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And what have **we** learned from all this...?

After many decades of development aid you would have thought we might have picked up a thing or two ourselves, yet as Judith van de Kamp confirms in her thesis *Asking Them* (in this MT), knowledge and information remain a one way street, mostly going in

one direction, with little regard for cultural differences. "We in the West know best what is good for the rest" quotes Steven Smit in the book review section, and other regions it seems, have very little to teach us. We are after all the wealthiest, greediest, most violent (in



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military terms), section of the world population, and have no need to be considerate, or even remotely interested - that would be a sign of weakness. Unfortunately, it is becoming desperately clear that the western life style itself is unsustainable, became unsustainable some time ago. You might have expected this to make us a little more modest in imposing our views and practices and even to look more closely at the older cultures, to see if we can learn something. We have always been sustained by the idea that 'science' and 'progress' would find a solution for the problems, but lately science has been uncooperative, and often only succeeds in making things worse.

So what can we learn? The true meaning of sustainability; that a mud or adobe hut is in the end better for the environment than bricks and mortar. That a bicycle uses sustainable energy (unless the hill is very steep) and that walking is a healthy mode of transport that prevents obesity if you apply it for an hour a day. That many symptomatic medications can be grown in your garden, and do not need to be expensively produced by a multinational pharmaceutical company. That life is part of nature and death is part of life.

We can learn that not everything is scientifically testable, and that mysteries must 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."

JOHANNES BORGSTEIN



Photo: H. de Vries

The Beijing genotype of *Mycobacterium tuberculosis*

FINDINGS AND ONGOING RESEARCH

DNA fingerprinting of *Mycobacterium tuberculosis* isolates has proven useful to study transmission of tuberculosis at various scales⁵. In addition, significant differences in the population structure of these bacteria were found in geographic areas with a low and high prevalence of tuberculosis. In general, the genetic variation in *M. tuberculosis* isolates in high-prevalence areas is much lower than in low-prevalence areas. This suggests recent clonal expansion of the predominant genotype families in high-prevalence areas and the existence of selective advantages that favour their spread.

In the past decade, many studies have pointed out the significance of the Beijing genotype strains in the worldwide tuberculosis epidemic. It has been estimated that one third of the worldwide tuberculosis cases may be caused by the genetically highly conserved bacteria of the Beijing genotype family¹. In South-East Asia, parts of Western Europe, the former USSR Republics, the Baltic States, Cuba and South Africa, Beijing strains are emerging and are, in most of these areas, also associated with (multi-drug) resistance¹.

Currently, research is focused on the evolutionary development of Beijing strains. Within the Beijing lineage an 'ancestral' and a 'modern' lineage were distinguished. The 'modern' lineage is highly prevalent worldwide and may represent a BCG-vaccine escape mutant². Mutations in putative DNA repair genes in strains of the modern lineage may enhance these bacteria's resistance to anti-tuberculosis drugs and the BCG-induced immune response⁴.

Within the framework of the European Union supported project 'TBadapt' researchers from 11 international

institutions are trying to disclose the mechanism of adaptation of *M. tuberculosis* in response to vaccination and exposure to anti-tuberculosis drugs, including the possible role of changes in putative DNA repair genes.

In Europe, the interest in the Beijing genotype has recently been awakened. While 5-7% of the susceptible isolates in Europe are of the Beijing genotype, 85% of the MDR-TB transmission can be attributed to spread of Beijing strains. Moreover, one cluster of 174 MDR-TB cases has been detected, re-emphasizing that particular genotypes are capable of gaining poly-resistance without losing fitness³.

More studies should be done on the dynamics in the population structure of *M. tuberculosis* worldwide, especially in Africa.

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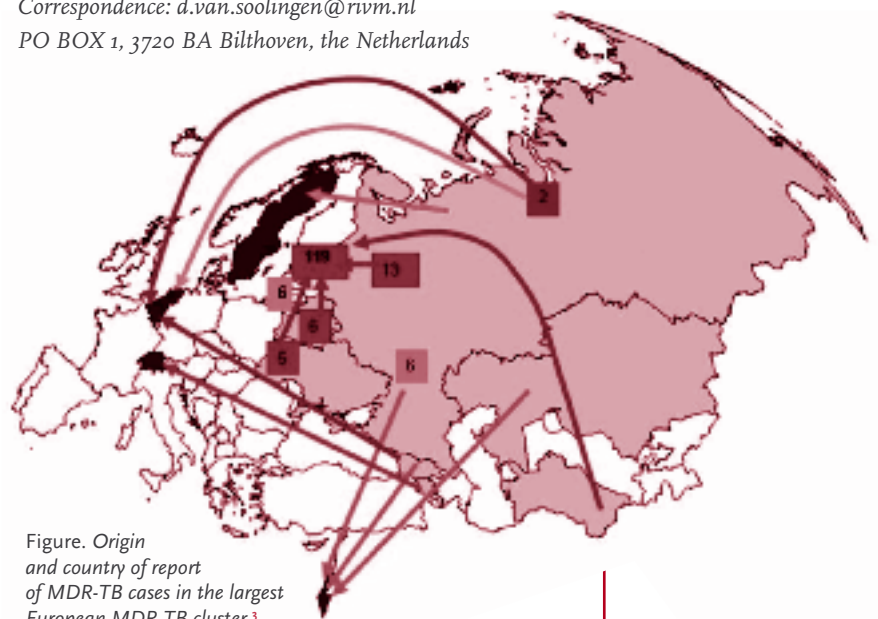


Figure. Origin and country of report of MDR-TB cases in the largest European MDR-TB cluster³

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It has been estimated that one third of the worldwide tuberculosis cases may be caused by the genetically highly conserved bacteria of the Beijing genotype family

Excerpts from the PhD thesis of Gibson S. Kibiki

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EPIDEMIOLOGICAL, CLINICAL, AND IMMUNOLOGICAL STUDIES OF PULMONARY TUBERCULOSIS IN HIV-INFECTED TANZANIANS

Almost 70% of the 33.2 million HIV-infected individuals in the world reside in sub-Saharan Africa (sSA)¹. The estimated adult HIV prevalence in Tanzania between 2003 and 2004 was 7%². The estimates show an incremental trend³.

The current prevalence of HIV infection has fuelled the tuberculosis (TB) epidemic. As a result, up to 30% of new TB patients in sSA are HIV co-infected⁴.

In Tanzania the TB prevalence increased five-fold between 1983 and 2001, largely due to HIV/AIDS⁵. Currently TB is the most common disease associated with

HIV/AIDS and the leading cause of hospitalization and death in HIV-infected patients⁶.

This thesis describes the epidemiological, diagnostic, clinical and immunological aspects of TB in HIV-seropositive Tanzanians.

The data were largely derived from in- and out-patients of the Kilimanjaro Christian Medical Centre (KCMC). KCMC is a 450-bed referral hospital located in Kilimanjaro region (northern Tanzania). KCMC serves about one third of the 36-million Tanzanian population

EPIDEMIOLOGY

A retrospective study in 1242 HIV-seropositive patients admitted at KCMC between 1997 and 2001 showed that pulmonary TB was the most prevalent diagnosis in adults (21%), followed by malaria (14%), gastroenteritis/ diarrhea (12%), and non-TB pulmonary infections (10.1%)⁷. In total, pulmonary infections accounted for about one third of all of reasons for admission of HIV-infected individuals.

A systematic analysis of a prospective study based on bronchoscopy and bronchoalveolar lavage fluid (BAL) of 120 severely HIV-immunocompromised patients showed that *Mycobacterium tuberculosis* (MTB) was the leading single causative agent of pulmonary infections (23%)⁸. Bacterial causes of community acquired pneumonia were also very frequent. MTB infection in HIV-infected patients was directly associated with high death rates, especially during the first month of follow-up whereby one-third of TB patients died.

A study on MTB strains, being one out of few of such studies conducted in sSA only, revealed that in the study area there was a wide diversity of strains that are found in different parts of the world, indicating increased human movement coupled with high transmission rates in this area⁹. High transmission rates were further substantiated by the predominance of two strains: CAS1-kili (30%) and LAM11-ZWE (15%). HIV infection did not influence the prevalence of the strains. CAS1-kili, though highly prevalent, was not associated with anti-TB drug resistance.

In the study, 11% of MTB strains were resistant to anti-

TB drugs. Isoniazid monoresistance (7%) was most prevalent. Similar trends have been demonstrated elsewhere in sSA^{5,10,11}. Almost 3% of strains were multi-drug resistant (MDR); a more than two-fold increase compared to data from previous studies⁴.

DIAGNOSTIC AND CLINICAL FEATURES

The diagnosis of pulmonary TB (PTB) in HIV/AIDS is difficult, especially in developing countries. On the one hand TB frequently has atypical clinical and radiographic features, on the other hand different causes of pulmonary infections in HIV/AIDS are often indistinguishable on the basis of clinical and radiographic features¹².

We found that micronodules on chest x-rays were the only feature significantly associated with TB in HIV/AIDS⁸. Anaemia was the only clinical parameter associated with TB in this group of patients.

Sputum is generally used for the diagnosis of TB. However, MTB detection rates in sputum smears are low, especially in HIV/AIDS^{13,14}. In addition, only few HIV/AIDS patients produce adequate sputum in terms of quality and quantity.

The use of a molecular technique (real-time PCR to detect presence of MTB DNA) showed to have the highest ability to detect MTB¹⁵. However, it could not differentiate active disease from latent infection in this setting. The role of this promising technique warrants further studies.

IMMUNOLOGICAL FEATURES

The immune status of HIV-positive patients is expressed in CD4 T cell count; the lower the CD4 count, the

The estimated adult HIV prevalence in Tanzania between 2003 and 2004 was 7%

Up to 30% of new TB patients in sSA are HIV co-infected

worse the immune status. Classical radiographic features of PTB, such as cavitory lesions and large cavities occur when the cellular immunity is fairly preserved (high CD4 count). This thesis confirmed that chest x-ray features of PTB depend on the level of cellular immunity, i.e. high CD4 counts were associated with formation of cavities. The study also showed that radiographic features represented the host response to local infection which is expressed by cytokine production¹⁶. The presence of high levels of two cytokines (interferon γ -inducible protein 10 and interleukin-7) in BAL fluid obtained from HIV-positive patients with PTB was associated with atypical chest radiograph features, indicating advanced AIDS.

The association between TB and the macrophage migration inhibitory factor (MIF), another factor involved in the local immune response, was studied as well¹⁷. Previous studies in HIV-seronegative patients with PTB showed a relation between high MIF concentrations and severity of the disease and death. However, in the present study low levels of MIF were associated with death in TB and HIV/AIDS patients. Finally, the association between the occurrence of a certain polymorphism that impairs the function of the Toll-like receptor 4 (TLR4, a receptor that mediates cytokine production in TB-infection) and the deve-

lopment of active TB was studied¹⁸. Patients with impaired TLR4, were at higher risk of developing active TB and had lower CD4 counts than patients without the polymorphism in TLR4. A surprising finding, since this polymorphism was an evolutionary adaptive response to cope with severe malaria and reduce death due to malaria.

CONCLUSION

This thesis highlights various important features of TB-HIV co-infection in Tanzanian patients. TB is the most prevalent diagnosis in in-patients who are HIV-infected and it accounts for high death rates in these patients. Diagnosing PTB in HIV-positive patients is challenging since sputum smears are often false-negative. Using real time PCR for diagnostic purposes should be evaluated more extensively, as the results from studies in this thesis are promising. Several cytokines and other factors related to the host immune response to TB could be of use in diagnosing, staging and treating TB. Associations between some of these factors and disease staging have been shown in studies presented here. More research is needed to evaluate the possible future role of these factors.

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D Diagnosing PTB in HIV-positive patients is challenging since sputum smears are often false-negative

The list of references & cited articles can be requested

Asking them

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GHANAIAN HEALTH WORKERS ABOUT DUTCH SHORT TERM HEALTH WORKERS IN GHANAIAN HOSPITALS

BACKGROUND

In the last few years an undefined but growing number of Dutch health workers is visiting developing countries for medical work for a few weeks or months. Both older and younger people are involved in this short term work, both individually and in teams, providing basic health care and specialist care, going through an organization and self-organized.

In August 2006 a broad public debate started in Holland when some former tropical doctors openly expressed their concern about this new trend. One of the objections raised was that these short term health workers underestimate cultural differences, resulting in a negative influence on the quality of their work.

Stressing that this debate has been focussed too much on what the Dutch have to say about it, I would like to take this opportunity to discuss the topic from the perspective of health workers in developing countries. After all, they are the ones that have to 'put up' with whatever Dutch health workers do within their hospitals.

RESEARCH OUTLINE

One of the questions I did research on for the master 'Medical Anthropology and Sociology' at the University of Amsterdam, is: How do local health workers experience the work of Dutch short term health workers? To obtain information I visited Ghana, a country quite popular among Dutch health workers. I visited five hospitals which are regularly visited, not only by the Dutch, but also by other foreign health workers. Qualitative data was collected through a combination of interviews, observations and (in)formal conversations.

MEDICAL ANTHROPOLOGY

To be able to understand the anthropological analysis of the results presented a little further in this article, we need to take a look at two anthropological assumptions.

First of all, there is the assumption that culture - as the total of customs, beliefs, attitudes, values, goals,

laws, traditions and moral codes of a people (King 1966) - subconsciously determines a great deal of people's behaviour. Contact with people from other cultures can be problematic, because we are not aware of the underlying causes for our differences in thought and action. This also applies to views on health and disease, and therefore also to the way people seek treatment. Some Dutch health workers in developing countries wonder why some people refuse to give blood for transfusion, or do not seem to accept family planning. Some wonder why the local health workers do not cooperate with them, or arrive 'late'. Without having studied the local culture thoroughly, it is impossible for any outsider to understand it. It is much easier to state that the patient is unwilling to recover, and the local health worker unwilling to work hard, whereas this is not necessarily the case.

The second anthropological assumption I would like to draw attention to, is that the way people think and act is determined by the situation they are in. Health workers in developing countries are in a totally different situation from the Dutch health workers. Unlike many people in their country they have received high education, and they have got a relatively good job. They work in a hospital with an insufficient amount of health workers to be able to run it most effectively. That is their daily reality. Working harder than they already do, will not improve the situation. They are used to working with old machinery because there is no money to renew it. They know the cultural background of their patients, know about the power relations, and the way the hospital functions as a whole.

RESULTS

The Ghanaian general director of one of the hospitals I visited, told me that he receives request letters from European volunteers on a regular basis. He receives most of them in October, and his explanation for that is that Europeans want to escape from the cold winter. He says that most young people are tourists that want to benefit from working in his hospital by getting free accommodation and food. Sometimes they are not even qualified, and in those cases he does not respond to their letters. He thinks they will get a place else-

Note that the information in this article is abstracted from my thesis 'Aanpakken en wegwezen: een antropologisch onderzoek naar de kortstondige inzet van Nederlandse gezondheidswerkers in ontwikkelingslanden'. For a complete presentation of the results and analysis I refer to that document. Digital copies are available on request.

Culture - as the total of customs, beliefs, attitudes, values, goals, laws, traditions and moral codes of a people (King 1966) - subconsciously determines a great deal of people's behaviour

Contact with people from other cultures can be problematic, because we are not aware of the underlying causes for our differences in thought and action

where, though. Another reason to come, he says, is to narrow a gap in between two jobs, or while waiting for exam results to get in. In short: in a lot of cases the actual work within the hospital is not the main reason for foreign health workers to come. He states the following:

I've had questions from foreign health workers that simply are embarrassing. One lady [from Austria] asked me whether we sleep in rooms or under trees. Then she asked whether these rooms have windows and doors, so I wrote: 'Of course'. She also asked what we eat and whether we drink water. I wrote to her that I didn't force her to come, and that she could import her own water if ours was not good enough.

An orthopaedic surgeon who has been working in one of the hospitals for 25 years, has had assistance from both Dutch and English teams since 2005. On average these teams stay for two weeks. His experience with the teams is negatively influenced by the fact that the visits are never announced by the board of the hospital. The following quote makes clear why he is also not very optimistic about the work of the visiting teams:

Some think they are god, they come as big heroes! They say they come to help me with all the work. I didn't ask for their help. If I asked, I would like to choose. It is not a way of helping, it is disrupting my system. My instruments... I don't know where they are! The Dutch had brought boxes, stuck names on them and put everything in different places. They organized it their own way without asking me anything. It may have looked chaotic, I am chaotic, but every single instrument had its own place. They have thrown away very old, but good things! Why throw something away, because it is not nice, not aesthetic? For me it had a purpose, a mission.

The staff in the theatre have something else they are more concerned about in relation to working together with the teams. The team members always want to operate as much as possible, but they forget to take into account the local working hours. The local health workers are forced to stay until all work is done, which means that they make extra hours which they do not get paid for. One of the Ghanaian operation assistants states: "They sacrifice a lot, but we sacrifice too much".

Another point, made by people in several hospitals, is that the presence of foreign health workers can cause financial problems, because in most cases the hospitals are expected to pay for transport to and from the airport, electricity, accommodation and food. This is illustrated by an example from a hospital which was visited by a team of fourteen eye specialists at the time I was there. The team decided to operate for

free, so the hospital did not receive any income from the patients. And because one of the two theatres was being used for eye operations, other operations which would have been paid for, had to be postponed. While the team members felt they were doing the hospital a favour, the hospital ended up with a financial loss.

The last problem I would like to point out has got to do with registration. In Ghana everyone working medically for a certain amount of time, has to be registered with the Dental and Medical Council (DMC) or Nurses and Midwives Council (NMC) to be able to work legally. In March 2007 the Christian Health Association of Ghana (CHAG), concerned because many foreign health workers do not seem to register, sent letters to Ghanaian health institutions to remind them to show the foreign health workers their responsibility. It can be a problem for the local medical directors, as I saw in one case, where the Ghanaian medical director was afraid of losing his job, because the foreign eye specialists refused to register.

In short, the results show that the short term medical work of Dutch health workers is not always appreciated, because some have their own interests, act arrogantly, feel the need to change the existing system without knowing how to handle such changes in the particular cultural setting, do not contribute to the direct needs of the hospital, and have not informed themselves about national and local regulations.

ANTHROPOLOGICAL ANALYSIS

When we look at the two anthropological assumptions described earlier, the results - although undesirable - are not surprising. People from two different cultures meet in one country, both thinking and acting according to what they have been taught and what has worked for them in their own situation. The Dutch health workers are convinced that their work is needed, but some of them seem to forget that help works best if asked what kind of help is most needed in that particular setting.

One of the reasons why local hospitals do not speak up about their objections, is that their position of suffering from a great shortage of health workers "does not allow them to create an image of refusing help", as said by a Ghanaian general director. This emphasizes the responsibility of Dutch health workers to work in such a way that it is in accordance with what is needed and appreciated most. Unfortunately, there is no simple answer as to how to do this. It may be one of the biggest challenges of Dutch short term health workers in developing countries.

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The way people think and act is determined by the situation they are in

They come as big heroes!

They sacrifice a lot, but we sacrifice too much

ADDITIONAL INFORMATION

There is a whole range of anthropological literature which explains different views on health and disease. They can be helpful to Dutch health workers working in another country, in order to understand the behaviour of both patients and local health workers.

A REQUEST FOR CIRCUMCISION IN NAMIBIA

NIENKE VAN DEN HEUVEL
graduated from medical
school in August 2007 in
Groningen, the Netherlands



Before she started studying medicine she already knew she wanted to work in a developing country as a doctor. As part of the Dutch medical training programme for 'expanded general practitioner' she would start working as a surgical intern in the Boven IJ hospital in Amsterdam in September. Just before starting this job, she went hiking with her brother in Austria. During this trip Nienke and her brother got killed in an accident in the mountains.

Nienke was an incredibly enthusiastic, dedicated and loving person. She would have become a superb ('tropical') doctor. In memory of her we present to you this article which she wrote when she was doing the last part of her rotation in Namibia in the summer of 2007

Ladies and gentlemen, our patient, a 28-year-old Ovambo, requested a circumcision at the surgical outpatient clinic of a district hospital in the remote north of Namibia. Because of my poor Oshivambo and his equally poor English the history was taken with the help of an interpreter. When asked for the reason for his request, he said he was troubled by recurring itching skin rash on his penis and foreskin. He had no other complaints and he claimed to be HIV negative. On examination he looked healthy. On inspection and palpation there were no abnormalities of his genitalia and no rash was observed. After being asked again about the reasons for his request it turned out that he had heard from "friends" that circumcision would prevent HIV infection.

CIRCUMCISION AND HIV IN AFRICA

Circumcision, the total removal of the foreskin, is one of the oldest surgical procedures and is practised in Africa on a large scale for religious, cultural, and medical reasons. Its prevalence varies, however, per region, country and tribe. More than 80% of men are circumcised in North and West Africa, in Namibia the prevalence is estimated to be only around 18%. The age at which circumcision takes place can vary from soon after birth to adulthood.

Circumcision is medically beneficial. It reduces the risk of (para)phimosis, balanitis as well as the risk of urogenital infections. Penile cancer occurs less frequently in circumcised men and their spouses get cervical cancer less often. Under optimal conditions circumcision is a simple, safe procedure. The complications which occur in adults at a rate of 2-4% are minor, usually infection, bleeding, side-effects of anaesthesia or a temporarily oversensitive penis.

In Africa, however, circumcision is often done under less favourable conditions and this may result in serious complications such as mutilation or even death. Exact figures for the rate of serious complications are not available.

As in many other parts of sub-Saharan Africa, HIV infection is widespread in Namibia. It is mainly heterosexually transmitted. The prevalence rate is 20% nationally but it varies between the regions from 8 to 40%. In the region of our hospital the prevalence is 24%. Since the first description of HIV infection in 1981 the national average life expectancy at birth dropped from 61 years in 1991 to 40 years in 2006.

Several factors contribute to the high prevalence of HIV in Africa: poverty, lack of education, poor access to medical care, high risk sexual behaviour (polygamy, dominance of men and sexual abuse) and a high incidence of other sexually transmitted diseases (STD's). Lately there is a lot of attention for the HIV/AIDS problem. People in Namibia can be tested for HIV free of charge and anti-retroviral therapy is subsidized. About 50% of the HIV-positive patients make use of these facilities, a relatively large group when compared to 28% in South Africa. Through educational programs and media efforts, the government tries to diminish the spread of HIV. Large "ABC" billboards are seen along the road, where "A = Abstinence from sex", "B = Being faithful to one partner" and "C = Condomise". Free condoms are widely distributed. Efforts to educate the population about HIV are ongoing but still have a long way to go. Myths addressed in the media campaigns are for example: "An HIV infected person is easily recognized", "AIDS can be cured by medicines", "HIV is spread by unclean drinking water", "HIV penetrates rubber", "The use of a condom is un-African" and "Sex with a child or virgin cures AIDS".

CIRCUMCISION AND HIV PROTECTION

In December 2006 the "National Institute of Health" of the United States halted early two randomized clinical trials running in Kenya and Uganda. Their results convincingly demonstrated that circumcised men acquired HIV infection less often than controls - 53% reduction in Kenya and 48% in Uganda. Hence, it was considered to be unethical to continue the trials. Prior

to these trials, the idea that circumcision might reduce HIV transmission had been suggested because of the similarity of the geographical distributions of circumcision and HIV. The trials in Kenya and Uganda made clear that this similarity was due to circumcision and not to other factors such as differences in sexual behaviour.

WHY DOES CIRCUMCISION PROTECT?

There are multiple reasons why circumcision protects against HIV infection. The foreskin is a vulnerable surface area with many HIV receptors. The inside of the foreskin is a thinly keratinized layer that keeps the glans penis warm and humid and hence allows pathogens to accumulate easily. During sexual intercourse this vulnerable epithelium can easily be damaged and makes an excellent entry point for micro-organisms. This part of the skin also contains high concentrations of immune cells with CD4-receptors to which the HIV virus can attach. In addition to the removal of this vulnerable area circumcision stimulates the glans penis to keratinize, making its CD4 cells less accessible to HIV. Circumcision also reduces the risk of STD's which may encourage HIV transmission.

THE FUTURE

WHO is debating on whether to offer free circumcision to all men in Africa to reduce the spread of HIV. An important worry is that men will overestimate the protection by circumcision and not practise safe sex. Various organizations are currently examining the financial, cultural, practical and humanitarian aspects of this new approach.

BACK TO THE PATIENT

After the patient's expectations had been clarified we explained to him that he was right to believe that circumcision reduces the risk of HIV transmission but it was emphasized that this protection is not complete. It was made clear that other measures are necessary such as correct and consistent use of a condom, careful partner selection and even abstinence. After this the procedure itself was explained and the possible complications in order to let him make a well-informed decision. The patient persisted in his request and he underwent an uncomplicated operation 3 weeks later.

DISCUSSION

It would have been easy to accept this patient's request for circumcision straight away. However, this would have ignored the underlying demand for help: protection against HIV infection. This irrational idea is widespread among the Namibian population. To avoid giving a patient a false sense of safety, it has to be

carefully explained that circumcision does not prevent HIV transmission. It should be made clear that the operation is an addition to other safety measures. Only when the patient understands this, the operation should be performed.

Ladies and gentlemen, the case of this patient provides lessons of a more general nature than just the protection against HIV by circumcision. First, the patient's request does not have to reflect his true expectations. Second, addressing the request may not sufficiently resolve the problem. Dignified patient treatment requires exact determination of the underlying expectations.



Photo: J. Borgstein

It should be taken in mind that medical personel from an other cultural background may not be familiar with the real expectations of the requested help.

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It be kept in mind that medical personnel from another cultural background, may not be familiar with the expectations of the requested help.

The list of cited articles can be forwarded on request.

Circumcised men acquired HIV infection less often than controls
53% reduction in Kenya and 48% in Uganda

Dignified patient treatment requires exact determination of the underlying expectations

Internship in the St. Francis Designated District Hospital, Ifakara, Tanzania

DANIËLLE VAN DIEPEN
FLEUR BOOT

EXPERIENCE OF TWO DUTCH MEDICAL STUDENTS

During the 6 years in Medical School students from the Netherlands have many opportunities to do an internship in a developing country. This raises some questions: what are the motives of students to do an internship abroad? Does it contribute to improving health care in hosting countries? At which stage in Medical School should students go?

We had the opportunity to do our elective internship at the St. Francis Hospital in Ifakara, Tanzania. We are both in the 6th year of medicine and have completed our internship in the Netherlands.

It was our first time in Africa, and our first time working in a foreign country for two months. So we are not able to make a comparison with other hospitals, other countries or other situations. But we will tell our story.

The St Francis Designated District Hospital in Ifakara is a big hospital that covers a population of over 500,000. We chose to do an internship in surgery, although we expected that doing an internship in an African district's hospital would involve work in all fields of medicine.

The hospital in Ifakara was bigger than we thought. It has 4 major departments: surgery, medical, paediatrics and obstetrics & gynaecology. Each department has its own Tanzanian senior and intern doctors (the 6th year medical students). We could restrict ourselves to working in the surgery department only. This department has about 100 indoor patients.

We did not know what to expect regarding responsibility. Students who have been in developing countries tell different stories; some did everything, others observed mainly. We think that the extent of the res-

ponsibility given to foreign medical students depends on the hospital size and human resources available. At the small hospitals where the number of medical staff is limited, foreign student doctors will get (too) many responsibilities, because these hospitals need all the help they can get. Foreign students in such hospitals will turn from relatively passive intern doctors in their own country to intern doctors doing everything that an accomplished general practitioner does. District hospitals on the other hand, can manage themselves; they do not need the help of foreign students.

In our case, after we had joined a major ward round at the surgery department on our first day, together with 2 senior doctors, 3 Tanzanian intern doctors and 10 assistant medical officers in training, the worries of getting too much responsibility swiftly faded away.

Of course we did not come to Tanzania only to observe health care. After 6 years of medicine, it's time to practice! After we put a name tag with 'intern doctor' on our white coats, it was clear to everyone that we were equal to the Tanzanian intern doctors who are responsible for the wards and emergency care, assist at major surgery and do minor surgery themselves. We experienced that you can do as much as you want. Just show what you would like to do and what you are capable of.

After one or two weeks the medical staff noticed that we were interested, energetic and eager to learn and do something for the hospital. The doctors and interns involved us in everything. They thought that it would not be a problem for the Tanzanian interns to be absent for a while. The interns left for their graduation in Dar-Es-Salaam and we were told that they would not be around for one week. One week turned out to

This section of MT offers reports or evaluations written by students and is open to students international health and related medical areas. Contributions as well as comments from all countries are welcome.

It should be noted that these contributions are written by young professionals, often based on a first - or relatively short term - visit - to another country. The editorial board may not always agree with the perspective of the authors but value the importance of exchanging views and opinions.

Bertrand Russell (English philosopher 1872-1970) stated that 'if another opinion makes you angry, it probably means your own opinion is uncertain'.



Photo: H. de Vries

What are the motives of students to do an internship abroad?

be two weeks and we had to manage everything by ourselves. Looking back, this was the period when we learned most. We had to cover the wards, teach the assistant medical officers, assist at all surgical procedures and try to do clinics while using a Swahili dictionary! This would have been too much responsibility if we had not yet completed our internship in the Netherlands. The health of patients would have been at risk, as well as our own mental health. Our humble opinion is that we did well.

We managed to fulfil all tasks of the Tanzanian intern doctors and the patients did not seem to suffer under our supervision. This satisfied us; we felt useful. In the Netherlands interns usually do not feel all that useful, though they wish to.

Another important happening in the two months we spent at the St. Francis Designated District Hospital was a major traffic accident. A big truck full of patients arrived after a four hours' drive from the site of the accident. Some patients died on the way, others were in shock. Most patients needed immediate help. Neither of us had experienced a situation like this before, and for a moment we could only remember the ABCD (Airway, Breathing, Circulation, Disabilities) sheets from college. Our heartbeat rose and we needed a few seconds to think what to do. We could not ask the doctors, since they were busy. But after evaluating the first patient, we could concentrate and started doing whatever we could. Again, we benefited from the fact

that we had already done our internship in the Netherlands. We knew how to suture, how to insert a cannula and what to do with patients in shock, because that is what we learned in the Netherlands. We had to give instructions to the nurses, tell them what to do. This only works if you have confidence in what you are doing.

Coming back to our initial question about when to go abroad for an internship, we think that if you want to learn how to manage a ward, expand your skills and to help, it is better to go to a hospital in a developing country after doing your regular internship.

However, going to a hospital such as the St Francis Hospital for a short medical elective subject could be an interesting experience to a second or third year student as well.

After all, the St Francis Hospital has enough medical staff most of the time and it is a teaching hospital where foreign students can learn a lot. To get the chance to just see tropical pathology is already a great experience. Younger foreign students will more easily be in a position to observe and learn than 6th year students who will have to function as an intern doctor. Local doctors are eager to teach and they will allow also the younger students to assist at surgical procedures. All in all, students should clearly state the limitations in their skills and knowledge.

Correspondence: fleurboot@yahoo.com

Our humble opinion is that we did well

Students should clearly state the limitations in their skills and knowledge

CONSULTANT ONLINE OR ONLINE CONSULT?

MARCO VERSLUIS
ALEXA TER HORSTI
TROIE, Working group
Tropical Doctors in Training

ROELAND VOORHOEVE
NVTG Working group
Tropical Surgery

“When it is you or nobody”, many doctors are able to surpass themselves, and perform far better than expected

It is necessary to have easy access to a specialist on the subject who is also acquainted with the conditions in rural hospitals of poor countries

Through their web site: www.tropenpleiding.nl, TROIE offers the possibility to submit a case to Dutch consultants by e-mail

A part from lack of equipment, lack of information is one of the major problems faced by many doctors working abroad. Often the doctor has little experience in dealing with the extreme pathology that comes his or her way. This is especially true where experts are not available or referral is impossible. Certainly, “when it is you or nobody”, many doctors are able to surpass themselves, and perform far better than expected. Nonetheless, this is a problem where modern technology may be able to contribute to a solution.

Recently for instance, a Dutch doctor working on the Thai - Burmese border was confronted with a newborn baby with a large omphalocele. He managed to get online expert advice within 24 hours.

However, to achieve this, it is necessary to have easy access to a specialist on the subject who is also acquainted with the conditions in rural hospitals of poor countries. Additionally, the consultant should have the opportunity to read his mail regularly and provide useful, well-balanced advice.

This has led the organisation for Dutch doctors specialising in tropical health care (TROIE) to establish an online consultation service for doctors abroad. Through their web site: www.tropenpleiding.nl, TROIE offers the possibility to submit a case to Dutch consultants by e-mail. After logging on to the site, doctors abroad can send an e-mail which is then forwarded to a pool of selected consultants in collaboration with several occupational societies in tropical health care. So far, we have obtained consultancy groups in the fields of surgery/traumatology, gynaecology/obstetrics, dermatology, ophthalmology and ear/nose/throat. These consultants, all with experience in the tropical field will then, wherever possible within 24 hours, reply with their advice. It is a simple, straightforward way to get expert advice on medical problems. They may also, if necessary, provide a telephone number where they can be reached for further discussion.

Any colleague in need of advice on a particular clinical problem is invited to log on to www.tropenpleiding.nl (free of charge).

You are requested to provide the following information:

Referring physician

- Training, years in practice
- Hospital facilities and possibilities of referral

Medical field in which the consultation is required

Patient's data

- Age and gender
- Previous disease, HIV status: positive/negative/unknown
- Present complaints
- Physical examination
- Laboratory and additional examination (photos etc.)
- Treatment delivered so far

Specified question

- Considering diagnosis, therapy or other

Every applicant is requested explicitly to provide us with follow up information on the case, and to tell us whether the advice was considered to be useful or not. Naturally, all responsibility remains with the physician who is actually treating the patient and the advice is never legally binding.

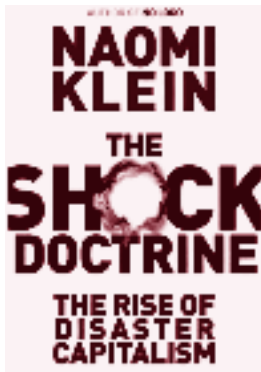
In due course we will be pleased to inform the readers of MT about the use that has been made of Consult Online.

For additional information on the online consultation please contact: consultonline@tropenpleiding.nl



Photo: H. de Vries

BY: JOHANNES BORGSTEIN



THE SHOCK DOCTRINE: THE RISE OF DISASTER CAPITALISM

Naomi Klein

Allen Lane, London, 2007

£12.99

photo: J. Borgstein



If, like me, you have been surprised by the rapid advance of radical capitalism and the seemingly unstoppable advance of globalisation, leaving in its wake a trail of escalating poverty, bloodshed and misery, especially in those countries that can afford it least, it would be well worth your time to breeze through Naomi Klein's new book *The Shock Doctrine*. Though 555 pages long, and dedicated to the politics of economics it reads like a novel and is literally hard to put down, except to rest your arms from time to time. With well-documented research, she analyses the global domination of the Chicago school of economics under the intellectual leadership of Milton Friedman - Nobel prize winner and much celebrated hero of the multinational corporations dedicated to advancing the free market concept to all countries in the world. Klein uses an interesting metaphor of the CIA-funded research into psychological torture methods, perfected by Canadian psychiatrist Ewen Cameron working at McGill University in the 50s. Cameron used his unsuspecting patients to advance his dangerously flawed theories, by attempting to 'erase' their brains with a combination of electroshock and psychedelic medication, to subsequently 'build' them up again without the original errors...

Similarly, Friedman proposed shock tactics for entire countries, followed rapidly by the imposition of a triad of permanent measures, before the population has had time to recover from the shock. A suitable shock may be a dictatorial coup as in Chile under Pinochet, or a natural disaster, such as a tsunami or the flooding

in New Orleans. Also, currency speculations were found to be very effective in bringing a country to its knees. After this, in rapid succession a series of measures is imposed:

1. Free trade and floating currency (economic protection is prohibited)
2. Reduction of government spending
3. Privatisation of state industries and services

This combination is supposed to 'rebuild' the national economies much in the way Cameron tried to 'rebuild' his victims' minds after virtually destroying them. And where Cameron's victims were very docile and depressed after their ordeal, the countries 'treated' by Friedman became docile supporting actors in the international scene of global multinational rape and pillage.

The enforced free trade (invariably imposed by the International Monetary Fund before it will supply a loan) also includes removal of job security and sets the scene for full-scale exploitation of workers. The reduction of government spending includes abolition of minimum wage and allows multinationals to come in and utilise virtual slave labour, while the sale of state services to private enterprise produces at best a small elite of local billionaires like in Russia, but usually a tremendous feeding frenzy for the multinationals. All this, Friedman's theories insist, will lead to a healthy stable (global) economy, and it certainly does, for any dissidence is instantly punished by the volatile electronic markets that can siphon off a country's entire financial assets overnight, leading to an instant depression. Interestingly, the psychiatric metaphor remains solid, for Cameron's patients, even years later, suffered depressions and hallucinations far worse

Good agreement on the degree of cervical dilatation between examiners is possible



than anything they were originally treated for. Cameron's methods were eagerly taken over by the CIA who discovered them to be the most effective forms of torture yet invented by man, while Friedman's theories have proved very popular with the global investors and large multinationals for whom it seems tailor-made.

Klein takes well-documented examples from Chile to Indonesia, and in the course of her book covers almost all countries, with Friedman's therapies finally coming home to the US where they were imposed to sell off the state school system after the New Orleans flooding.

I once read that liberal capitalism by its very nature could know no limits on technological advance, and few on social behaviour.

The combination of democracy and Global Commerce will finish off everything (resources, economies, political stability) and provides an irresistible force dedicated to short-term profit. Not so much a conspiracy as a Gollum or Frankenstein's Monster. A man-made monster spiralling rapidly out of control. It is especially in the poorest countries that the effects are the most rapidly felt, but no country is immune, and we may see similar programs being implemented worldwide in the very lucrative health market and in education:

- Abolition of government subsidies
- Free competition amongst hospitals and universities (free trade)
- Privatisation of hospitals and universities

The (electro) shock required to force the medical profession into accepting these measures has already been found - it is managerial and administrative.

Jeffrey Sachs:
"We in the
West know
best what is
good for the rest"



Photo: H. de Vries

By: STEVEN SMITS

Does the West know best what is good for the Rest?



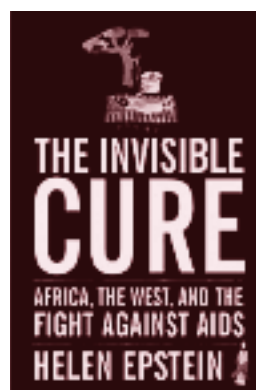
THE WHITE MAN'S BURDEN

Why the West's Efforts to Aid the Rest Have done So much Ill and So Little Good

William Easterly

ISBN 978-0-14-303882-5 (US \$16) (paperback, also available in hard cover)

AND



THE INVISIBLE CURE.

AFRICA, THE WEST, AND THE FIGHT AGAINST AIDS

Helen Epstein

ISBN 13: 978-0-374-28152-6 and ISBN 10: 0374-28152-1 (US \$ 26)

When William Easterly was asked in an interview with the journal IS (International Co-operation, the journal of the Dutch Committee for sustainable Development), whether he saw a change in approach to helping Africa away from the ideas of Jeffrey Sachs and the Millennium Development Goals (MDG), he stated: "In the US, Sachs has lost the debate, in Europe I am not so sure..."

That debate is between "planners" and "searchers" in development aid, and professor William Easterly, economy professor at New York University and formerly head of research of the World Bank, is a committed "anti-planner" and critic of development aid in its present form. During a recent visit to Holland he drew large audiences and much attention to his ideas and while the way he presented his ideas and convictions may have caused some irritation, it is unlikely to be the case when reading this much acclaimed book. The main theme in the book is a description of the "planners and searchers" over the years. It goes back to pre- and early colonial times and depicts the struggle between them in late colonialism and the ensuing transition into independence. With many examples he illustrates clearly how "planners", during all these periods, even with good intentions -let alone the not

so good ones- could turn these into failures and even disasters. The main cause of failure was our belief in the unquestioned superiority in knowledge and understanding of our society, coupled with disinterest, lack of understanding and even total disregard of “the locals” and the dynamics of their societies. In one respect -us knowing what is best for them- he likens the “planners” of today to the colonial administrators of the past and argues that the latest example of this attitude is the whole Millennium Development Goals discussion and the ideas of its creator Jeffrey Sachs, best summed up as: “We -in the West- know best what is good for the rest”.

It is indeed tempting to bring under that heading the promotion of exclusively technical solutions to the major Poverty Related Diseases (PRD’s), without much regard for the environment in which these would have to be implemented.

That is exactly what Helen Epstein, “author and speaker”, scientist with many publications on Public Health, does with respect to AIDS in her, also much acclaimed, book: “The invisible cure”. (Not surprisingly very favourably reviewed by Easterly in the “New York Review of Books” under the title: how, and how not, to stop AIDS!) Here, too, the theme running through the whole book is the notion that solutions that do not involve the people concerned have very little chance of being effective. It argues that there is insufficient understanding and respect for the own efforts of people themselves and their communities; and that the best we can do is to support and assist their search for solutions. We can help them with finding out how to implement the present technical knowledge in their circumstances. What we can deliver is technical knowledge and experience from elsewhere. That is what the “searchers” try to do and both these authors do not deny the need for planning, but then go on to make a strong plea for the “searchers” and the modesty that comes with being one. Both repeatedly argue that the planners are not only ineffective in delivering aid, but also have a potential to do harm to the development process. (We may remember what Laurie Garrett argues in her article: Do no Harm: The challenge of Global Health. (Foreign Affairs February 2007, reviewed in the first MT))

Easterly and Epstein are both firm believers in the potential of poor societies if given the chance, for positive dynamics. Both provide magnificent examples from past and present to illustrate their points. One does not have to agree with all their ideas and observations, to see these books as real eye-openers with a lot of food for thought. That “wake up” element in particular should make these books essential reading material for all of us involved in development co-operation. Both these books are highly recommended!

New Wemos report: A Bitter Pill



‘The West has such a voracious appetite for new and improved drugs that it sometimes seems justified to make these available at any cost,’ says Dr. Heleen Dupuis, Professor of Medical Ethics and member of the Dutch Upper Chamber of the States General in A Bitter Pill, the new Wemos publication on clinical drug trials in developing countries.

In A Bitter Pill, Wemos describes the risks involved when carrying out clinical drug trials on the inhabitants of developing countries, and puts forward concrete proposals for the improved protection of these vulnerable test subjects. Core of Wemos’s plea is the call for ‘fair’ medicines, drugs which have been ethically tested.

In the booklet, experts give their opinion. Among them is Dr. Amar Jesani, coordinator of the Indian Centre for Studies in Ethics and Rights: ‘Many doctors in India involved in clinical trials are given enormous sums of money in return for recruiting patients. This leads to a conflict of interests, of which the patients are the victims. When they find they need medical attention, the financial obstacles they encounter tempt them to close their eyes to the possible risks of clinical trials.’ Also discussed is the Pfizer-trial, during which Nigerian children received the experimental antibiotic Trovan.

Last month, a coalition of five organizations, including Wemos, the Centre for Research on Multinational Cooperations (SOMO), Foundation Farmacie Mondiale, the European Medical Students’ Association (EMSA) and Health Action International (HAI) Europe, presented A Bitter Pill, along with the new SOMO report Ethics for drug testing in low and middle income countries to Members of the European Parliament (MEPs) in Strasbourg. Following the presentation, thirteen MEPs submitted questions to the European Commission. The answers are expected early April.



Wemos works to promote ‘fair’ drugs, medicines which have been ethically tested

To order a free copy of A Bitter Pill or to stay informed about the Wemos work, please go to www.wemos.nl.

Dr. J.J.M. van Roosmalen

will be inaugurated as a Professor in National and International aspects of safe motherhood

Friday, April 25, 15h45

Location: Aula VU, De Boelelaan 1105, Amsterdam

Vacancy

Tropical Doctor or Pediatrician

Haydom Hospital, Tanzania

Wanted: Adventurous, passionate yet patient doctor needed for the pediatric population at one of the largest rural hospitals in the country (vacancy available 1st of April 2008, duration 2 years with extension)

For more information see: www.nvtg.com



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Contributions and announcements (Word document) should be submitted to the editorial office by email: MTRedactie@xs4all.nl
Closing date for the coming edition: May 1 - 2008

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