IFMSA was founded in May 1951 and is run by medical students, for medical students, on a non-profit basis. IFMSA is officially recognised as a non-governmental organisation within the United Nations’ system and has official relations with the World Health Organisation. It is the international forum for medical students, and one of the largest student organisations in the world.

The mission of IFMSA is to offer future physicians a comprehensive introduction to global health issues. Through our programs and opportunities, we develop culturally sensitive students of medicine, intent on influencing the transnational inequalities that shape the health of our planet.
Dear reader,

I am very happy and excited to present you with MSI 22 – Health and the City! We, the Editorial Board 2009-10 put a lot effort to make this issue a pleasure to read for you.

In 1900, 15% of the world population lived in urban areas. Nowadays, the number increased to approximately 50%, still increasing.[1] It is obvious that urban health problems will play even a bigger role in the future than it does right now.

MSI 22 will reflect various medical students’ opinions, thoughts and analyses on this increasing topic. As future health care professionals it is our mission to make this world a better place to live in!

Each year Mercer publishes its Quality of Living Survey.[2] This survey compares 221 cities (2010) according to 39 factors, grouped in 10 categories. It’s insightful taking a closer look at it! You will find the full list on page 19.

Finally I want to thank my whole team for making this happening. Special acknowledgements goes to Jenny Spruell for sharing a bunch of photos for this edition.

Enjoy reading!
Alexander Werni, Editor in Chief

References
Health and the City

Message from the IFMSA President

Silva Rukavina, IFMSA President 2009-2010

Dear IFMSA members and friends,

For 59 years, the IFMSA has supported and coordinated the joint efforts of medical students across continents in order to help achieve a healthier planet. We have done so both by investing in the education and development of future physicians, as well as by supporting community outreach projects addressing public health issues. The IFMSA has no less than 1.2 million members from 97 national member organisations. As well as providing a great deal of support for the needs of medical students in different communities around the world, we are committed to looking after the best interests of medical students, and broadening the horizons of medical education.

In accordance with the observed trends in global urbanisation, we have decided to give special attention to urban health – selecting the theme of Health and the City for the 59\(^{th}\) General Assembly. For the first time in history, living in a city is a reality for more than half of the overall global population. This trend is not curbing, particularly in Asia and Africa, where explosive growth is occurring. As well as natural population growth, rapid migration from rural areas is putting further pressure on limited resources in cities.

Living in urban areas is not inherently bad for health, as general indicators show that city populations are better educated, have greater access to social and health services and live longer. Unfortunately, not all cities and models of urbanisation are planned, managed or governed well. Cities concentrate opportunities such as jobs and services, but they also concentrate risks and hazards for health, as clearly outlined by WHO though their campaign for World Health Day 2010.

Education about the social determinants of health, including community experience, is greatly under-represented in the medical curriculum. Discrepancies and disparities between the populations living in rural and urban areas are increasing. Every city in the world accommodates both extremely wealthy and extremely poor dwellers. Comparing the two within the same city is a true indicator of existing gaps, including those related to accessing health care. Societies with the most pronounced differences in opportunities, income, employment and overall health also tend to hold the highest burden in mental health disorders and injuries/violence.

We are witnessing a paradigm shift; in the 21\(^{st}\) century the greatest burden of poverty is found in the cities. It is estimated that around one third of those living in urban areas (nearly one billion people), live in urban slums, the great majority of which are in developing countries. Living together, sharing limited space, services, and sanitation, especially if accompanied by extreme poverty, does greatly impact on health. In such conditions, there are many health threats. Contamination of soil, food, water and air all have detrimental health effects. Disease outbreaks (particularly TB, HIV, hepatitis and diseases related to lack of sanitation), unsafe housing and greater adverse effects of natural disasters all pose a serious threat to health. Apart from these obvious health hazards, cities tend to promote unhealthy lifestyles; sedentary behaviour, abundance of foods rich in fats and sugar, smoking, and the harmful use of alcohol and other substances all increase the burden of chronic diseases and the number of deaths related to risky behaviour.

It is crucial that medical students gain a better insight into demographic changes on our planet, as well understand the complexities of urban living. Root causes of urban health challenges can and should be addressed through an interdisciplinary approach to urban planning. We should promote healthy behaviour and safety by ensuring urban infrastructure is planned in a way that enables public transport and physical activity, particularly in providing user friendly options for all generations and people with disabilities. Legislation that controls tobacco/alcohol consumption and food/water safety is equally necessary. These efforts can jointly mitigate health risks.

After obtaining a better insight into the effects of urbanisation on health of our communities, it is evident that public health and the global trend of urbanisation are closely related. Adverse effects need to be tackled and medical curricula needs to adequately respond to these threats to ensure that the new generation of physicians is equipped with knowledge and skills to serve their communities in the best possible way. Medical students should be active contributors and initiators of change when it comes to their medical curricula. This publication will give a comprehensive overview of the interests of medical students when it comes to health related challenges of urban living. I sincerely hope that IFMSA will continue to provide a platform for sharing and learning for many years to come.
Green GA?

About the 59th IFMSA August Meeting 2010

Yassen Tcholakov

We have tried to organize the greenest GA possible for you. First off, certain things that you might have already noticed: we have offered you electronic delegate packages instead of physical ones; this is because we believe that it is extremely wasteful to print hundreds of copies of the same document considering today’s very digital world.

Furthermore, you might have already noticed that the venue in which you are staying is at walking distance from the Palais des Congrès where the GA activities are being held; we have also tried to bring most of the social events nearby to keep you within the heart of downtown for the entirety of the GA.

Encouraging walking is very important both because of the benefits of physical exercise as well as the advantages of diminishing fuel usage; it is a way to stay healthy while having a busy lifestyle.

One important thing that we’d like you to observe is that throughout Montreal, you will find that many places have recycle bins placed next to or near garbage bins. I would recommend using those whenever you have something recyclable to throw away. There are generally two types of bins: one is for paper (papier in French) and the other one is for other recyclable products, such as plastic or glass, (plastique or verre in French). The bins are generally identified with drawings of the corresponding items or the French words corresponding to them. Furthermore, for the GA, we will provide composting bins in the area where food will be served, we recommend that you use those to dispose of the food that you do not eat; any food leftover except meat and fish. We have also chosen to provide you with recyclable and compostable utensils and plates and we would appreciate it if you could properly dispose of these.

One last aspect of the GA which has been made to accommodate a more environmentally friendly conference is the menu for the meals served. You will notice that there will be a number of vegetarian meals, this is because animal products require a lot of vegetable products to be used in order to feed the animals which, in turn, creates more pollution by the increased use of pesticides and waste of drinking water for growing the crops.

In short, we have taken various measures in order to have the greenest GA possible with the limited resources accessible to us. We hope that you appreciate our efforts and that you reconsider some of your lifestyle choices in order to adopt a more environmentally friendly way of doing things.
Health is intricately linked to the environment. This has been a known fact ever since the beginning of the debate opposing the outcomes of nature versus nurture. We have significant evidence that shows concrete health consequences of almost all environmental topics of discussion. I will base my arguments on the opinions of two eminent figures in their fields of practice, Hubert Reeves, astrophysicist and fervent environmental activist, along with François Reeves, Hubert’s nephew and also cardiologist who has an interest in environmental medicine.

Firstly, I will discuss the concept of the sixth extinction. In the history of life on Earth, there have been five known extinctions during which a significant proportion (more than 50%) of the species living on the planet have been eradicated because of various causes. In all of the above mentioned extinctions, the dominant species was eliminated by the event, leaving the planet accessible for another class of animals to reign. The most widely known extinction was the Cretaceous-Tertiary extinction event, which caused the disappearance of dinosaurs and opened the door for mammals to rule the Earth. The importance of this historical background comes from the very destructive nature of the human species; since our appearance on earth we have disturbed ecosystems in ways such that some biologists believe are about to cause a sixth extinction. Why is this significant? Because, despite its resilience, life has only been able to recover after the disappearance of the extinction’s causal entity (us humans).

We, as a species, live within an intricate web of symbiosis with all other organisms with which we co-inhabit the planet. It seems that in the past, we had forgotten this and had never thought of the environment as something that we should care for. Nevertheless, the effects of this carelessness are now such that we have scientific data showing us what we refuse to see otherwise. Indeed, a phenomenon almost never observed is expected to happen very soon in developed countries; life expectancy will come to a stall or might even start decreasing because the prevalence of a variety of life-shortening chronic diseases is now increasing. But what is causing this increase? According to François Reeves, personal habits such as overeating, lack of exercise and smoking can be causes of those illnesses. The answer may also be found in history. There was a historical increase in the prevalence of cardiac diseases which preceded the advent of lifestyle changes (which are generally credited for the increase) and went beyond the borders of countries where the industrial revolution caused them. That is because, according to François Reeves, the environmental pollution that followed the mass increase in use of coal for steam engines during the industrial revolution was the cause of those diseases. Either way, the environment appears to play a very important role in the development of such diseases.

The examples above demonstrate some examples of the way in which the environment is linked to health. There are countless other areas of health that are strongly linked with the environment: the increase of the prevalence of asthma in regions where the air is polluted, the greater incidence of allergies all over the planet, and the spread of certain diseases due to ecosystem changes are some other examples. This GA has been organized with these elements in mind and the organizing committee has taken many concrete measures to reduce our environmental impact.

References


For the first time in history, the majority of the global population now live in urban areas rather than in rural areas. This trend is expected to continue with 6 out of every 10 people living in towns and cities by 2030 rising to 7 in 10 by 2050.\(^1\) In recent times, the growth of urban areas in low-income countries has been four times as fast as the growth in high-income countries. This trend, too, is expected to continue in coming years.

**Key points to consider**

- Most of the world’s population growth is expected in urban areas in low- and middle-income countries: Some cities and regions are experiencing rapid growth, whereas other cities and regions are in population decline. However, the world’s urban population in the less developed regions is projected to increase from 1.9 billion people living in cities in 2000 to 3.9 billion in 2030.\(^2\)
- Growth will be primarily in small and mid-sized cities: Urbanization and its health impacts are not just an issue for megacities with over 10 million residents. In fact, much of the urban population growth will occur in small and mid-sized cities. Whilst large cities of developing countries will account for 20% of the increase in the world’s population between 2000 and 2015, small and mid-size cities, with less than 5 million inhabitants, will account for 45% of this increase.\(^3\)
- Urbanization involves migration, reclassification and natural growth: In addition to migration, the demographic make up of a city changes with growth leading to reclassification of towns and hamlets as they are absorbed into the city. Migration and reclassification account for 40% of urban growth, with the remaining 60% coming from natural growth of existing populations.\(^4\)
- Speed of growth can outpace infrastructure requirements: In many cases, especially in the developing world, the speed of urbanization has outpaced the ability of governments to build essential infrastructure. Failure to plan for continued growth results in inadequate health services, water, sanitation, education, and essential infrastructure.

### Why Does it Matter?

A description of current status and impact of urbanisation on population health

Omar H Safa

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**Health determinants in urban settings**

Many cities in developing countries already have a heavy burden of disease. In the future the main threats to health include:

- Infectious disease, exacerbated by poor living conditions;
- Noncommunicable diseases – such as heart disease, cancers and diabetes – and conditions fuelled by tobacco use, unhealthy diets, physical inactivity, and harmful use of alcohol;
- Accidents and road injuries, injuries, violence and crime.

These threats to health are the result of a complex interaction of various determinants of health that can be affiliated to urbanization. Living and working conditions vary widely within and between cities and they are the “causes of the causes” of ill-health. They can be grouped in the following categories:

**Housing, land tenure and security**

Most urban poor live in slums and squatter settlements. These settings tend to be unregulated, precarious, overcrowded, and are often exposed to hazards. Inadequate, overcrowded or deteriorating housing in informal settlements increases the health risks from environmental hazards, violence and crime, and is associated with injuries, respiratory problems, infectious diseases, and mental health problems.\(^5\)

**Water**

Approximately 5.9 billion people – 87% of the world’s population – are using safe drinking-water sources, according to the WHO/UNICEF Joint
When the World Health Organization focused its World Health Report on risks to health, the only two environmental risks that figured in their top ten risks were unsafe water, sanitation and hygiene and indoor air pollution (WHO, 2002).

It is estimated that in the year 2000, unsafe water, sanitation and hygiene accounted for about 1.7 million deaths (3.1 per cent of all deaths), and the loss of 54 million disability-adjusted life-years (3.7 per cent of DALYs).

In the same year, indoor air pollution accounted for an estimated 1.6 million deaths and the loss of 39 million DALYs. (Ezzati et al., 2002; WHO, 2002)

Monitoring Programme report on sanitation and drinking-water. Although 94% of urban residents in developing countries use “improved” drinking-water sources (that means, the availability of at least 20 liters per person per day from a source within 1 km of the user’s dwelling), grave risks of water contamination still exist due to the unreliability of supplies and related water storage practices.

Outdoor and indoor air pollution

In 2004, outdoor urban air pollution killed some 1.2 million people worldwide. WHO estimates that 1.5 billion urban dwellers face higher levels of outdoor air pollution than the maximum recommended limits.

Of urban air pollutants, fine particulate matter, mainly from vehicle and industrial fuel combustion, has the greatest effect on human health. Worldwide, fine particulate matter is estimated to cause about 8% of lung cancer deaths, 5% of cardiopulmonary deaths and about 3% of respiratory infection deaths.

In 2004, exposure to indoor pollution was estimated to cause about 2 million deaths worldwide, mostly from pneumonia, chronic lung disease and cancer. As poor households tend to be more dependent on solid fuel for heating and cooking, they are thus most exposed to indoor pollution.

Sanitation

Although the vast majority of people without access to water and sanitation live in rural areas, some 807 million city dwellers (24% globally and 32% in developing cities) lack access to what WHO defines as “improved sanitation” – household latrines or flush toilets that are connected to sewer, septic, compost or covered pit – hygienically separating excreta from human contact. Of these, more than 170 million urban residents do not have access to even the simplest latrine and are forced to defecate in the open.

About 500 million urban dwellers worldwide share sanitation facilities with other households. Globally, an estimated 3% of all deaths are the result of diarrheal diseases caused by unsafe drinking water, sanitation and hygiene.

Food

Another health determinant in cities is access to safe and quality food, and in sufficient quantity. Inadequate diet reduces resistance to disease, especially for slum dwellers, because they live in the constant presence of pathogenic micro-organisms. Urban poor populations in the developed and developing world often rely on street food, fast food, processed and cheap food, leading to nutritional problems such as vitamin/mineral deficiencies, dental problems and obesity.

Urban transport

Public transport, walking and cycling are the major travel modes in some large cities of Europe, Asia and the Americas. But in many developed and fast-developing cities, trends are moving in the opposite direction. As people become more affluent, the lack of public transport infrastructure and services or good networks for cycling and walking along with social aspirations for a more affluent lifestyle has spurred a rapid transition to cars or motorcycles leading to enormous increases in traffic, along with traffic-related pollution, injury risks to pedestrians and cyclists, and a reduction in physical activity.

Physical inactivity is a major risk factor for cardiovascular disease, diabetes and certain cancers. While everyone in a city may be affected by a lack of transport options, poor neighborhoods often lose out the most, as they lack good public transport access to health centers, grocery stores, schools, and jobs.

Road traffic injuries also stand out as an important and growing transport-related public health problem. Globally, road traffic injuries constitute the ninth leading cause of death and ill-health, and will rise to the third position by 2030.

Noise exposure

Noise, a common urban problem, is a consequence of transportation and construction. Intense and continuous exposure may
be associated with hearing impairment, high blood pressure and cardiovascular disease.[16]

**Climate change**

Climate change has major environmental health impacts in the cities of the developing world, which can be generally more vulnerable to the impacts of climate change. Key vulnerability factors include coastal location and exposure to the urban heat-island effect, whereby urban temperatures may be as much as 5-11°C higher than in surrounding rural areas due to the greater heat absorption of dense urban built spaces and lowered capacity for evaporative cooling.[17] The potential health impacts of climate change range from direct (e.g. ill-health from heat exposure) to highly indirect (e.g. spread of infectious diseases to new locations through ecological changes).[18]

**Social environment**

A city’s social environment can support or damage health.[19] Variable levels of provision of social support are likely to have health consequences.

Negative characteristics of the urban social environment may include social pressure for health damaging behaviors like drug abuse and violence and high levels of social stressors such as social isolation. [20] Interpersonal violence is fast becoming a major security and public health issue.[21] Violence tends to be greater in faster growing and larger cities. In urban areas, young people aged 15 to 24 commit the largest number of violent acts and are also the principal victims of violence. The lives and health of city dwellers are also at risk during wars and conflicts.

The transition to an urban way of life presents opportunities for improved health care provision and for implementation of public health strategies which can benefit many people within a relatively confined area. However, there are also numerous threats to health resulting from the rapid expansion of cities in low and middle income countries. There is a real risk that governments and public health agencies will not be able to keep pace with the rapid rate of growth. It is essential that health care workers have knowledge of these threats so that they can advocate for strategies to mitigate against the grave threats to health in the urban environment. These threats will affect all social classes but the poor will be affected most. Thus strategies should be designed to target assistance to those who are least able to adapt to these changes and who otherwise would share a disproportionate burden of the health impact of rapid urbanisation.

**References**


Lifestyle

I looked up the word *lifestyle* from the Concise Oxford English Dictionary, and found the following definition: “The way in which a person lives”.

It is often said that you are what you eat! I find much truth and sense in this saying. Consider for instance obesity as a medical condition. Obesity is defined by the WHO as a BMI of over 30 kg/m². It results when the calorific intake is in excess of the expenditure.

I have observed and noted over the years the higher prevalence of obesity in the capital compared with the prevalence in my home village. I have been in the capital city of Ghana, Accra for the past six years of my life in the medical school. I stayed almost the whole of my life in my father’s village, Akrokerri – a village near Obuasi, a gold mining town in the Ashanti Region of Ghana. Let me say here that my claims are not based on a scientific study. They are based on personal observation. When I first came to Accra in the year 2004, I had little knowledge about the size of the problem until I moved on to Korle-Bu Teaching Hospital for my clinical studies. Almost every female patient I was assigned to had a BMI of over 30 kg/m²! This was even worse when I started my junior clerkship in Obstetrics and Gynaecology.

A host of modern lifestyle issues could account for these findings:

- Most young Ghanaians are exposed to alcohol at an early stage and unfortunately most drink before a meal. This habit aggravates the problem of obesity.
- It is generally not acceptable for a young woman to be slim especially after being newly married. It is regarded that such slim women are not being catered for well by their husbands! Being round and plump is regarded as a sign of affluence. Many women, young and old, are engaging in practices to gain weight.
- City dwellers do not engage in physical activities like farming, or manual labour. Most people nowadays own cars and drive to their workplaces. There are lifts in many office buildings and avoiding the stairs is the norm.

Conclusion

We make choices everyday that affect our health. Obesity is a problem of lifestyle and life choices. It is sadly turning into an epidemic in the capital. The situation can be better in Ghana with the effort of all. Eat healthily, live healthily! My opinion, my thoughts.
Through History to Future

About the development of cities.

Altynay Satylganova

The history of cities goes back more than a thousand years. They developed and grew through years and centuries, changing the people in them and changing themselves. Historically cities were created as a necessity, but nowadays we can barely imagine our lives without them.

But what stands behind the definition of word *city*? A city is a relatively large and permanent urban settlement. Cities generally have advanced systems for sanitation, utilities, land usage, housing, and transportation. The concentration of development greatly facilitates interaction between people and businesses, benefiting both parties in the process.\(^1\)

In ancient times, cities were created and grew because of developing trade connections. The conventional view holds that cities first formed after the Neolithic revolution. The Neolithic revolution brought about agriculture, which made denser human populations possible, thereby supporting city development. The advent of farming encouraged hunter-gatherers to abandon nomadic lifestyles and to choose to settle near others who lived by agricultural production. The increased population density encouraged by farming and the increased output of food per unit of land, created conditions that seem more suitable for city-like activities.\(^1\) Cities were places where ancient merchants could meet to make their businesses. They were created to ease their lives and soon became centre of development and progress. Everything new and modern was usually invented or brought to cities. Cities became the center of political and social life, science and art. Along with the development of cities, the health of its inhabitants changed. Historically, the people who lived in the first cities used to be wealthier than their “countryside brothers”. They had more variety in foods (as the city was centre of trade), easier access to health care and was more updated in terms of new achievements of hygiene and principles of public health. As an example, I could mention the historically progressive sewerage system in Ancient Rome, also called the system of “Cloaca Maxima”, which can be accepted as prototype of modern canalisation systems. But contrary to all the reasons that made “a citizen” healthier, there were lots of factors that badly influenced health. Cities are highly compact environments, so called “space economy”, living; with a high population density. That means that any kind of infectious or contagious disease could easily spread and affect big numbers of people. History gives many examples of when diseases such as the plague or dysentery caused massive loss of life in cities. The Plague epidemic of 1700 in Moscow and St. Petersburg, where the disease spread within days, almost desimated the cities’ populations. People were running from it, spreading disease to other places, so authorities had to close “city doors” to cease the traffic of people.

As a positive outcome of epidemics, I can name the fact that it gave a push for development of better sanitation and improved epidemic supervision systems of cities. But till now the population of cities are still exposed to seasonal infectious diseases, such as influenza and others. We should understand that cities are an area of high risk and we should take responsibility for each other. As an example, I want to highlight the importance of wearing medical masks in public places if you are sick. I insist on people not being egoistic, because this is how contagious diseases are spread.

With development and growth of world population, cities also grew. They improved peoples’ quality of life, giving more opportunities for “brain jobs”, making less people work physically difficult jobs. This prevents “hard-physical-work-related” diseases, but on the other hand according to studies of some scientists, “brain jobs” made humans less steady to adverse environmental conditions. Living in cities has made us fragile to life out of the city. We walk minimum
distances, because we use transport, or else because everything we might need is just round the corner, and this, in turn has caused the increasing number of cardiovascular diseases.

Industrial development of cities created such exclusively “city-related” diseases as noise disease, some types of depression, increased number of pulmonary diseases and especially bronchial asthma due to growing air pollution. As an inhabitant of a city with a population of less than 1 million people, while travelling, I am always amazed how big cities are alike. You can be in different points of planet, but you can still find Starbucks, McDonalds or Pizza Hut round the corner. Cities are losing their uniqueness, becoming clones of each other. You might say: “Well, this is globalization!” but if so; this globalisation is playing bad joke with us, globalising our diseases as well. It is not a secret that fast food types of meals can be found in any city a bit bigger than a village and this mentality is spreading obesity, cardiovascular diseases, as well as making us lazy and big. I really believe that before taking something from one city, we should analyse how much this will influence our lives and whether or not it is necessary.

Solutions to some of these problems are coming from today’s modern cities: the modern metropolis now offers free gym visits, well-spread bicycle systems, tobacco policies, and big cities are “going green” in the support of environment-friendly facilities. As an example of such cities I can name giants as New York, Tokyo, and San Francisco. In my opinion the concept of “Cities Go Green” will be a milestone in the history of cities.

Historical evolution of cities made human evolution happen, and I think that the directions the ‘cities of the future’ are taking now, will bring us to a better, healthier point of our evolution.

References

Globalization was created by the rules of international trade formed in 1944 and 1995. The rules of international trade discriminate against developing countries. Globalization and the rules of international trade are increasing inequalities between and within countries.

Poverty is linked to higher mortality rates. The main challenge in achieving global health equality is the capitalist attitude of desiring faster, larger economic growth over ensuring an improvement in the whole population's quality of life.

Introduction

The universal declaration of human rights, article 25, states “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care...”[1] In this SSU I am going to put forward an argument explaining how the profit-driven capitalist society we currently live in is unsupportive of global health equality.

Method

A search was carried out on voyager for “globalization”, and “global health inequalities”. Literature searches for “global health inequalities” and “capitalism and inequalities” were made using METALIB. Google searches were made for “UN human development report” and “universal declaration of human rights”.

Globalization and Capitalism

500 years of history have been shaping the dominant capitalist economy to become more efficient in producing faster economic growth, although at the expense of equitably dividing the income it generates.[2,3] Soon after the end of the cold war, advances in technology facilitated the fastest ever rate of communication around the world, as well as enabling the sharing of information once only held by people in power.[2] These changes allowed the old system of government-directed economies to be upgraded to a faster, more efficiently productive capitalist system, initiated by globalization and producing fiercely competitive global free markets.[2,3,4] However, globalization only came about due to the introduction of the international trade rules in 1944 (the World Bank and International Monetary Fund (IMF)) and 1995 (the World Trade Organization).[4]

Globalization doesn’t aid global equality, but takes advantage of inequality to promote efficient economic growth in countries that are able to dominate the global free market.[2,3,5] In this way, free markets only benefit relatively few people, creating growing inequalities within and between countries.[2,3,4,5] Without differences in countries’ economies, global markets would not experience the rapid growth they do, as John Gray writes, “had the wages, skills, infrastructure and political risks been the same throughout the world, the growth of world markets would not have occurred.”[2,6]

To be competitive in this global market, an enterprise needs to have constant access to and take advantage of the newest technology.[2] In order to satisfy consumer demand they also need to be able to provide the highest quality commodity at the cheapest possible price.[2]

The competitive nature of free market capitalism coupled with the world trade laws are supportive of the growing human growth development gap between countries; this is the basis for why globalization is making richer countries even richer, and poorer countries even poorer.[2,3,4,5] (see figure 1)

International trade rules

In 1944 the World Bank and the IMF were formed to provide long and short-term loans to countries who had been involved in the second world war and needed aid to rebuild their infrastructure.[5] They were
never intended to provide loans for developing countries. The US led the meetings in the formation of the IMF and World Bank which goes some way to explaining why the international trade rules are in favour of developed countries. In 1944 “the wealth and welfare of its [US] citizens were tied to its huge industrial capacity and its flexibility and inventiveness to adapting to new industrial needs.”

The US was perfectly adapted for competitive global markets, whereas developing countries still relied on agricultural exports from small business as their main source of income.

Soon after 1973, the World Bank and IMF, in order to protect their profits, started providing development loans to developing countries at high interest rates. The developing countries struggled to repay the debt and required taking out further loans. In 1980, the World Bank introduced structural adjustment policies (SAPs) in conjunction with its loans to developing countries. When a recipient country receives a loan, it must adhere to the SAPs conditions.

SAPs are intended to help developing countries repay their debts, however a critical condition of SAPs is that the governments must reduce expenditure on social services, such as health and education, so that more money can be spent on producing exports to repay their growing debts. The government must then privatise its services which reduces jobs in the public sector and gives the world bank some power over the running of its country.

A second SAP imposed on developing countries is trade liberalization. Trade liberalization is responsible for destroying domestic markets and increasing poverty in developing countries. This is because developing countries are “more inefficient in both technology and management” by developed countries standards, and therefore sell lower quality commodities at higher prices compared to developed countries. Due to competition, local business are bankrupted as consumers buy imported goods.

The Common Agricultural Policy
International trade is infiltrated with double standards and this can be clearly shown in the international sugar trade. Competitive trade is designed to reward efficient producers and destroys inefficient ones, however protective policies enable the EU to be the primary exporter of white sugar even though it costs the EU $660 to produce one tonne of white sugar, but it only costs $280 to produce in Mozambique, one of the poorest countries in the world.
The common agricultural policy (CAP) provides EU sugar farmers and processors with subsidies to enable it to engage in the global sugar markets and protect itself from opening its borders to the global sugar market.\[9\]

Sugar produced by and sold in the EU costs three times as much as the global market price (statistics taken between 1990 and 2002).\[9\] Trade liberalization would allow for global competition and export opportunities for more efficient producers in developing countries. However it is crucial to highlight the fact that although developed countries impose trade liberalization policies on developing countries, by influencing the IMF and World Bank to enforce it through SAPs, they themselves are not bound to implement them and therefore enjoy rich-country protectionism.

The EU imported only 9% of its sugar supply in 2001 but without the CAP to provide subsidies to the farmers and processors, it would have to import 3.7 million more tonnes of sugar.\[9\] Mozambique was blocked out of EU markets until 2001 when the EU permitted restricted access for Mozambique, and other developing countries, to its sugar market.\[9\] However if Mozambique had unrestricted access it could have earned up to $106 million between 2002 and 2004.\[9\]

Subsidies from CAP means that the EU produces more sugar than it needs, and the excess sugar produced is then put on the global markets at a price which is far cheaper than the original cost of production, and even cheaper than the most efficient producers in developing countries.\[9\] Farmers in Mozambique are not allowed to receive subsidies, due to loan conditionality from the World Bank and IMF, therefore they cannot compete with the heavily subsidised price of EU sugar exports.

The result is that the EU supplies 40% of the world's white sugar exports and dominates international sugar trade to Africa, selling 770,000 tonnes of white sugar to Algeria and 150,000 tonnes to Nigeria in 2001, as well as other potential markets for developing world producers.\[9\]

### Driving down prices

In a competitive market, if a company can produce the same commodity as many other companies but at a lower price, it will have a greater appeal to consumers and will therefore make bigger profits. To remain competitive, other companies will also have to drive down the price of their commodity to equal or beat the lowest selling price. In order to drive down the price of commodities companies attempt to reduce the costs of labour, regulatory or tax costs.\[6\]

Multinational corporations looking to reduce the costs of labour have their products manufactured in developing countries where workers lack legal rights, unions are discouraged and hours of work and wages are unregulated.\[4,5,10\] Many are guilty of multiple violations of human rights.\[5,11\] Developing countries also have looser rules on health and safety, as well as waste production and disposal, which benefits multinational corporations who would have to comply with much stricter regulations in developed countries.\[4,5,10\]

Workplace accidents are numerous and claimed 140,000 lives in China's export processing zones in 2003.\[4\] Workplace accidents can be partially attributed to a lack of union representation, resulting in people being overworked, although underpaid.\[6\] In China, many people work up to 18-hour days, seven days a week, for months at a time.\[4\]

### Poverty and health

The international trade rules, as set out by the World Bank, IMF and World Trade Organisation, discriminate against poor countries as they were not created to suit the infrastructure of developing countries, but developed countries. Developing countries rely heavily on agricultural exports as a source of income, whereas developed countries have access to the latest technology and a successful industrial sector that is well suited to the competitive nature of globalization. Structural adjustment policies force developing countries to adhere to trade liberalization policies whilst developed countries enjoy rich-country protectionism and are able to protect their internal market.\[9\]

Globalization has created a winner-take-it-all market and therefore inequalities are growing within and between countries.\[2,3,4,5,6\] Poverty is increasing. The World Bank estimates that "neoliberal globalization has created 200 million new poor people between 1993 and 2003.\[5\]

Poverty is shown to be linked to lower life expectancy (see figures 2 and 3), therefore increasing income inequalities is leading to increasing health inequalities within and between countries (see figure 4).

No alternative model to capitalism can produce faster economic growth; however there are serious by-
products of this system. There are increasing social and economic inequalities within and between countries. In transnational corporations we see profit being more highly regarded than people’s quality of life. The double standards in the international trade rules between developed and developing countries show a callous disregard for equality and fairness. The root of the problem lies not in the financial difficulties in achieving global health equality, but in the psychological ones. Until people’s quality of life is seen to be of higher importance than the speed and growth of the economy or achieving bigger annual turnovers, global health inequalities will always remain a problem.

References
The Royal Ontario Museum is just one of several museums in Toronto, Canada.

The health system is all tangled up. Where else can the people turn to but the sky?
Maria Lourdes M. De Castro
University of the Philippines, Manila

Two cyclists in Melbourne, Australia prepare for Walk Against Warming, a climate change rally that was attended by more than 10,000 Melburnians.
Comment: Liveability

I come from the third most liveable city in the world. It is something that I simply take for granted. The Melbourne peak-hour traffic annoys me, the urban sprawl is endless, it’s another cold day. We host the Australian Open Tennis, I feel safe when I walk home after dark, we sometimes gather for city-wide pillow fights. On hot summer days the smoke from nearby bushfires fill the air. What does it actually mean for a city to be “liveable”?

Culture can denote both the general atmosphere of a city and the artistic and sporting interests of its citizens. It can manifest itself as museums, concert halls, stadiums, art galleries, festivals, TV shows and much, much more. Toronto, Canada, the world’s fourth most liveable city, does not only have multiple museums, but its presence in the TV world is obvious to all as the CN tower dominates the skyline. However, culture can also be more subtle. Does your city have a culture of hospitality towards visitors? A culture of relaxation? Is your city multicultural and diverse? Is it welcoming of same-sex marriage? Do the city officials that you have elected belong to a more liberal or conservative political party? Melbourne, the third most liveable city in the world, prides itself in its diversity, sports, arts and environmental activism.

Anny Huang
Female Genital Mutilation (FGM) is any procedure involving the partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons. There are four main types of FGM according to the World Health Organization classification, Type I being the mildest form and Type IV being the most severe. FGM is a traditional custom since antiquity that is practiced mainly in Africa and in some parts of the Middle East and Asia. Amnesty International estimates that over 130 million women worldwide have been affected by some form of FGM, with over 3 million girls at risk of undergoing FGM every year.

The exact origin of Female Genital Mutilation is not quite clear, but many believe that it dates back to the time the Pharaoh rule in Egypt. Story has it that one night the Pharaoh had a dream that a man would be born among the Jews who would bring his thrown to the ground. In order to ensure that no male would be born without his knowledge he circumcised all the women and that way a midwife would have to be there during the time of birth and kill all the boys born.

Others also believe that it originated in the time of the Pharaohs but for a different reason. Pharaohs believed in the bisexuality of their gods and accordingly mortals (reflecting the traits of their gods) possessed both a male and female soul. The feminine soul of the man was located in the prepuce of the penis and the masculine soul of the woman was located in the clitoris. For healthy gender development, the female soul had to be excised from the man and the male soul from the woman and thus all mortals must be circumcised.

Ever since then there has been great controversy and debate regarding the legitimacy of such practice and people all over the world have been trying to pinpoint the main reasons behind the continuous practice of FGM and basically narrowed it down to one of two reasons; religion or tradition.

**Tradition**

Many of people in countries where FGM is common say that it is done because they are simply following the traditions of their forefathers. They believe FGM is essential for the preservation of the woman’s virginity and that without it she is likely to go astray and become ineligible for marriage. There are even stories of women being married and then “returned” when found to be uncircumcised, either indefinitely or until she gets circumcised. Some believe that a man gets more pleasure out of having sexual intercourse with a woman who is circumcised and since, in their point of view, a woman’s main job is to satisfy her husband then she should accordingly be circumcised. They commonly perform Type III FGM which is also known as the pharoahic type.

**Religion**

The majority of circumcised females are Muslims. Many Muslims believe that it is a Sunna (one of the ways or saying of the Prophet, which Muslims use as a guide through their own lives). Most of the sources they resort to in this case are weak ones, with broken chains of transmission or poor in authenticity. The UNICEF reported that: “...Al-Azhar Supreme Council of Islamic Research, the highest religious authority in Egypt, issued a statement saying FGM/C has no basis in core Islamic law or any of its partial provisions and that it is harmful and should not be practised.” A point that is often overlooked by Muslims who believe in FGM is that surely if the Prophet believed in circumcision then all his wives and daughters would be circumcised, but none of them are. Those who perform FGM for religious reasons usually perform Type I, which is also referred to as the “Sunni” type.
The complications of FGM are numerous and some even fatal. Because FGM is usually performed using unsterile items such as broken glass, scissors, razor blades and sharp edged rocks, pelvic inflammatory disease (PID) and urinary tract infections (UTI) are common among circumcised women. Severe pain, shock, hemorrhage, urinary retention, ulceration of genital region and injury to adjacent tissue infection are but a few of the immediate complications of FGM. More long term complications include dermoid cyst and keloid formation, difficulties in menstruation and urination and the increase need for episiotomies or even c-sections for all deliveries. All the above – not to mention the psychological consequences of undergoing such a traumatic procedure at such a young age – usually under nitric oxide anaesthesia, are some of the main reasons why FGM should not be performed under any circumstances.

The World Health Organization and the International Federation of Gynecology and Obstetrics have opposed FGM as a medically unnecessary practice with serious, potentially life-threatening complications. The American College of Obstetricians and Gynecologists and the College of Physicians and Surgeons of Ontario, Canada, also opposed FGM and advised their members not to perform these procedures. In 1995, the Council on Scientific Affairs of the American Medical Association recommended that all physicians in the United States strongly denounce all medically unnecessary procedures to alter female genitalia, as well as promote culturally sensitive education about the physical consequences of FGM. The American Academy of Pediatrics (AAP) believes that pediatricians and pediatric surgical specialists should be aware that this practice has serious, life-threatening health risks for children and women. The AAP opposes all forms of FGM, counsels its members not to perform such ritual procedures, and encourages the development of community educational programs for immigrant populations.

FGM has been characterized as a practice that violates the right of infants and children to good health and wellbeing, part of a universal standard of basic human rights and is now considered illegal in many countries all over the world. Though people are subject to criminal prosecution FGM is still being performed!

**Conclusion**

In conclusion, whether due to religion, tradition or for no reason at all, FGM is a harmful unnecessary violation of human rights which has absolutely no benefits or legitimate reason for it. People all over the world should stand together as one in the moral battle against FGM, by not only increasing the severity of the punishment against those who perform FGM but also increasing the awareness of people in communities where FGM is still being performed.

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Love without Consequence

No Bad Women – Just Bad Laws.

Mary Keniger

You’ll never, ever make sex work disappear, says Justin Gaffney, a consultant nurse in sexual health who has specialised in providing healthcare for sex workers for over 16 years. However, the Home Office continues to attempt the eradication of this so-called “informal economy” – the unregulated, untaxed industry which strives to remain invisible to the state.

New UK legislation to “tackle the demand for prostitution” came into force on April 1st 2010, as part of the government’s Coordinated Prostitution Strategy. The new ruling prohibits collaborative prostitution, making brothels illegal, and criminalises the purchase of sex from those forced into prostitution, using the chilling flagship slogan “Walk in a punter. Walk out a rapist”. But, will the government’s new rules help the vulnerable people they wish to target?

Between April and September 2009, Gaffney and his colleagues collected data from a survey of male sex workers, not only challenging ingrained views of sex work as an exploitative, coercive underworld of crime, drug addiction and social exclusion, but also highlighting serious unmet health needs of sex workers. For example, although the majority of the survey’s respondents were engaged in sex work by choice, over two thirds of those working in the porn industry had engaged in “bare-back porn”. They mistakenly believed that the production companies employing them, despite being both independent and unregulated, were responsible for ensuring they were protected against contracting HIV on-set. Although 85% of the men had had an HIV test, the vast majority had little or no understanding of post-exposure prophylaxis (PEP) or how to access it, correlating with a lack of contact with outreach health services.

Gaffney’s concerns are shared by colleagues working in parallel with female sex workers. Andrea, a nurse who specialises in the sexual health of prostitutes, is worried about the risky sex her clients are engaging in. “The sex industry is saturated at the moment”, she tells me, “The market’s flooded by girls immigrating from overseas and the recession has also caused a drop in custom. We find the girls offering increasingly risky sexual services, such as unprotected oral sex, because it allows them to charge more money. We have to do a lot of work educating the girls about contraception”. Aren’t drugs a problem in this population? “Drugs aren’t particularly common amongst our patients” Andrea tells me, “you find the odd pocket of girls using crystal meth to help them cope with long hours, but they usually avoid substances that affect their judgement. One of our biggest problems is that a lot of our girls don’t have a valid immigration status, so they’re afraid to access NHS healthcare services. A private abortion costs £ 500 – with an insecure income, and when supporting children and families back home, these girls haven’t got that sort of money”.

The review, that was used to back the UK’s new legislation, boasts the use of research, audits and ministerial visits to Europe to inform its recommendations. Of the 21 “stakeholders” listed as participating in this research, none are actually sex workers, however, two thirds are members of the UK Network of Sex Projects (UKNWSP), a non-profit, voluntary association of agencies and individuals working with sex workers.

Unfortunately, the UKNWSP feel their views and experience have been disregarded and have published a 26 page document detailing their dissatisfaction with the new legislation. “Most of the suggestions put forward by this project were completely ignored. The Home Office, was insistent on taking on board only recommendations from prohibition and abolitionist organisations that see all sex work as violence against women and children.” Gaffney tells me. The
UKNSWP have observed that attempts to criminalise individuals involved in the sex industry erode the probability that sex workers will be able to access social support and healthcare by driving sex work further underground. “It takes a lot of effort to reach the girls”, says Paz, an outreach worker at a sexual health and social support practice in central London, “We have to work hard to gain their trust – even just to make that first contact and give them some free condoms. It’s now illegal to advertise using calling cards, and most girls use the internet to advertise so it becomes very difficult for us to keep track of them. They move a lot and they’ll often put the phone down on you if they don’t know who you are.”

The UKNSWP fear that the government has failed to address violence against sex workers and improve their safety. The three Bradford murders reported in May this year exemplify the most brutal examples of violence against prostitutes, but such tragedies are not the only danger a prostitute faces. “Robberies are common” says Venetia, who runs a drop in health and social clinic for female sex workers in central London, “Men will pose as clients but have a gang who force entry to the flats when the girls open the door to them. The girls don’t understand that they have the same rights to police protection as anybody else”. Venetia and others like her are also worried that new laws criminalising those who buy or profit from sex compromise the girls’ safety, “Men buying sex obviously want to avoid prosecution, so they’ll encourage women to go to more remote locations to provide services. Criminalising brothels forces girls to work alone- this is very dangerous”. Venetia, like so many of her sister organisations runs an “Ugly Mugs” scheme which allows women to anonymously report assaults against them by so-called “dodgy punters” which are then circulated to try and avoid similar attacks on other sex workers.

But not all clients are violent, so who else is buying sex? Even the government can only provide “suggested motivations” including “dissatisfaction with existing relationships”, “loneliness”, “having no sexual outlet” and “curiosity”. It seems there is no typical client. Consider Nick Wallis, a young man born with the severely life limiting and disabling muscular dystrophy, who lost his virginity to a prostitute at the age of 22. Previously feeling that he was living “an existence, not a life”, Nick wanted to ensure he experienced “physical intimacy” before he died. His needs would be understood by Tender Loving Care, a trust that seeks to enable professional sex workers to fulfil those who are “sexually dispossessed”. The TLC trust claim that sex workers “rescue disabled people from personal anguish, sexual purgatory, and touch deprivation” and that “Two stigmatized groups provide each other with triumph: sexually-deprived disabled people get laid, and sex workers gain a renewed pride in their work.”

The government’s own researchers have warned that the new legislation has already been shown to be imperfect. In Sweden, following criminalisation of demand, the working conditions for street workers appeared to deteriorate, and there was evidence of the market simply shifting indoors. Researchers also speculate that the low risk of arrest to an individual purchaser of sexual services cannot act as an effective deterrent in reducing the demand for sexual services. And of all the evidence they had analysed, the researchers stated that “methodological difficulties plague research... There are many gaps in the research and much of the evidence is weak or inconclusive”.

The UKNSWP has declared that concentrating on criminalisation rather than further investment in support services for sex workers represents “extremely poor social care planning”. They believe that the government is failing to tackle the reasons people enter street work, and to provide adequate specialist health services such as counselling and drug treatment services, housing, counselling and employment advice and training. “Women can become very institutionalised in sex work and find it very difficult to leave” says Venetia, “They may ask us for guidance on finding and training for another career. Interestingly they often seem to choose careers that share that element of “Love without consequence”. Beauticians, hairdressers, pet-groomers, and that sort of thing”.

Perhaps it is time the government listened to the prostitutes themselves. Sex worker, Thierry Schaffauser, no longer wishes to be branded a public nuisance or spreader of disease. He writes “The first step in the fight against “whorephobia” is to name the oppression… A further step would be to fight the hate crimes sex workers suffer instead of criminalizing us”. Perhaps the hope for the future can be summed up by the tag line of the International Prostitute Collective: No Bad Women – Just Bad Laws.

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In Asia, the AIDS pandemic continues to spread and grow. Taiwan is no exception. In Asia, about 6 million people (of the 40 million or so in the world) live with HIV/AIDS. AIDS cases have doubled from 2005 to 2007 although and have decreased slightly since 2008 in Taiwan. According to the Centers for Disease Control (Taiwan) statistics of May, 2010, there have been total of 19,683 reported cases of HIV/AIDS in Taiwan since 1984.

Taiwan is left out in the cold

This point has been raised by Japanese Dr. Joseph Limoli Deyama, a Stanford University-trained, retired plastic reconstructive surgeon, who volunteers internationally for people living with HIV/AIDS (PLHA).

The most important thing is that “Taiwan is not a member of the United Nations or the World Health Organization.” said Dr. Deyama. That means there is no international funding available. While the UN, World Bank, and the Gates and Clinton foundations provide millions of dollars and actual physical help to most of our neighbors, Taiwan is left out in the cold.

Populations Vulnerable to HIV Infection in Taiwan

At present, the main two groups with a high risk of infection are MSMs (men who have sex with men) and IDUs (intravenous drug users).

MSMs are known traditionally as a high-risk group in terms of carrying and spreading the virus in Taiwan. “Due to severe stigmatization and discrimination against the MSM population, gay men may not access diagnostic services or seek medical care, even if it is available free of charge. This only leads to an increasing number of gay men at risk of being infected with HIV.” said Dr. Deyama.

IDUs have become more susceptible to the transmission of HIV recently, because heroin from Afghanistan is more readily available and is also relatively inexpensive. Needles and other equipment are shared with fellow addicts leading to spread of blood borne viruses. “Although the government is making an effort to give free needles, users tend to stay underground and share needles. Several countries treat IDUs as a being in need of medical care, not a criminal punishment. Therefore, the spread of HIV/AIDS have lessened considerably.” Dr. Deyama explained.

Young people, who are becoming more sexually active, are contracting the virus in increasing numbers. In Japan, for example, more and more teenagers are having one-night stands in the past few year, especially because the internet is more and more popular. People meet sexual partners through the internet and have casual sex. In addition, studies have shown that only 30% of college students use condoms each time they have sex.

Women: In 2003, the male-to-female prevalence of HIV infection was 21:1. However, there has been a steady increase in female cases over recent years, and the ratio fell to 12:1 in 2009. One of the vulnerable populations is sex workers. Taipei is now considered as one of the sex capitals of Asia, with sex readily available 24 hours a day at many clubs, on the streets and via the internet. Moreover, Taiwanese women who married Taiwanese businessman may have a higher risk of HIV infection, because their husband might have unsafe sex with prostitutes and escorts while traveling.

Serious imbalance between different locations of Taiwan

Taipei is the capital city of Taiwan. Most of Taiwan’s major industry offices and business centers are located in Taipei with resources being concentrated in the capital city rather than in central and southern Taiwan. For example, eight of the eleven organizations which fight to combat HIV/AIDS in Taiwan are located in Taipei. By way of contrast, only two of them are based in Taichung (in central Taiwan) and one in Kaohsiung (southern Taiwan). This situa-
tion may have arisen because it is easier to maintain personal relationships between fundraisers and their backers if organisations are located in the capital city. As a result of the absence of organized activity in southern Taiwan, the number of HIV-positive cases has increased substantially recently. In conclusion, one thing becomes obvious: for both financial and psychological reasons, few of these organizations have the capacity for simultaneous activity in other parts of Taiwan.

Only if the campaign against HIV is waged on a national scale, and if each individual group, community and government member becomes fully educated and works closely together, will we be able to change the entire nation slowly. Fortunately, several organizations are taking action where necessary in the south and in the islands close to Taiwan (such as Penghu and Ludao). However, such activity is still irregular.

Conclusion
The disparity observed across geographic areas implies imbalance of health resource distribution. The government in Taiwan should take notice of the causes of this inequality in order to design policies to improve the equality in health care. Furthermore, Taiwan, an island nation of 23 million people, is literally not on the map for international aid agencies including those from China. Taiwan does not get any of the millions of dollars and humanitarian relief work which its neighbours receive from Asia and the United Nations. “This means that the vast majority of support, education and perhaps most urgently, shelter must be provided by the Taiwanese government and/or through individual and community efforts. Dr. Deyama however said that currently these efforts have not been adequate. Luckily, several volunteer and governmental groups are making concerted efforts to educate the public about HIV/AIDS. The most important way to change risky behavior is by health education. It leads to higher health literacy and general cognitive ability. Each group, community and government member must now get fully educated and work closely together to help those affected and to battle this terrible disease.

References
Giving them back their Lives

Some aspects of suicide in south east Asia.

Phudit Buaprasert, Thawalsak Ratanasiri

Can you imagine how many people die from suicide a year? It is very curious that every 40 seconds, one person dies from suicide; and this rate could rise to every 20 seconds in the year 2020. In this article, we will focus on what influences people to commit suicide.

Influencing Factors

First; consider social factors. Though there are individual problems which differ from society to society, most of them can be linked to the same main factors such as economic stress or the competitive society. As a result of this, some people may feel uncertainty in their life or being over manipulated. Both of these can lead to loss of self esteem and self-confidence. Finally, if they cannot face their feelings and discomfort, they might decide to commit suicide.

The second factor concerns mentality. Most of the people who have been trying to commit suicide feel that they are not empowered. This makes them lack the skill to face and fix their problems; so they might think suicide is the only way to avoid the problems.

Thirdly, there are medical factors. According to a study, 9 out of 10 people who try to commit suicide have a psychiatric illness. The main reason is that they are depressed, stressed or alcoholic. Half of them also suffer from sadness and depression. One of the most popular ways to commit suicide is by painkillers. Another way is to take chemicals like insecticide. Suicide mostly occurs at home.

Business stress and suicide

Suicide usually occurs when society is under rapid change, especially when the economy is depressed, followed closely by business chaos. As seen in 1997, the business crisis affected all social classes in many countries in south-east Asia. Chaos, and uncertainty brought about a feeling of alienation of people in society and eventually loss of will to live in some people. Moreover, their responsibility in taking care of their family led them to face psychological problems, stress, discouragement, hopelessness and confusion which caused people to commit suicide. Family members also suffered the consequences whether the suicide succeeds or not.

Poverty and unemployment are the main causes of suicide. The former always comes along with numerous other problems (e.g. living cost, crimes, divorce, and alcohol-related issues) which eventually lead to suicide. It's obvious that the suicide rate is higher in people living in poverty. The latter brings about money problems simultaneously, and causes problems with family, living conditions and social status which affect the suicide rate significantly. It is also seen that an increase in the unemployment rate has a connection with an increase in the suicide rate.

Cyber Suicide

Nowadays, the internet has an important effect on our lives. It is the easiest way to get information about anything around the world. Information about suicide is no exception. Several reports indicate that adolescents are exposed to various information on suicide via the internet. The websites provide much advice about suicide, such as ways to commit suicide and chances of success. These websites usually encourage the reader to commit suicide. In addition, the web society also reflects an increasing chance for people who intend to commit suicide to influence each other. Suicide that is influenced by the internet is also known as "Cyber Suicide". Many countries, such as Australia, drastically attempt to solve this problem by outlawing such websites.
**Suicide in Teenagers**

Most suicide in children and adolescents is found at the age of 15. Boys are more likely to commit suicide than girls. The factors that can cause this problem are mainly about relationships in their family, such as family arguments, divorces, etc. Some of them may experience pressure in their family. Their personality or the relationship (between patient and counselor) is considered to be an important factor.\(^{[10]}\)

In helping at risk group (such as teenagers), the relationship between doctor and patient during treatment is the significant factor that encourages the patient to accept treatment. The principles of treatment are to try to solve the current problem, give full treatment for psychiatric patients, increase skill for solving problems and controlling his temper, and provide knowledge to the family to let them cooperate in caring for the patient.\(^{[10]}\)

Therefore, many organisations try to promote events to reduce the suicide rate. For instance, in Thailand, the Department of Mental Health, Ministry of Public Health has set up a plan to solve this problem. The plan began in 20 provinces in 2001 and was extended to cover all provinces in 2004.\(^{[2]}\) There are three strategies used to prevent suicide and help depressed persons who have a high risk of committing suicide:

1. Build awareness and skills to prevent people from having problems,
2. Develop a service system and improve human resources, and
3. Improve the organisation of information.

**Conclusions**

Although suicide is an ever present problem, understanding of the reasons for suicide, limiting the opportunities to commit suicide, and having in place a well-prepared counselling system for both potential suicides and those around them can limit the problem. As has been shown in Thailand, the suicide rate can be capped and reduced by a determined government health program. All humans should be given back the self respect which stops them from ever considering taking their own life.

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