project’s website, Facebook page, Twitter and Instagram accounts, highlighting the broad spectrum of locations where global health doctors work and the various dimensions of their career. These locations included the Netherlands and high-income settings as well as places where they worked abroad.

It was not long before endorsements

## TRIODOS FOUNDATION TED VAN DEN BERGH

‘The Netherlands has a long tradition of training ‘tropical doctors’, who have been able to widely spread their knowledge. There is a growing need for these experts in the field of international health and tropical medicine because of increased migration, globalisation and exchange between the Western world and low- and middle-income countries, especially since climate change is causing tropical diseases to spread northwards. We can’t let this expertise disappear because of lack of funding. That would be a terrible waste.’

for the work of the global health doctor came in. In the summer of 2017, we received support from international experts such as Professor Rose McGready of the Shoklo Malaria Research Unit on the Thai-Myanmar border and Mr Stuart Ferguson, leader of the ‘Global Citizenship in the Scottish NHS’ movement.

One of the highlights of the campaign was the ‘Into the World’ public event on the 9<sup>th</sup> of December 2017, where the book *Into the World* was presented to an audience of over 400 stakeholders, including medical practitioners, supervisors, students, policy makers and NGO representatives.

The press was invited to attend, but serious media attention only took off some weeks later with the publication of two articles in the Dutch national newspaper ‘Trouw’. The articles examined the role of the global health doctor in international health and in low- and middle-income countries, and

## GLOBAL CITIZENSHIP IN THE NHS STUART FERGUSON

‘It is morally correct for health workers from well-resourced health systems to stand together with counterparts in low- and middle-income settings, who battle daunting health challenges with precious little resource. But there is also a compelling pragmatic argument. As recent infectious disease outbreaks have highlighted, the health and safety of our populations depend – at least in part – on the functionality of healthcare systems far from our own. Our health systems and our health workers will also gain resilience, fresh perspectives, and new experiences in thinking and acting globally. We are one global village of interconnected and interdependent people who must work together to meet the health challenges of our time.’

their contribution to the Dutch health care system. Other media channels picked up this message and asked why there was no sustainable funding for an apparently much needed training programme. Initially most attention was directed towards the role of the medical doctor global health for tropical diseases and preventive medicine. Soon other stakeholders, such as the hospitals involved in training global health doctors started to advocate too, highlighting the role in curative medicine and urging the government to provide funding.

## MÉDECINS DU MONDE/ DOKTERS VAN DE WERELD CHAIR TON TEUNISSEN

'Médecins du Monde advocates for continued investment in the training programme for Medical Doctors Global Health (AIGT in Dutch). The training programme is unique and offers doctors a solid base and opportunity to support other countries with their experience and expertise. They bring back to the Netherlands this unique expertise and their valuable experience of dealing with resource constraints. Working in the tropics is a unique speciality. We should not return to the days when doctors went abroad out of goodwill without a proper training. We need to encourage doctors to look beyond the walls of our health care system. It presents us with an opportunity to continue improving and optimising the health system in the Netherlands.'

In this MTb we provide a bird's eye view of our campaign with a wide selection of snapshots of how international global health experts value the training programme and of how global health doctors themselves value their work experience abroad and how that relates to their current day-to-day work in the Netherlands.

### EPILOGUE: THE WAY FORWARD

The campaign has picked up pace and continues to receive support from a variety of public, political and (global) health stakeholders. Public awareness of global

## CAPA CARE

'The recent West-African Ebola outbreak was an important wake-up call, demonstrating that failed health care systems may turn small epidemics into large global threats. In the same way as climate change demands international collaboration and solutions, many health issues demand similar international approaches. By spearheading programmes where the focus is to innovate, transform, improve and rationalize, often under very challenging conditions, the Dutch global health doctors are an important part of the development of healthcare systems in resource-poor countries, and build invaluable bridges to our Western health systems.'

health doctors is greater than ever, after several late-night talk-show appearances and a prime-time documentary episode of *Floortje naar het einde van de Wereld*, featuring a Dutch global health doctor in Papua New-Guinea. This media attention finally led to questions being asked in the Dutch Parliament and discussions are underway with the Ministry of Health (VWS) on funding options.

The journey that started last year is far from over. With renewed vigour, the NVTG, the 'Into the World' campaign team and other stakeholders continue to build an evidence base for sustainable funding. You will find more information on our website and social media channels: [www.artsinternationalegezondheidszorg.nl](http://www.artsinternationalegezondheidszorg.nl), and you are most welcome to join our advocacy!"

## ROSE MCGREADY

'Global health doctors have profoundly influenced and inspired our work. They have a solid training in the basics and know how to implement these. They also have a goal to pass on their skills in our setting to those who missed out on training opportunities due to conflict as well as a vision to make a difference in the corner of the world where they work. I do not know of a country as generous as the Dutch in this area – the global health doctors are excellent ambassadors for the Netherlands.'

## MÉDECINS SANS FRONTIÈRES / DOCTORS WITHOUT BORDERS

'The Medical Doctors Global Health train local staff and transfer practical knowledge and skills. They have been trained to do this in a culturally appropriate way. Global health doctors 'think outside the box' and look beyond the borders of their examination room and / or hospital. They are, for example, also advocates for equity in access to health for all.'



HELEEN KOUDIJS - MEDICAL DOCTOR GLOBAL HEALTH IN TRAINING, DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY, ALBERT SCHWEITZER HOSPITAL, DORDRECHT  
HMKOUDIJS@GMAIL.COM



IRENE DE VRIES



**A**fter working for two years as a medical officer in Saint Francis Hospital in Katete, Zambia, Irene worked for a year in obstetrics and gynaecology at the OLVG West in Amsterdam. ‘After a few months, I realised that this job was not my primary interest - maternal health in a low-resource setting. I knew then that I did not want to pursue a clinical career in the Netherlands. Recently I started working at KIT (Royal Tropical Institute) as advisor in sexual and reproductive health and rights (SRHR), with an emphasis on maternal and newborn care. At KIT my team supports governments and NGOs through capacity building, knowledge generation, and strengthening health systems in the area of SRHR. We work together with local partners in LMICs and - through qualitative and quantitative research - evaluate the efficacy of local programmes and interventions aimed at improving care.’

JEANETTE VAN OS



**M**y work in the clinic includes seeing patients as a general practitioner. We also have a small ward for short-term admissions. Surgical and obstetric patients are referred to the community hospital in Monkey Bay, 25 km from our clinic. My work focuses mainly on HIV and consultations that I do in our HIV-clinic, where we treat patients with anti-retrovirals and provide long term follow-up. Additionally, I supervise the other doctors and nurses who do voluntary work in the clinic and residents from the Irish General Practitioner programme who can choose to do an internship in our clinic as part of their residency.’

TESSA THIADENS



**P**eople often ask me if I don't think working in elderly care is rather boring after having worked for Doctors without Borders in conflict zones. The answer is no. Whether it's in South Sudan or Zoetermeer in the Netherlands, patients consult you with a question every day, and that's what you deal with. There are actually quite a lot of things comparable in both settings. In both you deal with vulnerable people, work rurally, and lack specialist health care. There are no extensive diagnostic tests available, which requires creativity and flexibility.’



JOSINE BLANKSMA

**J**osine Blanksma recently started working as general practitioner, having graduated from the AIGT/ MD Global Health programme in 2011. After completing her residency programme, she joined three missions for MSF (Médecins Sans Frontières) in South-Sudan, India and the DRC with a focus on care for severely malnourished children. During her last mission, she ran a popular blog and featured in a documentary about everyday life as a physician for MSF in Congo. Josine did the first year of her GP training on Texel. In the final year, she volunteered for the Boat Refugee Foundation (Stichting Bootvluchteling) on Lesbos, providing care for migrants. Since 2014 she has been a board member for MSF Netherlands.

## REMKO SCHATS



**R**emko Schats is a general practitioner and researcher. He started his career as global health doctor in 2003 and has been on three international missions since. In Chad he worked for Doctors Without Borders (MSF) as the only doctor in a camp serving 17,000 refugees from Darfur bearing both the physical and mental scars of a prolonged ethnic conflict. Missions for other organisations followed. Remko worked in Ghana in rural hospital and later as a clinical trainer for a post-tsunami malaria control initiative in Aceh, Indonesia. He returned to the Netherlands in 2007 and started training to become a general practitioner. Besides his work as GP, he has continued his efforts in global health as board member for the WHIG, a platform for family medicine and international health. From 2011 to 2014, Remko also carried out malaria vaccine research as part of his PhD programme at the University of Leiden in collaboration with Radboud University Nijmegen. He performed clinical trials immunizing and challenging healthy volunteers with live, deadly malaria parasites via bites of malaria mosquitoes. The outstanding nature of his work was recognized at the annual conference of The American Society of Tropical Medicine and Hygiene in 2013, where he won an award for clinical research.

## RINSE MEESTER



**R**inse Meester worked from 2010 to 2012 as global health doctor in the rural North of Congo Brazzaville. Pokola, the little town in the jungle where he was based, has a medical health post offering medical facilities to 30,000 Congolese people. Rinse's work consisted of diagnosing and treating (tropical) infectious diseases, supervising mother & child care, surgical procedures, conducting ultrasounds, hospital logistics, and out-of-hospital care for HIV patients. He was involved in local public health programmes aiming to prevent common infectious diseases such as malaria and HIV and was on local television and radio to raise awareness of these programmes. Rinse is currently back in the Netherlands, training to become an orthopaedic surgeon, and is in the fifth year of his residency. As a member of the Netherlands Society for International Surgery and the 'G4'-alliance, he remains committed to marginalized populations.

## ERIK STAAL



**E**rik Staal knew he wanted to become a global health doctor when he saw the father of his wife Jiska, global health doctor and surgeon himself, working in Sikonge, Sengerema in Tanzania. Erik completed his residency programme in Kennemer Gasthuis Haarlem and left with Jiska for Tanzania in 1998, where he would work for 5 years in Sengerema District Hospital. Here he focussed on surgery, orthopaedics and gynaecology. They returned to the Netherlands in 2003 as a family, and Erik started his specialty training to become a surgeon, first in Canisius Wilhelmina Hospital and later in Radboud UMC. He now works in Slingeland Hospital, Doetinchem, as trauma surgeon with a special interest in head/neck surgery. As a former board member of the foundation behind the training institute for global health doctors (OIGT) and as daily supervisor for the four global health residents during their surgical training, he is still committed to global health. Together with colleagues from Slingeland, Erik organizes two missions to Sengerema Hospital each year and supports local staff by treating and operating complex cases such as patients with neglected trauma, clubfoot and severe osteomyelitis. All participants are volunteers.



## Goodwill alone is **not enough**



In a busy Tuesday morning, in between his performance in surgery and a multidisciplinary team meeting, I got a chance to talk to Matthijs Botman, plastic surgeon at the VU Medical Centre and global health doctor (formerly called ‘tropical doctor’). Matthijs is the initiator of the Into the World project, a multimedia campaign, and the ‘face’ of the campaign to a wider audience. Recently we saw Matthijs on Dutch television where – sitting beside a former politician and a famous world traveller – he explained why the world ‘needs’ our global health doctors. The format of these shows seldom allows for providing a broad context to the issue at hand, which is why it was appropriate to focus on a few “burning issues”:

- Why are NVTG and the AIGT<sup>[1]</sup> training institute knocking on the doors of the Dutch Ministry of Health for financial support of the training programme?
- Is there actually a role for the global health doctor in the Dutch health system?
- What are the odds for success and what is the way forward?

But before discussing these issues, let’s look at what inspired Matthijs to set the campaign train in motion. What made him spending much of his free time on meetings preparing the publication, planning with the campaign team, or sitting in a make-up room for yet another public appearance on TV.

### DRIVE

It all started when he was chair of the

NVTG working group ‘Global health Doctors in Training’ (TROIE). Matthijs was one of a cohort of medical doctors enrolled in the AIGT training programme for ‘tropical doctor’. The contours of this training had remained relatively unchanged since the early nineties – consisting of clinical internships in gynaecology and surgery, followed by a 3-month public health course – although calls for a change were already being heard. Students and trainers saw the need to revise the training programme within the context of a wider development in which all medical professions were being asked to revise their curriculum in line with the CanMEDS<sup>[2]</sup> competencies [see also the article on the revised curriculum for the training of the Doctor of Global Health and Tropical Medicine elsewhere in this edition]. Matthijs, at that time hesitating between becoming a fulltime ‘tropical doctor’ or going for a career in surgery, got involved and advocated for a thorough revision of the curriculum of the training programme. His argument was that the training of doctors who dedicate part of their careers to working in low- and middle-income settings needed to undergo the same quality control as any other medical specialisation training programme in the Netherlands - no more no less.

### MINISTRY OF HEALTH: ‘WE NEED SUPPORT FOR...’

And so it happened that the curriculum was revised and the training programme professionalised, largely as a result of the sustained dedication and commitment of a core group of people. In 2012 the training institute was established providing a more solid base for the training programme. However, due to changes in the Dutch health care system, hospitals that had offered clinical internship places started to reconsider their offers.

For many years the existing agreements had been silently renewed, mainly out of goodwill. However increasingly hospitals withdrew from the training programme because of lacking compensation for their inputs. The request to the Ministry of Health (VWS) was therefore quite straightforward: include our training programme in the funding scheme for medical specialisation training programmes, which would add up to roughly € 140,000 per student per year (totalling 6 to 8 million per year). Granting this funding would end the dependency of the training programme on the goodwill of hospitals, investments by private donors, and students themselves, who privately invest about € 7000 each in their training. Besides financial sustainability, it would finally be a recognition of the value of retaining this pool of expertise – built up since the 1960s – in the Netherlands and in our globalised world. The Dutch government would be putting the money in a place dear to the hearts of many. Moreover, as Matthijs frames it, *‘Public funding for the AIGT training would be a true commitment to quality, which in the end is priceless. Let quality be our driving force.’*

### GLOBAL HEALTH DOCTORS IN THE NETHERLANDS – A CONTRADICTION IN ITSELF?

Two times already the Ministry of Health has declined the request for funding and played the ball back to NVTG. Why should they finance a training for doctors who were believed not to directly contribute to the Dutch health system? That would seem a reasonable enough argument, if indeed the global health doctors left after their training and never came back to work in the Dutch health system. But Matthijs - and many other doctors like him - prove this argument wrong. After having worked for some years in the Republic of Congo,



diseases etc.), emerging diseases like Dengue or Leishmaniasis (on the rise as a result of globalisation and climate change), and the emergence of exotic diseases such as Ebola, Marburg, MERS, Zika etc. In many cases they arrive here due to increased global mobility.

'WE HAVE THE REPORTS OF 12 DOCTORS IN THE INTO THE WORLD BOOK AND MANY MORE STORIES, ENDORSEMENTS BY HOSPITAL MANAGEMENT, MEDICAL ASSOCIATIONS, AND THE WIDER PUBLIC ON THE WEBSITE'.

he came back to the Netherlands where he continued his medical specialisation and now works as a full-time plastic surgeon in one of our hospitals. Some 30% of those who return from abroad follow suit, another 30% continue as general practitioners (GP), and another 30% find a job working in public health settings (for example in municipal public health departments), as consultants in global health, or as GH policy makers. All contribute to health care and public health in the Netherlands, with an estimated 90% of their further careers being spent in the Netherlands and not in Africa, as the public image would have you believe. So the reality is quite different.

Of course, the issue remains the same. How can the Ministry be convinced of the added value of the global health doctor in the Dutch setting? Richard Smith [see elsewhere in this MTb edition] does not need to think long about the added value of GH doctors. *'A Ministry of Health in any high-income country can achieve a quadruple win by investing in a global health doctor programme like this one.'* The quadruple win he talks about can easily be explained simply by pointing out the areas where a GH doctor adds his specific expertise. These include migrant health (addressing imported diseases like tuberculosis, malaria, HIV, hepatitis A and B, skin

#### WHAT NEXT?

The Dutch Ministry of Health is asking NVTG and the training institute to prove the added value of this new type of medical doctor for the Dutch care system. This is tricky, as we have not been systematically recording and quantifying the *added value* of being a *Doctor+* (a specialist doctor with a global health and tropical medicine view and background). There is a need to present more than anecdotal evidence, preferably hard figures and facts. The challenge is to find ways to measure the added value of aspects such as:

- The positive influence of the 'GH approach' on cost-efficient behaviour (for example in referrals in a GP practice or the use of equipment in a hospital setting).
- Being more responsive to the needs of migrant populations who have different cultural backgrounds (for example being able to understand the context where migrants are coming from).
- The hands-on experience that is increasingly needed in travel medicine.

Research is slowly picking up on this. For now, as Matthijs points out,

The quest for the structural embedding of AIGT training programme has also gained support from many sides in society and medical professionals. This will help to put the ball firmly back into the court of the Dutch Ministry of Health. And so the dialogue continues.



ESTHER JURGENS - POLICY ADVISOR NVTG AND CONSULTANT GLOBAL HEALTH  
EJURGENS.NVTG@XS4ALL.NL

#### REFERENCES

1. AIGT acronym for Medical Doctor Global Health (global health doctor)
2. CanMEDS is an educational framework that describes the abilities physicians require to effectively meet the health care needs of the people they serve / <http://canmeds.royalcollege.ca/en/framework>



## A patient with a painful thumb (nerve-wracking pain)

### CASE

A 35-year old woman without previous medical history presented with progressive intermittent stabbing pain in her right thumb since six years. The pain lasts for 10-30 seconds, several times a day, for a few days in a row. The pain is most intense just below the cuticle and radiates more proximally to the arm up to the shoulder. During an attack there seems to be loss of strength of the hand while sensitivity remains normal. Attacks are provoked by heavy work, sneezing and cold. Since three years, there is a dark discoloration of the skin on the dorsal side of the thumb and the skin is as thick as leather. There is a full range of motion in all joints. No other abnormalities are found during physical examination.

### SETTING

This case is from Kikori District Hospital on the southwest peninsula of Papua New Guinea. The hospital has 80 beds and limited diagnostic capacity. Ultrasound is available, but there are no X-ray facilities and laboratory tests other than those used to diagnose HIV, syphilis, tuberculosis and malaria. Due to its location in the middle of the jungle, transport and therefore referral is difficult and only possible for those who can afford to travel.

### SPECIALIST ADVICE

Neurologists and plastic surgeons were consulted for advice on this case, in particular on differential diagnosis and therapy.

The plastic surgeon mentioned, among other, a glomus tumour or osteoid osteoma as possible causes and suggested palpating the nail to look for discoloration and pain provocation, which is pathognomonic for a glomus tumour. Furthermore, an X-ray of the thumb was advised to rule out osteoid osteoma although plain radiographs are not always diagnostic.

The discoloration of the skin could be due to the treatment of local healers or use of creams, the result of inflammation, or atrophy because of disuse of the thumb.

### FOLLOW-UP

After putting pressure on the nail, a small blue discoloration was visible and recognizable pain was provoked, compatible with a glomus tumour. As treatment option of complete surgical excision was offered. However, as the patient was afraid to undergo surgery, she opted for a biopsy and to wait for the results. Two years later (!), the results of the biopsy, which was sent to Australia, came back. The pathology report stated: 'Squamous hyperplasia in thick skin with some underlying and intrakeratotic haemorrhage. No fungi, parasites or neoplastic infiltrates are seen'. The intrakeratotic haemorrhage could result from the glomus tumour. The patient then agreed to surgical excision and is now waiting for a surgeon to visit the hospital.

### BACKGROUND OF GLOMUS TUMOUR

A glomus tumour is a rare benign vascular neoplasm arising from a glomus body, a contractile vascular structure involved in thermoregulation in fingers, palms and soles that is highly concentrated in the subungual region. Hyperplasia of these vascular structures and smooth muscle cells can lead to swelling and cause pain provoked by pressure and histamine release in response to cold. In addition,



*Leathery, thickened skin of the thumb below the nail with dark discoloration*



non-myelinated nerve fibres penetrating the tumour are another potential source of pain. The cause of the hyperplasia is unknown, but subungual tumours have been associated with neurofibromatosis and reactive hyperplasia may be secondary to trauma. Middle-aged women are most at risk. <sup>[1]</sup>

#### CLINICAL FEATURES

A glomus tumour usually presents as a small bluish or pinkish-red, painful nodule or discoloration of the nail. The clinical triad of severe focal pain, pinpoint tenderness and cold hypersensitivity is highly suggestive. <sup>[2]</sup> Diagnosis is made clinically with help of three highly sensitive and useful tests. In Love's pin test, pressure is applied on the tumour with a pinhead causing extreme pain. In Hildreth's test, a tourniquet is applied along the arm to induce ischemia which will remove the pain. Another test is the cold-sensitivity test, by provoking pain when applying ice cubes or cold water on the tumour. <sup>[1]</sup>

Despite the classical presentation, delay in diagnosing these tumours for many years is common. Frequently patients are treated for neuropathic pain or hypersensitivity and undergo unsuitable treatments. The differential diagnosis of solitary painful tumour such as haemangioma, neuroma, leiomyoma or eccrine spiradenoma should be kept in mind. <sup>[1]</sup>

#### IMAGING

A plain radiograph can show cortical thinning or erosive changes in the adjacent bone in some cases. Ultrasonography is useful in demonstrating the

size, site and shape of the lesion but is highly influenced by the experience of the user and difficult in the subungual region. An MRI is most accurate in diagnosing patients with atypical symptoms and to prevent misdiagnosis. <sup>[1]</sup>

#### HISTOPATHOLOGY

Histological features of glomus tumours include a variable composition of glomus cells, blood vessels, and smooth muscle cells. There are three types: solitary glomus tumours that are composed mainly of glomus cells, glomangioma characterized by the abundance of vessels, and glomangiomyoma with a predominance of smooth muscle cells. <sup>[2]</sup>

#### THERAPY

Complete surgical excision is a must to achieve complete pain relief and to avoid recurrence. This can be approached from above after a nail extraction, but there is a high risk of permanent damage to the nail. Multiple modified surgical approaches have been described

to prevent this complication. In the lateral approach, an incision is made close to the edge of the nail creating a large flap to reach the tumour avoiding excessive retraction of the nail. This flap is replaced after complete resection of the tumour. Although it is a benign tumour, it is necessary to remove it radically to avoid recurrence. In general, the prognosis is very good and most solitary glomus tumours do not recur. <sup>[1]</sup>



NICOLE FIOLET - MEDICAL DOCTOR GLOBAL HEALTH AND TROPICAL MEDICINE IN TRAINING  
CONSULTONLINE@TROPENOPLEIDING.NL

IRIS DE RIDDER - MEDICAL DOCTOR GLOBAL HEALTH AND TROPICAL MEDICINE. KIKORI DISTRICT HOSPITAL, GULF REGION, PAPUA NEW GUINEA.

#### REFERENCES

1. Morey VM, Garg B, Kotwal PP. Glomus tumours of the hand: Review of literature. *J Clin Orthop Trauma*. 2016; 7:286-291.
2. Sanchez IM, Ilkovitch D. A case of a glomus tumor presenting as an atypical hyperkeratotic papule of the hypothenar palm. *JAAD Case Rep*. 2017; 18:38-40. Onderkant formulier



# MEDICAL JOURNAL of the DUTCH INDIES 1852–1942 – a rich source for research

A few years ago about twenty Dutch experts in tropical medicine and medical history embarked on a project to study the history of the medical journal ‘Geneeskundig Tijdschrift voor Nederlandsch-Indië’ (GTNI: Medical Journal for the Dutch Indies). Over a period of 90 years, this journal played a prominent role in the exchange of medical knowledge and expertise in what used to be called the ‘Dutch Indies’ – which later became Indonesia – with a wide variety of articles mainly written in the Dutch language. The project has resulted in a book, which was published in November 2017 by the Indonesian Academy of Sciences (AIPI) under the title ‘The Medical Journal of the Dutch Indies 1852-1942; a platform for Medical Research’<sup>[1]</sup>. The book opens GTNI to the international research community as it constitutes a rich source of information around medical science and practice in the Dutch Indies. This paper presents an outline of the book.

GTNI was established in 1852 by Willem Bosch, the Dutch Chief of Medical Service posted in the colony, as the official journal of the Society for the Advancement of Medical Sciences in the Dutch Indies, which he had founded a year earlier in 1851. GTNI ceased to exist in 1942 after the Japanese occupation of the Indonesian archipelago.

## FOCUS OF GTNI

During GTNI’s 90-year history, about 4500 articles were published, mainly in the form of case studies. Initially, it also contained proceedings of the Society and annual reports of the Medical Service. Later, annual reports and scientific contributions were added from other medical institutions such as the laboratories in Jakarta and Medan and the Parc Vaccinogène in Jakarta, which later became the Institut Pasteur in Bandung. Before 1920 the case studies that were

published dealt mainly with beriberi (by Eijkman amongst others) and infectious diseases, in particular cholera and plague. With the development of medical sciences at the beginning of the 20th century, papers from other specialties were published, starting with anaesthesiology, bacteriology (showing the value of microscopy in clinical diagnostics), radiology and immunology. During the 1920s and 1930s, attention shifted toward non-communicable diseases such as cardiovascular conditions, cancer, intoxication, child health problems and obstetrical complications. Most of the reported studies were conducted in Java, especially the cities of Jakarta and Semarang, or in plantations in Sumatra where many of the European doctors were deployed. Indonesian physicians and scientists also authored publications (in Dutch). With a share of 12% of the total number of GTNI articles, their papers were pretty similar in terms of topics and content to those written by European authors. It seems as if Indonesian authors also avoided traditional medicine, such as the use of indigenous medicinal herbs, and phenomena such as ‘amok’, the Malaysian and Bahasa Indonesian term for a psychopathological disorder.

As a Eurocentric medical journal, GTNI typically did not pay attention to the way in which European medical doctors pictured indigenous patients nor to issues such as: tension between European and Indonesian physicians, the health policy of the colonial government and in particular its rather late shift towards health care provision to the indigenous population, or the socio-medical conditions of plantation labourers and their families.

## OUTLINE OF THE BOOK

After an introductory chapter on the medical historiography of Dutch Indies, the book is divided into two sections. Part I focuses on the broader political and organisational context of the colonial government in which medical services were provided. Part II deals with specialties and a number of diseases.

Part I starts with a description of the political and socio-economic context in the Dutch East Indies during the period GTNI was published (1852-1942). It is followed by a chapter on the Dutch Medical Service, which was divided into the Military Medical Service and the Civil Medical Service, which provided health care to the military and civilian population

respectively. For a long time the colonial medical administration was predominantly focused on the former group with little or no concern for the indigenous population. Chapter 3 describes the emergence of the hospital system, which distinguished general hospitals from specialized hospitals. At the beginning of the 20th century, the colonial government started to allow the establishment of church-related mission hospitals which provided care to indigenous populations. Chapter 4 provides insight into the contributions of missionary doctors and nurses to the training of indigenous medical personnel and the development of the so called Yogya system, which involved the establishment of peripheral clinics around a central hospital to provide medical care to local communities. Another chapter gives a brief impression of how the colonial army was involved in armed conflicts in Sumatra. This includes the Aceh war, the infamous



armed conflict between the Sultanate of Aceh and the Kingdom of the Netherlands, which started in 1873 and lasted nearly 30 years. Gradually the colonial government created more opportunities for Indonesians to train as physicians and their numbers started increasing. This also explains the increase in local authorship of GTNI publications in the 1920s and onwards, which is described in the final chapter of Part I of the book.

Part II of the book describes the emergence of several medical specialties covering the following topics:

- cholera control in Jakarta;
- the debate on the nature of leprosy during the period 1865-1897;
- hernia treatment;
- trachoma and the struggle against blindness;
- the treatment of yaws and syphilis;
- plastic surgery;
- the rapid development of general pathology;
- general paralysis of the insane and treatment by induced malaria (dementia paralytica);
- the development of neurology;
- establishment of the cause of beriberi, which led to the granting of the Nobel Prize to Christiaan Eijkman in 1929;
- psychiatry and the care of people with mental illness;
- the development of forensic toxicology;
- the early phase of physical anthropology;
- growth and mortality of indigenous, Chinese and (Indo)European infants, toddlers and children;
- the hookworm controversy;
- first phase of modern malaria research (1880-1918) and Robert Koch's visit to the colony;
- developments in anaesthesia.

Unfortunately, the book does not cover developments in orthopaedics, urology, or obstetrics and gynaecology. The latter subject will, however, be covered in a Bahasa Indonesian version of the book which is due to appear soon.

#### A PLATFORM FOR RESEARCH

The book has the potential to stimulate

further historical studies of medicine, both in Indonesia and the Netherlands. In Indonesia the book may trigger further studies of how medical infrastructure was rehabilitated and expanded during the post-colonial period. Unlike the UK and Germany, the Netherlands has a weak record in medical history of its former colonies

[2]. This book may stimulate more comprehensive historical research and may encourage further collaboration between Indonesian and Dutch researchers in the history of medicine.

#### FOLLOW-UP ACTIVITIES

The book will be presented on two occasions - on 18 May 2018 during a symposium in the congress centre Kumpulan, Bronbeek in Arnhem, the Netherlands, and on 27 June 2018 at the Congress of the Asian Society for the History of Medicine in Jakarta ([www.ihp.sinica.edu.tw](http://www.ihp.sinica.edu.tw)).

Price of the book: € 20.00. It can be ordered by transferring € 20.00 + postal charges (€ 6.95 in the Netherlands) to bank account NLR7 RABO 0139001816 of Vereniging KITLV. Don't forget to mention the title of the book and your name and address.

Digital versions of GTNI are temporarily available at <http://metadataconversion.nl/GTNI>. They will become accessible via the renewed NVTG website later this year, along with digital versions of the Tropical and Geographical Medicine journal (TGM).



GEERT VAN ETTEN (PHD) - GLOBAL HEALTH ADVISOR  
GMVETTEN@GMAIL.COM

LIESBETH HESSELINK (PHD) - INDEPENDENT RESEARCHER  
MEDICAL HISTORY  
EQ.HESSELINK@HETNET.NL

#### REFERENCES

1. van Bergen, Leo, Liesbeth Hesselink and Jan Peter Verhave (eds), *The Medical Journal of the Dutch Indies 1852-1942; a platform for medical research*. Jakarta, 2017. With contributions from Beck P, Busman D, Doesschate M, van Etten G, Faber W, Haeseker B, van Heerde P, Kager P, Keijser A, Mochtar B, Polderman T, Pols H, Quak L, Soedirman J, Teepen H, Veerman A, Verburg G, van Wijhe M, van Wolferen W and Zondervan S.
2. van Bergen, Leo, *Van Tropische Geneeskunde tot Internationale Gezondheidszorg. Een geschiedenis van honderd jaar Nederlandse Vereniging voor Tropische Geneeskunde*. Amsterdam, 2007.





## NVTG

Membership of the Netherlands Society for Tropical Medicine and International Health (NVTG) runs from January 1<sup>st</sup> to December 31<sup>st</sup> and may commence at any time. Membership will be renewed automatically unless cancelled in writing before December 1<sup>st</sup>. Membership includes MT*6* and International Health Alerts. An optional subscription to TM&IH carries an additional cost. Non NVTG members can subscribe to MT*6* through a student membership of the Society for € 40 per year by sending the registration form through our website [www.nvtg.org/lidwoorden.php](http://www.nvtg.org/lidwoorden.php) or by sending name and postal address by e-mail to [info@nvtg.org](mailto:info@nvtg.org) or [MTredactie@nvtg.org](mailto:MTredactie@nvtg.org). Contributions and announcements should be submitted to the editorial office by e-mail: [info@nvtg.org](mailto:info@nvtg.org) or [MTredactie@nvtg.org](mailto:MTredactie@nvtg.org). Closing date for the June edition is 13-04-2018.

Disclaimer: all views expressed in this journal are of the authors only and are not necessarily shared by the editors of MT. Letters and articles may be edited for purposes of clarity and space.

Netherlands Society for Tropical Medicine and International Health

President: A.A.L.J. (Ankie) van den Broek

Secretary: M.G.P. (Marieke) Lagro

Secretariat: J.C. (José) Hoppenbrouwer

P.O. Box 82

3738 ZM Maartensdijk

The Netherlands

+31(0)6-53515773

[info@nvtg.org](mailto:info@nvtg.org)

[www.nvtg.org](http://www.nvtg.org)