MDG 1

ERADICATING EXTREME POVERTY & HUNGER
Some of you might wonder what's the value of this publication? What would the writings of a bunch of medical students change? Or just say: MSI 13...so what?

The magazine theme is the MDG No. 1; to eradicate extreme poverty and hunger, the same theme of IFMSA March Meeting 2006 in Chile. In this way, MSI 13 has united the IFMSA message for all its members and partners. For the majority of medical students who couldn't make it to Chile, still they can get the IFMSA message in March 2006: Eradicate Extreme Poverty and Hunger. For many of the IFMSA partners and other international counterparts, they can still hear the voice of medical students worldwide saying; Make Poverty History.

Other than achieving these goals to promote and strengthen the Federation's values, still MSI 13 has just taken the first step in making up the minds of the future doctors about poverty, the worst human constraint. MSI 13's real impact would appear in the readers' better understanding of poverty, after getting new facts and different opinions about poverty.

The magazine shows that IFMSA intercultural diversity and spread all over the world didn't prevent its unity to support MDG1. I'm really proud that it is produced solely by medical students from various countries. MSI 13 proves once more that IFMSA doesn't just Act Locally, but also Thinks Globally very well.

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Letter from the Editor-in-Chief

Dear Medical Students,

It is my sincere pleasure to introduce to you the 13th issue of Medical Students International. Our pervading theme is the United Nations Millennium Development Goal (MDG) No. 1 & the pages of this issue will take you on a journey exploring health in all corners of the world.

It is indeed a hopeful goal for United Nations to attempt to eradicate extreme poverty and hunger. MDG No. 1 aims to reduce by half the population of people living on less than a dollar a day while also reducing by half the proportion of people suffering from hunger. But just as every success begins with a dream we must do everything in our power to build a brighter future with our international colleagues by acting now.

The best way to get involved immediately is through educating ourselves regarding the issues facing healthcare on an international level. Medicine was not born in a vacuum. As such, the education of student doctors must include significant emphasis on the responsibilities of the physician in the community - both locally and globally.

As tomorrow's doctors and leaders in healthcare, I urge you to take a stand. We must stand up for peace and we must stand up equality. Only then will we be able to make significant progress in reaching the Goals and achieving better health globally.

This issue includes articles about the state of health and poverty in countries such as Germany, Rwanda, India, Nigeria, Nepal, Bangladesh, Palestine, the Philippines and Canada. Poverty is not a plague confined simply to those deemed as "developing nations" but affects the biggest and smallest of countries worldwide. No one can remain complacent when the battle against poverty rages in everyone’s backyard.

Let us open your eyes to the truth about the world we live in.

On behalf of the Editorial Board,  
Ripudaman Singh Minhas  
(MD Class of 2008, University of Toronto)
Medical students and the Millennium Development Goals

Nowadays, over 1 billion people live on less than $1 a day with nearly half the world’s population living on less than $2 a day. This has an enormous impact on primary health care access worldwide. The eight Millennium Development Goals, ranging from halving extreme poverty to halting the spread of HIV/AIDS and providing universal primary education, are the world’s time-bound and quantified targets for addressing extreme poverty in its many aspects. Focusing on income poverty, hunger, disease, lack of adequate shelter and primary care, while on the other hand promoting gender equality, education, and environmental sustainability.

We recognize that the Millennium Development Goals are putting health at the center of development thinking and the global health agenda, giving the health professional a great deal of responsibility and opportunities to make an impact in poverty and development issues.

We have the opportunity in the coming decade to cut world poverty by half. Billions more people could enjoy healthy food and products of the global economy. Tens of millions of lives can be saved. Millions of people can enjoy safe drinking water. More than 500 million people will be lifted out of extreme poverty. More than 300 million will no longer suffer from hunger. Rather than die before reaching their fifth birthdays, 30 million children will be saved. All that is needed is action.

There's more. Achieving the Goals will mean 350 million fewer people are without safe drinking water and 650 million fewer people live without the benefits of basic sanitation, allowing them to lead healthier and more dignified lives. Hundreds of millions more children will go to school. Behind all these large numbers are the lives and hopes of people seeking new opportunities to end the burden of grinding poverty and to contribute to economic growth and renewal.2

However, there is a need to understand that the Millennium Development Goals are goals, but they do not tell us strategies on how to achieve those goals.

During the previous months IFMSA has committed itself to address poverty and hunger problems worldwide and raise awareness about this global challenge among medical students worldwide.

As future healthcare professionals, we are in a position to reverse this widening gap in society. This can be achieved by acknowledging that such problems exist, and by working hard to give every single person the opportunity to afford primary health care, no matter where he or she lives.

Students in many of our 94 member organizations educate themselves about poverty, hunger and health inequalities problems worldwide or take part in community projects.

We believe in a future where doctors play a strong role in helping local, national and international communities to both prevent poverty and hunger and protect those most vulnerable to it. Through our extra-curricular activities, we prepare ourselves for that role.

For more information about medical students activities in fighting against poverty and hunger, see www.ifmsa.org/projects and contact our Project Coordinator. We’ve come a long way, and we’ve got a long way to go. Now let’s really get started.

Jana Kammeier
President IFMSA
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Organization for Economic Cooperation and Development: www.oecd.org
UN Millennium Project: www.unmillenniumproject.org

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MDG: Eradicating Extreme Poverty and Hunger
Poor healthcare coupled with widespread poverty (45% of the population live under the poverty line) and infectious diseases are a major cause of mortality in Bangladesh.

Around half of the country lacks adequate sanitation facilities. Over half of children under five years are underweight. The issue worsens during the floods each year when crop destruction and the mixing of sewage and flood water leads to poor nutrition and unhygienic conditions.

The catastrophic proportions of this was only made clear to me when I spent some time at a small clinic for the poor, in Khulna, Bangladesh, where I shadowed two general practitioners. Patients came to them with many problems that included cholera, typhoid, dengue fever and tuberculosis.

It soon struck me that many did not seek healthcare unless they had waited a considerable amount of time for their symptoms to go away. The treatment of patients is subsidised by the community but many patients could still not afford the treatments, suffer from malnutrition and cannot afford to take time off work.

One such example was a patient who had tolerated a cough, breathlessness and night sweats for weeks. He only came in when he observed blood in his sputum and was eventually diagnosed with tuberculosis (TB). Around a quarter of TB cases in Bangladesh go by undetected and over 80,000 people die each year from the disease despite highly effective treatment being available.

Many patients were barely able to pay the doctor's fees and could not afford to pay for treatment. Sometimes the doctors could give their free drug samples from pharmaceutical companies. Some patients began treatment regimes but discontinued them, sometimes later coming back in a more serious condition. Some just decided that their body would have to deal with the problem itself.

In addition to this there were those who opted to take advice from an authoritative family member, or selfprescribed. Antibiotics were easily available from local pharmacists without a prescription and, with paracetamol, were the most commonly taken medications, especially for high temperatures and diarrhoea. For example, one patient had started taking Amoxicillin for dengue fever (a viral disease) and only sought help when there was no improvement after a couple of days and worsening pain of NGOs Bangladesh has begun taking steps to tackle some of these issues.

I left the clinic with a very bleak outlook on the state of infectious diseases in Bangladesh. Fortunately all is not as bad as it seems. With the help of NGOs Bangladesh has begun taking steps to tackle some of these issues.

One of the major developments has been the adoption of the directly observed treatment short-course (DOTS) for tuberculosis. DOTS treatment, which is provided free of charge, has an 84% success rate and with increasing case detection the horizon looks a little brighter. Moreover, drives to increase vaccination against tuberculosis (95% coverage among one year olds), tetanus, diphtheria, polio have all helped to target infectious diseases and decrease mortality rates.

Photos courtesy of Faisal Rahman

Infants gathered for polio vaccinations. The last polio case reported in Bangladesh was in 2000.
In addition there have also been recent attempts to increase sanitation coverage and improve hygiene. Organisations such as BRAC, UNICEF and other NGOs are now working with the government to ensure 100% sanitation and safe water coverage by 2010. Approaches include providing water purifying tablets, advice on cooking food and the building of sanitary latrines.

Although there is progress being made there still remains a lot more to do to give the poorest populations of the world an opportunity at life. As medical students we can also help Bangladesh and countries suffering from similar problems. For example we can volunteer with organisations to work in these countries. I hope to do this in the summer with the Bangladeshi NGO BRAC. If this is not a plausible option, many of us often forget that there are many chances to work with local branches of international NGOs in our own countries to campaign and help raise money. It is a rewarding experience and you feel that you are making a difference to those in need.

Faisal Rahman
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Reference:

Poverty & Conflict in Nepal: A Vicious Cycle

Situated between two of the world’s emerging economies, India and China, Nepal is one of the world’s poorest countries. Here, 31% of the population lives below the poverty line. Over a third of the population consumes less than 2250 Kcal per day. A clear sign of extreme poverty and hunger is that 48.3% of children in Nepal are underweight, a rate higher than that of war-ravaged Afghanistan. Low economic growth, social inequality, widespread corruption, violent conflict and political instability are the major causes of poverty in Nepal. Whereas the economies of neighboring countries China and India are growing at a fast pace, around 9% and 8% respectively, Nepal’s growth rate was 2% in 2004/2005. The kingdom has been in violent conflict since 1996 when the communist party of Nepal, the Maoists, declared a people’s war. The political situation has worsened since the King seized power in February 2005.

Social inequality

Nepal has traditionally been a Hindu kingdom. There is great social inequality and suppression based on religion and caste. Gender bias against women is marked, especially in rural areas where they are deprived of education resulting in a 65% to 43% difference in literacy rates between men and women. Also, on average, a woman’s income is just the half of what a man earns.

The indigenous people and ‘Dalits’ (the suppressed caste) face the most grueling inequalities. They are deprived not only of educational and economic opportunities but also of social activities such as entering temples for prayer and collection of drinking water from public taps or wells. In 1999, indigenous people and Dalits constituted 36% and 15% of total population but they held just 8.42% and 0.17% posts in government agencies respectively.

Violent conflict and political instability

Violent conflict in Nepal originates in the country’s underlying poverty and social discrimination. In effect, the conflict also fuels the plight of the poor who are the most vulnerable group in such unstable times. In 1996, the year the Maoist insurgency began, the poverty rate was 72% in the mid and far western regions and only 4% within Kathmandu valley. Maoist insurgency began in those regions and they are still the worst affected areas today.

Farmers in the rural area have been worst affected by the conflict. Very often farming villages are compelled to provide food and shelter to the Maoist guerrillas. They are taxed by Maoists and are often not allowed to harvest their agricultural products. These farmers then late face the threats and torture from government security forces for alleged support of the terrorists.

Farmers find it hard to sell their products and get income because of a series of strikes called by the Maoists. In May 2004, nearly 300 farmers from the Chitwan district dumped fresh vegetables worth $15,000 on the main road out of frustration over the prolonged strikes that pre-
vented them from selling their products. Elsewhere there were images on television of people under similar circumstances who were pouring milk onto the road.

More than 80% of people of Nepal are farmers living in rural areas. They have found it impossible to live in their home and have dispersed to other parts of the nation and to neighboring India. Indeed, estimates indicate that between 100,000 and 200,000 people have been internally displaced. These people have faced poor living conditions and hunger. There is little prospect for the development of many villages now left without working manpower, but the elderly and women.

**Hunger**

The population living below the poverty line suffers from ‘hungry seasons’ lasting up to two or three months each year. In 31 of the 75 districts in Nepal food production is significantly less than the demand, the worst affected being mountainous regions. The government is unable to supply the normally required amount of food to these areas, let alone a stock in case of emergencies. This becomes much worse in light of the insurgency as transport has been interrupted to many areas and there is frequent looting of the food by Maoists.

Poor weather and geographical conditions already makes food production in these areas difficult. Indeed, these regions lying at high altitude are referred to as ‘deserts in the sky’ because of the lack of monsoon rain.

**Is there hope for Nepal?**

Nepal had signed the UN millennium declaration committing itself to the achievement of all targets, set out to be fulfilled by 2015. Despite the political conflict and violence in Nepal it is on the track to achieve most of these goals. However, some seem unachievable unless there is a change soon.

The Nepal Millenium Development Goal (MDG) progress report of 20051 suggests it is likely to achieve all the goals except those regarding universal primary education and stopping the spread of HIV/ AIDS. The report cites a lack of initiatives, to reach children from disadvantaged and marginalized groups, as the main reason for the likely failure to achieve the MDG aiming to provide primary education for all.

The report also suggests that the implementation of programs to combat HIV/AIDS are not effective enough to prevent a likely epidemic in the future. Currently Nepal is in a state of concentrated epidemics of HIV/AIDS with the prevalence rates of more than 5% in certain subpopulations including female sex workers, intravenous drug abusers and labor migrants returning from India.

Can Nepal really achieve these goals? What lies beyond the MDGs? Even full achievement of the MDGs would not eradicate the problems that are targeted but it will reduce their burden. An end of the violence and political instability would have a much greater influence on the future of the country. Democracy is a must for progress on the issues discussed but when this might ever happen in Nepal is unclear.

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Overcoming Poverty with Wise Healthcare Practices

Poverty is a call to action --- for the poor and the wealthy alike --- a call to change the world so that many more may have enough to eat, adequate shelter, access to education and health, protection from violence, and a voice in what happens in their communities. (from The World Bank)

Poverty is a call for each one to recognize the basic human rights of other individuals. This recognition can only be comprehended by looking at another person like oneself with the same right to have food for bodily nourishment, shelter for protection, education for intellectual progress, & so on. In as much as an action, whether big or small, by any individual, that has contributed to unequal distribution of resources, we all are responsible for the offset of such inequality that has resulted to the sad reality of poverty.

No change of state is necessary in order to heed this call. So long as there is conviction to uphold humanitarian rights and good will, one can provide the springboard to participate in the worldwide concern to eradicate poverty in his place.

For the medical professional, promotion of health is a primary concern. It is precisely in this context that a doctor can best fulfill the call to fight poverty. Joining volunteer groups, organizing medical missions are great feats. However, these opportunities don't come by the day. A doctor spends most of his time in the clinic seeing a variety of patients, diagnose, treat, & most importantly, give advice on how to prevent another disease episode or a possible complication. With such daily routine, it is not at all surprising to overlook that part we usually reserve at the last segment of a consultation --- patient education on wise health-care practices. We could get lost in merely treating one patient after another so that we could finish seeing all those waiting in line. Or we could succumb to the satisfaction of having 'given aid' to those patients dwelling in city slums or remote road less lands where access to health is a hundred miles away, without even correcting misconceptions on health & hygiene, without giving cheaper yet valid alternatives for healthcare, without emphasizing the value of simple preventive measures such as eating more fruits & vegetables & less of fatty foods, using slippers, throwing away stagnant water, & other ways of healthy living which in the long run would be much more cost-effective.

Recent statistics of the causes of morbidity and mortality in the Philippines are communicable diseases; examples are pneumonia, diarrhea, bronchitis, influenza, and tuberculosis. Other causes include cardiovascular diseases and hypertension. While such preventable diseases apparently affect majority of Filipinos, family expenditure on medical care has risen from 1.9% in the year 2000 to 2.2% in 2003. What does this imply? More medicines, more laboratories, more check-ups, more hospitalizations. All that in spite of endless campaigns organized by the Department of Health (DOH) to promote healthy lifestyle. It would be very easy to throw back at DOH that their programs are not enough, that they do not reach as much people, that some healthworkers are inefficient, that they don't fight to increase the government budget in health, that they do not advertise often. It would be very easy as well to attribute the situation to the common people who seek consult by the time their sickness has gotten worse, who do not attend health classes after a door-to-door invitation by volunteers, who invest their little money on small-time gambling or texting while they complain of having to buy maintenance drugs, who lack the eagerness to transform their lifestyle into a healthy one. The list is endless. Numerous factors are put into play. Yet what does this whole health situation tell? What is the root of it all? Perhaps we have forgotten to look at the key figure...

A patient comes to us because he or she noticed something atypical from the structure or functioning of the body. We in turn see to it that we have gathered enough information about it before giving proper medications and advice. Then the more challenging part comes. Does the patient understand what I have mentioned? Will there be compliance in the medication? What keeps him from doing so? Can he afford all the work-ups? If he needs to be assisted in some activities, is his family willing to sacrifice time for that? What will make him be convinced that preventive means would lessen his tension and worry? These examples are just a handful among the many things we have to consider in approaching our patient holistically. We won't be able to treat our patient properly if we do not
know the circumstances around him.

As much as we are responsible for the management we apply in a particular patient, we have the duty as well to make another be responsible for his own health. By advocating wise healthcare practices to our patients, there would be fewer expenses to deal with morbidities. Less money would be spent on medicines. Children could now go back to school after working in a factory or sell retail goods because father and mother are now healthy for their jobs. The savings of a poor family would fortunately be allotted to more food instead.

Enumerating to our patients all the healthcare practices, however, is not yet the end. Going beyond that will make us much more participative in our role to eradicate poverty. It is the concern for how these people would be able to fulfill those practices we have advised. It involves looking at the situation of each patient, giving them abundant encouragement not to depend too much on aid given by numerous organizations and to strive to take the effort in putting priorities in place. It means helping the patient fix not only his body but also his life. Such undertaking may sound distant from the customary role of the modern physician to diagnose and treat. But it is actually what makes up a true and humanitarian physician.

We entered medical school with the sincere desire to 'serve humanity'. We hope to utter the words of the Hippocratic oath with that same longing. As soon as a patient enters the clinic door, may we commit to mind always: Many mouths await for nourishment. Many ears await for learning. Many eyes await for our example. Poverty is a call to action...the world awaits for us to heed that call.

Beverlee Mante

is Theme Advisor for this issue of Medical Student International. A student from the University of Santo Tomas Manila, she is an advocate of women's health, youth development, & environmental awareness.

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Have We Learned Anything? Rwanda Visited Ten Years Later

I set foot on the red dirt of Rwanda for a nearly a week in July of 2004. I arrived by bus from Nairobi, Kenya where I had arranged a summer elective for my medical degree. The capital city of Kigali is nestled among the rolling green hills that coined the nickname of the small central African country. "The land of a thousand hills," was not known to the masses of the so-called civilized world before the genocide of 1994. Most Canadians still can't find it on the globe. And really, why should they? On most any map, Africa's most densely populated country is so small that the name itself cannot fit within its borders.

Anatomy of a genocide

For those too young or unfamiliar with recent African politics from a decade ago: Over the course of one hundred days in the spring and summer of 1994, over 800,000 citizens were slaughtered by government sponsored Hutu extremists in the most efficient extermination of human life in the history of the world. The atomic bombing of Hiroshima and Nagasaki aside, there has never been a greater loss of human life in such a short period of time. The murder rate in Rwanda surpassed even that of the Nazi gas chambers of World War II. To put it into perspective: imagine a country with the population of Ontario where 8,000 people are killed every day for 100 days straight. That was Rwanda in 1994. The targeted victims were members of the minority Tutsi tribe and any Hutu moderates perceived to be sympathetic towards the "cockroaches."
What makes this massacre even more horrific is that the victims were put to death by their neighbours with crude handheld weapons such as machetes and garden tools, since bullets were too expensive. I had the opportunity to speak to a number of people on both sides of the historical conflict. The topic of the genocide did not always come up, but it could always be felt in words of its witnesses. It was not always possible to tell if those I met were victims of the violence, perpetrators or both.

I visited the southern village of Nyamata with a small group of travellers I met in the capital. On the edge of town there is a small brick church that marks one of thousands of massacre sites around the country. The victims believed they had found shelter in a house of God and barricaded themselves in the church; unfortunately, their terrorists were not deterred. Over the course of just five days, 10,000 Tutsis and Hutu moderates were killed. The entire process was aptly described to me by one genocide survivor:

“They didn’t kill 800,000 people. They killed one, and then another and another.”

What remains today in Nyamata is no longer a site of worship but a memorial to those that lost their lives to unimaginable hatred. It remains unchanged. The walls have gaping holes where the mob had gained access. The ceiling is peppered with thousands of tiny holes that allow the sunlight to shine through, creating a planetarium effect. The unnatural cause of the spectacle was grenade shrapnel; dozens of bullet holes marked the walls under the watchful eye of the remaining Christian statues that remain. The banner that hangs across the entrance is translated from the local tongue, Kinyarwandaïse, reading, “If you knew us and you knew yourselves, you would not have killed us.”

We were escorted around the memorial site by a survivor- a small greying man in his sixties whose only non-native language was French. A special memorial was built in a series of newly constructed caverns. Long bones and skulls of the victims are laid out on shelves in glass casings. There were too many to count. Below the church, there is a coffin. Our guide told the story of the person who was laid to rest inside:

_During the massacre, a young woman was tied down and violated many times before a spear was pushed through her from bottom to top, and her lifeless body was then thrown down a latrine onto a pile of corpses. When her body was discovered not long ago - among the pile of rotting carcasses - it was found preserved in some unnatural way._

He described how she was properly laid here to rest in the memorial below the church. The story, shocking yet not uncommon, was difficult for me to translate to the other foreigners in the group.

The moment of absolute tragedy struck after the impromptu tour, as we stood in silence before the compound. The small group was a mix of tourists and local people. Our guide pointed to a young man, not much older than I, and told me, since I was the only one who understood French, that he was the brother of the woman below. He was the only survivor of his family - everyone else had been eliminated. Overwhelmed by emotions that I have yet to sort out, I did the only thing that to me seemed proper to me; I walked over and hugged him. I know that I will never completely understand this man’s pain.

**Healing continues; scars remain**

Rwanda is not a manufactured death facility. It is a country. One that, in the face of so much recent pain and suffering, is moving forward. Its torment is still not over. Although the killings in the region have subsided and relative stability has embraced the land, many of the people on both sides of the atrocities remain. There are survivors who know which of their neighbours killed their loved ones. Paul Kagame, the general in charge of liberating his people from the genocidiars and Rwanda’s first popularly elected President, remarked, “Ten years on, the survivors of these gruesome crimes still suffer in silence. There has been dual survival; survival of the ordeal and survival of the aftermath of the genocide. A decade has done little to alleviate...
the anguish." The scars remain as the healing continues.

The international community could not have failed Rwanda any more if it had tried. Even the UN Refugee camps in Tanzania and the Democratic Republic of Congo (Zaire) largely served as staging areas for the genocidaires to perpetuate the killing. After all that has occurred, I am amazed that the Rwandan people are not bitter towards the world that ignored them in their darkest hour. They welcome foreigners and tell their stories of loss and heroism without disgust or hostility. They have an ability to overcome these obstacles in Rwanda that the rest of the world may never comprehend.

International responsibility

The world stood idle while Rwanda descended into chaos. Thousands of troops and millions of dollars of aid money poured into the former Yugoslavia, while the entire first world stood by and watched while one of the most brutal genocides in history took place in central Africa. The international peacekeeping community was in Kigali in the form of the United Nations Aid Mission for Rwanda (UNAMIR) when the slaughter broke out. It is now widely accepted that military reinforcements on the order of 2,500 troops would have ended the killing and stabilize the region. Instead, member countries such as Belgium and Bangladesh pulled their existing troops out of Rwanda, leaving an impotent UN force that could only witnesses the slaughter.

Retired Canadian Lieutenant General Romeo Dallaire, who in 1994 was in Kigali commanding UNAMIR, returned to Rwanda for first time this year. He said, "The Rwandan genocide happened because the international community - if I may be brutal, as the genocide was - didn't give one damn for Rwandans because Rwandans don't count. Rwanda is of no strategic value to anybody, and has no strategic resources." I believe he is exactly right. If this tragedy took place anywhere in the western world, the international community would have immediately put an end to the massacre.

The onset of the Rwandan genocide coincides with the same week that Kurt Cobain joined the so-called 'stupid club.' While the Echo Generation mourned the death of an angry man with a guitar, the real tragedy was unfolding an ocean away. The ten-year anniversary of the massacre's onset came and went on Apr. 7, 2004. With the exception of Belgium, Rwanda's colonial forefather, not a single western leader thought it important enough to attend the memorial ceremonies. Not even Kofi Annan, who at the time of the genocide was ultimately in charge of the UN peacekeeping forces in Rwanda, made an appearance.

"Failure of Humanity"

On my last day in Rwanda, the flame at the Kigali Memorial that marks the one hundred days of the Rwandan genocide was extinguished until next year. In 1994 the world stood idle while hell engulfed Rwanda. As Dallaire describes in his bestselling book, Shake Hands With The Devil, the situation was a, "failure of humanity." The collective international community is responsible for the past and the least we owe Rwandans is not our sympathies, but a future.

When I began to share my experience in Rwanda, my frustrations with the genocide were evident. A friend of mine passed on a quote from a different time and context, yet it appropriately applies: "It would be so much easier to just fold our hands and not make this fight - to say I, as one man, can do nothing. I grow afraid only when I see people thinking and acting like this. We all know the story about the man who sat beside the trail too long... It grew over and he could never find his way again. We can never forget what has happened, we cannot go back nor can we sit beside the trail." - Chief Poundmaker, 1842-1886

Right now, another gruesome version of the same events is taking place in the Darfur region of Sudan. The World Health Organization has reported that 70,000 people have died in the region while the world continues to diplomatically debate whether the definition of genocide applies. It is our responsibility as a just society to actively stop any clear violation of human rights and prevent it in the future. We are failing miserably. Let us stop sitting beside the trail.

Jason McVicar is a third year medical student at the University of Manitoba, Canada.
Challenging Poverty in Africa

Poor people lack sufficient income to obtain minimal health services, food, clothing, housing and education, which are the basic requirements for a decent life. And there are several millions still poor in the world today. Poverty is ultimately associated with an unhealthy life, either from starvation and malnutrition or lack of access to health services. High morbidity and mortality rates, especially among women and children and low life expectancy are significant indicators.

In Africa

Statistics and reliable projections show that millions of Africans live below the poverty line. Despite recent significant improvements in the overall gross domestic product (GDP), "poverty has been unresponsive to economic growth". A UN report of 2005 posits that this is because "the majority of people (in Africa) have no jobs or secure sources of income".

People who have a below-average ability to earn income are more likely to be poor, including the elderly, people with disabilities and single mothers. Lack of ample opportunity for education could also lead to poverty for this reason.

A low level of economic development is also implicated. African governments are constrained by the IMF and World Bank to follow certain economic laid-down recipes, some of which have perennially failed to yield expected results.

Some believe that poverty in the developing world is linked to accumulation of wealth in the developed world-the so-called north-south divide. Dr. Akonor of the African Development Institute however believes, that "the onus for Africa's development failures" including hunger and poverty, "lies primarily with its political leaders". "Rather than exercising foresight and originality in their policy options, Africa's leadership continue to embrace policies that disempower the mass of African society."

"Neoliberal reforms alone, with its emphasis on economic growth over social equity, cannot transform Africa's dependent economies into self-sustaining and viable entities ..."

The UN study outlines four challenges:

- "achieving structural transformation to break away from the under-utilization of rural labor;
- addressing widespread youth unemployment;
- harnessing globalization to create decent jobs;
- and creating an enabling environment for accelerated expansion of private sector job creation through increased investments".

World leaders, lip-service?

World leaders at the UN Millennium Summit agreed to work assiduously to reduce by half the number of people living on less than US$1 a day from 27.9 percent of all people in low and middle income economies to 14.0 percent. Health indicators for assessing this include a significant reduction in the prevalence of under-weight children under five years of age and the proportion of population below minimum level of dietary energy consumption. These are lofty and achievable but it appears we are not doing enough to achieve set targets. Warning signals are already being sent by relevant institutions that many nations are already falling short of expectations in these affairs.

Progress in eradicating hunger has been slow and conditions have worsened in some regions. For instance in Niger, the story has been reported of "the proud, round-faced mother of an infant named Raba, who walked a day's journey to bring her emaciated son to a feeding center. Already this mother (who was unwilling to give her name because of the stigma associated with her condition) has buried five of her 11 children after they succumbed to the hunger that increasingly gripped her land." Despite the focus on Niger's woes, the fact remains that "the country's 2.9 million hungry people are just a fraction of Africa's 31.1 million food-deprived masses, scattered across Sudan's Darfur region, Zimbabwe, Ethiopia, Uganda, and elsewhere." Despite increased democratization in many nations and the unending wars, and economic growth, Africa is the only region in the world becoming less and less able to feed itself.
Some assessments suggest that many countries are falling short and may be unable to meet up. On the contrary, African countries lack data to monitor progress if any is being made. There is therefore a need for increased statistical capacity. International efforts are being geared towards addressing this. A consortium of international organizations, countries, NGOs, and individuals has taken up this task in developing countries. The IMF and World Bank have an extensive program of technical assistance statistics to the developing countries. But these may not be adequate.

Significant international pressure is being brought to bear on African leaders for greater democratization of the polity in their countries. Support is being given in recent times for the clearance of the debts of African countries. Despite these efforts, poverty still persists. This suggests that alternative solutions be sought to the African problem.

It is necessary to highlight that "the creation of more decent jobs, accessible to the poor, constitutes the most effective channel through which poverty can be addressed in Africa".

**African leaders are trying, but there's more to be done!**

Can Africa meet up with the 2015 target for the Millennium Development Goals (MDGs)? Urgent action is necessary for an affirmative answer to be possible. Poverty and conflict resolution top the list of pressing issues for action if any significant progress would be made. Through the African Union, Africa is making significant progress towards effective conflict prevention and resolution.

African countries appear to be making significant economic progress in recent times. Greater democratisation of African institutions is being witnessed. Attempts are being made towards fully incorporating Africans into the global village. But are these resulting in better life for the average rural African?

I believe that Africa will meet these targets if the challenge is faced with the zeal required and the support of all.

**The Price of Negligence!**

Today, millions of people are unable to attend school or any form of proper education; have no access to healthcare; and are plagued by diseases. They are sufferers from poverty, with no end in sight. These people have lost all hope for improved conditions. If we allow these people to wallow in this state, we would suffer the consequences of our inaction, directly or indirectly.

Poverty is associated with serious social problems. Mental illness, alcoholism and high crime rates are common in areas dominated by poor people, for they are causes as well as effects of poverty. 'Poverty also breeds poverty'.

The health consequences of poverty are hideous. For instance, if poverty remains in our midst, diseases such as HIV/AIDS, tuberculosis, helminth infestations such as schistosomiasis, will continue to cause severe havoc, however effective our campaigns are, whatever their cost. Malaria, the number one killer in Africa could be eradicated if Africans could afford the requisite precautionary measures. Therefore, if poverty remains, our efforts in other directions may be futile.

**What we should do as medical students**

For us who are fortunate enough to have access to good health and sound education, and hope for a great future, we have a duty to contribute towards limiting the consequences of poverty. If we do not do this from altruism, we should at least do it for ourselves; to make our world a better place to live in.

First, we should identify institutions and people whose efforts can bring about significant change in society and do our best to convince them. We should talk to our governments to improve their efforts towards eradicating poverty in the world and most of all in Africa. Debt cancellation may help African governments redirect their funds towards development. Let's join in the campaign!

We should work through our organizations to raise awareness about poverty in Africa. 'Noise-making' efforts, petitions, walks, swims, accompanied by fund-raisers would help. These funds may be channeled through an IFMSA Poverty.
Action Project for the implementation of ideas generated.

Another approach is for national organizations in developed countries to collaborate with less developed ones. Education of people is a huge step towards saving them from poverty. Food security is another. As medical students, we may not seek to solve all the problems of the poor, but we can take significant steps towards alleviation; if not for their benefit, for ours.

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Explaining the inexplicable: why bumper crops don't impede famine

At first glance the situation seems quite bizarre. The numerous warnings were loud and clear, thanks to drought-management specialists reporting weekly to the central government. Despite their efforts, however, some 2.5 million people are now suffering from hunger and are likely to starve in large numbers unless there is provision from abroad of immediate, and massive, food supplies. Meanwhile, only a few hundred miles westwards in the same country, farmers are celebrating a record breaking harvest. Too contradicting to be true? Not at all! This is the sad situation people in northern Kenya, one of Africa's richest and most stable countries, face today.

To understand this absurdity one must review the underlying factors of phenomena such as hunger, famine and the subsequent efforts in academic circles to develop a comprehensive explanation.

Until the 1970s hunger and famine were generally explained by a shortage of food. This simple cause-and-effect relationship was tackled by Nobel Prize winner Amartya Sen who proved for the first time that the primary cause of famine is not a shortage of supply but rather a reduction of the possibilities to acquire food. In economic terms he defines the problem as one of distribution. He uses the expression 'Food Entitlement' - the right and ability of one to acquire food - to explain the genesis of a famine. A continuous decline of Food Entitlement of a social group explains the existence of famine and food surplus at the same time. Food Entitlement is influenced by many factors including the ownership of land and its cultivation, the possibility to buy subsidised food, the existence of a social security system and adequate employment or income.

This picture goes hand in hand with Sen's second proposition that hunger never affects all social groups equally. In Kenya farmers in the West refuse to sell their harvest to the government since they can realise higher gains by selling it to merchants in Tanzania. At the same time nomads in the North who suffer from food shortages resort to slaughtering much of their cattle (the only source of income for most) in order to survive, resulting in a simultaneous slaughtering of their livelihood. The ensuing decline of their purchasing power, combined with the high prices Western farmers reel in for their products results in ever gloomier prospects for those in the North. This scenario clearly shows that there are always winners and losers from such tragedies.

Sen's theory is still considered groundbreaking. Today virtually all publications on famine refer to his Food Entitlement Decline theory. In recent years social scientists have used his theory as a building block and added deeper and more structural explications onto his economic perspective. Robert Chambers, for example, introduced the concept of Social Vulnerability of the groups who are more likely to be threatened by famine than others. According to Chambers, this Social Vulnerability is two-fold. On one end there are external risks, such as droughts and floods, while on the other side there are internal possibilities which allow a social group to cope with these external risks. This includes the ability to cross national borders to look for better conditions.

However, if ethnic, political or cultural factors hin-
der these groups from reacting adequately to the external risks they are threatened by hunger. This approach refers to a much wider context than Sen’s and was further extended by Michael Watts and George Bohle. They included a long-term dimension to Chamber’s concept of Social Vulnerability. For them the destruction of ecological resources or a shift of the political and economic balance of power also counts towards the Social Vulnerability of certain groups. By adding this dimension, Watts and Bohle integrate parts of Sen’s approach and place the expression of ‘marginality’ at the centre of their concept. That is, certain social groups are vulnerable and in the case of emergency are thus the first to be threatened by hunger. Their marginalised state means they cannot, for whatever reason, take advantage of opportunities or sufficiently benefit from available resources.

Thus, to comprehend the contradicting realities of extreme hunger on one hand and record breaking harvests on the other one must analyse which political, social, cultural and economic possibilities are available to certain groups. Hunger becomes a question of societal hierarchy and the distribution of food reflects who participates in, and controls, the process of production within a country. As long as things go well, this delicate balance has no dramatic consequence. Yet as soon as critical external incidents occur - either natural (drafts, floods) or man-made (civil war, mismanagement, economic crisis) - their combined impact becomes horrifically apparent. In any case, more than one parameter will stimulate the rise of a famine.

This is the case in Kenya where a number of factors can be identified in the development of famine in the north. Many of these risks are homegrown and did not appear overnight. Nobody knows what happened to all the alarming drought reports in Nairobi since September. It is apparent, however, that these reports did not receive much attention. It was only just before Christmas, as more and more images of starving children were sent around the world, that President Kibaki flew to the suffering region, accompanied by two planes full of secretaries and ministers, to announce that the problem would be put at the top of the agenda. Yet the president and his entourage spent most of their time making speeches to the media and not more than 10 minutes with the underfed nomads. Only time, so precious for many, will tell how long this issue remains a priority on his agenda.

Given the circumstances it was a wise decision for the President not to travel through the countryside. Roads to the poor Savannah region are virtually impassable, which is less a problem of funding and more one of political will. The Kenyan government has never shown much interest in investing in basic public services in this remote area which has little economic importance. This failure now blocks people from leaving their hostile land and diminishes the incentive for the provision of assistance.

These examples by no means paint the entire picture. Aside from the as a natural disaster of drought, there are other contributing global factors including increasingly unbalanced world trade conditions. However, these global factors would never have led to such a catastrophe without the interaction of the homemade risks outlined above. In Kenya, for the most part, it is the internal factors that have led to the marginalization and continued suffering of the nomads in the North.

This combination of events has led to the point where the international community is now obliged to step in by sending food aid, with all its well-known negative long-term effects on dependency & the local economy. As long as vulnerable groups are remain at risk of being marginalised, it will only be a question of time until again we see people starving in spite of bumper crops in Kenya or elsewhere around the globe.

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International Federation of Medical Student Associations
Poverty in Palestine is more than a phenomenon related to certain parts of society. Indeed, poverty has become a sword that is directed towards most Palestinians. It invades rapidly and hit any social class at any moment. Poverty’s perennial nature and multifactorial elements makes any prevention policy complicated and difficult to extend to a wide range of people.

Many factors have led to the development of poverty in Palestine. These relate to the level of the social and economic developments and also the amount of resources allocated to Palestinians. This is all strongly related to the political environment both internally and externally. Closures imposed on the West Bank and Gaza has resulted in growing unemployment. Expansion of the private sector has been held back and there has been little creation of new job opportunities. In addition the infamous segregating wall around the West Bank has contributed greatly to the exacerbation of poverty in Palestine.

It is no secret that many Palestinian families are now left impoverished and dependent upon aid to survive. The number of people living in poverty in Palestine has more than tripled since September 2000 to approximately 2 million people. Today over two thirds of the population live below the poverty line on less than $2 a day. Subsequently there has been an acute rise of malnutrition, especially amongst children. According to a report by the United Nations in Palestine:

"Household incomes have been decimated as a result of the collapse of the economy within the West Bank and Gaza Strip and it is beyond the means of many households to procure even the most basic commodities. This in turn has provoked a serious increase in malnutrition rates amongst refugees, in particular children."

The exaggerated, hard conditions the Palestinians find themselves living in has made it possible to get aid from external authorities such as welfare organizations. However, this aid is still minimal and hardly ensures a minimum income or guarantees food and shelter for those in need. Also, the lack of coordination and cooperation between these organizations is a major problem and must be highlighted when discussing poverty in the region.

In short, the subject is not an independent and distinct entity. It doesn’t appear as a clear issue in past or recent plans for the region. Poverty is sadly missing from many of the discussions by decision makers in or outside the country. Review and revision of policies must take place. Strategies and programs are needed to improve the current situation and to highlight all factors that have led to this exacerbation of poverty country. Unless preventive measures are put into action the country will be affected severely in the long term.

Finally the people of Palestine are taking action. The Empty Pockets march took place on July 4th 2005 and aimed to raise many of the issues I have discussed. Hundreds of Palestinians, from all over the West Bank, responded to the Global Call to Action Against Poverty. They participated in a white-band march through the streets of Ramallah whilst the G8 summit was taking place in Scotland. The march was jointly organized by the International Federation of Workers Education Association in the Arab countries- Palestine.

Ibtihal Suwan
is the VPI of IFMSA-PS.

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Working in Mumbai was very challenging. I worked with HIV/AIDS aftercare for the poorest of poor. Looking at the living conditions brought tears to my eyes. One evening, we were on a home visit.

Walking for more than 45 minutes, the passage was small and dirty. There was a huge pile of garbage—a couple of dogs and pigs were near it. A few small children were playing on the top of a mountain of garbage.

With lot of struggle and difficulties, I managed to start vocational training for children infected with HIV. I have worked to create a platform for them so that they can perform and display their talents. Thus helping in inclusion and fight discrimination and stigma.

After much difficulty, we were able to establish vocational training. Courses were offered for girls training to be beauticians, tailors and cooks, along with simple courses for boys in cycle repairing, tailoring, and electrical basics. Many men and boys were given counseling on de-addiction. The population was provided with HIV counseling and importance of condom use.

One of the most affected poverty stricken groups is children with special needs are also terribly affected by the poverty since they cannot take care of themselves. They either die by roadside or you can find them in a government orphanage. I have introduced routines of exercise and meditation (as of marital arts) to the around 30 special needs children living in orphanages. The changes are very impressive. As a second-Dan black belt in martial arts, I have many years of experience teaching children martial arts. It has been very rewarding teaching deaf and mute children who went on to win tournaments. That itself is a very big achievement and you can analyze the hidden power of this training. The changes that we saw while teaching the orphanage residents are very encouraging. The conditions of residents at government orphanages are miserable, no water, no electricity, dirty torn unwashed clothes, beddings are stinking and you can see dirt and fecal matter all over the place. The food is not up to the mark. All the residents are malnourished, medication is not on time and above all, the caretakers were abusive to the children. It is very difficult to survive in these conditions.

A lot of hard work is involved and improving the standards is not an overnight task. The exercises and meditation helped them a lot with regular sessions of game therapy, water therapy and dance. Changes were seen in the areas of concentration, body balance, stamina, and togetherness, lowering of aggression, eye-hand coordination and more. Psychological changes seen in them are very encouraging and presently I am doing research to investigate how this training methodology may help to assist with their rehabilitation and integration into the workforce and society.

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My friend and I walk towards the car, one early morning, after a night spent sitting and talking about ourselves, the world and our future plans. It is around four in the morning, I think. We are twenty somethings, at the prime of our lives. We've been to places, experienced a lot of things. I am a medical student, my friend works for an IT company. Sounds good. We have a secure future. All possibilities lie ahead of us.

Then from out of nowhere, a little girl, thin, frail, her curly hair framing her face, runs towards us and holds out her hand clutching around three strings ofsampaguita (that's our national flower—small, white little buds strung together to make a necklace). "Sir, bilihin nga o la o, para makauwi na ko" (Sir, please buy this so that I can go home).

This is a typical scenario. It is around three or four am. Hmm, I wonder usually, we brush these kids off, with thoughts of doing this for their own good; or sometimes, plain indifference. But after a night of talking about our plans and how we dream of someday "putting up a foundation", or "making a significant contribution to society", we are more inclined to do otherwise. So we ask her to "walk with us to that side so that the other kids won't follow us" (there are other kids as well). After giving us the sampaguita in return for twenty pesos ($ 0.39), the little girl cheekily says: "You know, it's my birthday today, January 22". She looks so happy. We are charmed. "Oh really? How old are you?" "Eleven". "Wow, happy birthday! "Thank you, laban nga po din ni Pacquiao ngayon eh" (Thank you. It's Pacquiao's match today) [Manny Pacquiao is a world champion in lightweight boxing, the pride of the Filipino]. Obviously a smart girl, she beams with pride.

I can't forget the girl's face, as she hopefully, wistfully smiles at her future. At 4am, she has to walk the streets, hoping to sell some strings of flowers so that she can have something to eat for tomorrow. I wonder if she really goes to school, if she studies, at all. When she has to think about filling her tummy for tomorrow, how can she even 'make plans' for her future?

Multiply this scenario a thousand times over. Maybe a hundred thousand more. Last year, the streets swelled with children, doing odd jobs, wiping windshields during stops, begging, doing this and that. Trying to scrape some money off the streets. When questioned, all they say is: "we need it for some food for tomorrow". What's going to happen?

And these are just the children. How many more people were once images of these street children? What becomes of them when that is all the reality they know? Poverty is crippling. It robs people of their childhood, and every other right.

Hence, I return to the original conversation with my friend... that poignant ending of our night was simply a reminder that our plans were not to be in vain. We are young, we have freedom and opportunity. I know that we are not the only ones with these thoughts in mind. There are a lot of twentysomethings on the way to a career with a significant percentage of their thoughts on "helping", doing the best they can. Multiply this a thousand times over, and you see the scenario in my country. Over two thousand NGOs are the 'silent hands' that lift up this country. The unsung heroes, who could not live beside a neighbour in need without doing anything.

Is it too late? Will it be too late? Will we even achieve a measure of the goals UN set out? Reduce by half the proportion of people living on less than a dollar a day? Reduce by half the proportion of people who suffer from hunger? Quite a tall order, don't you think..? A daunting task. All these questions crop up, haunt, taunt. But that shouldn't be the focus. We, as medical
students, future doctors, definitely have a role to play. Like it or not, society puts a large weight on who we are and what we stand for. I think the best we can do is to be living examples, redirecting people to the true meaning of service. Our whole beings should radiate with the hope and conviction that, indeed, something can be done. The strength of our advocacy need not be buried under the weight of our responsibility. Instead, it should be the bastion that will support all our actions.

At the end of the day, we go back to who we are and what we’re doing. In med school, we were taught to look at symptoms, come up with our differential diagnosis, diagnose, and treat the underlying problem. In this bigger school, our problem cuts through deeper flesh, and we know the management may be long winded. Still, we go on. There’s a lot of work that needs to be done and the best is to start where you are!

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Inequality and Inadequacy: Examining the Imbalance of Canada’s Resources

The World Health Organization in Europe published a document entitled The Social Determinants of Health. In this document, ten determinants of health were presented along with evidence that these things largely dictate longevity and quality of life of individuals and populations. The determinants of health, according to this document are: the position of individuals or groups on the social gradient, the amount of stress experienced, quality of early life, the amount of social exclusion experienced, the quality of work available, the level of unemployment in the population, the social supports available, prevalence of addiction, quality of food available, and the quality of accessible transport. Furthermore, the document suggested that the presence or absence of the determinants of health have great effect on mental health and productivity of individuals.

In Canada there is a large discrepancy between poverty levels in aboriginal populations compared to other groups which live in Canada. If a few of the determinants of health are examined, it is evident that there is a very large difference between the aboriginal communities and the rest of Canada’s population. These differences can be illustrated through some of the statistics which have been gathered regarding the status of Canada’s aboriginal population over the last ten years. For example, 52.1% of aboriginal children in Canada live in poverty; this is nearly double the average for all of the children in Canada combined. Aboriginal youths between 15 - 24 are almost twice as likely to be unemployed then the national average for the same age, and 46% of Aboriginals have an income less than $10 000 compared to 27% of non-Aboriginal people. Early life experiences, unemployment and job satisfaction are all determinants of health, and are areas that need attention in Canada’s aboriginal population.

Last summer, I visited Garden Hill, an Aboriginal community located in northern Manitoba for a two-week medical exposure. Garden Hill is a very isolated community where all supplies must be flown in, except in the winter when unreliable ice roads allow for truck transportation. Limited access to this community results in the average cost of living being much higher then in communities which are not isolated. For instance, to feed a family of four in Garden Hill is costs more then 200% of what it would cost in Winnipeg, the capital city of Manitoba, located just a
little more then 600 km south-west. When it is considered that nearly half of aboriginal people make less then $10 000 a year, and that there are especially high levels of unemployment in isolated aboriginal communities such as Garden Hill, it is easy to see how people of these communities may not be able to afford the things they need to eat properly, let alone to give their children the same advantages, both educationally and socially, as people who live in less isolated communities.

The World Health Organization has made it clear that poverty and poor health are linked, and these two things are directly related to the resources available to people. In Garden Hill and Canada’s aboriginal population in general, it is evident that some of the important things which the World Health Organization has prescribed to have healthy populations and individuals are missing. These deficits need to be addressed by both the citizens and the government of Canada. For the World Health Organization has made it very evident that finding a solution to poverty is not the responsibility of those who live with it, but of those who can prevent it.

Maclean Thiessen is a second-year medical student at the University of Manitoba in Canada.
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