Youth and the Social Determinants of Health
The International Federation of Medical Students’ Associations (IFMSA) is a non-profit, non-governmental and non-partisan organization representing associations of medical students internationally. IFMSA was founded in 1951 and currently maintains 106 National Member organizations from about 100 countries across six continents with over 1,2 million students represented worldwide. IFMSA is recognized as a non-governmental organization within the United Nations’ system and the World Health Organization and as well, it is a student chapter of the World Medical Association. For more than 60 years, IFMSA has existed to bring together the global medical students community at the local, national and international level on social and health issues.

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.

Objectives:

• To expose all medical students to humanitarian and health issues, providing them with the opportunity to education themselves and their peers;
• To facilitate partnerships between the physician in training community and international organization working on health, education and social issues;
• To give all medical students the opportunity to take part in clinical and research exchange around the world;
• To provide a network that links active medical students across the globe, including student leaders, project managers and activists, so that they can learn from and be motivated by each other;
• To provide an international framework in which medical student projects can be realized;
• To empower and train medical students to become advocates in leading social change.
<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Editorial</td>
<td>Words from the Editor in Chief</td>
</tr>
<tr>
<td>5</td>
<td>Social Change, What we should do!!</td>
<td>Message from the IFMSA President</td>
</tr>
<tr>
<td>6</td>
<td>Youth Poverty in Canada</td>
<td>A description of current status and impact of urbanisation on population health</td>
</tr>
<tr>
<td>8</td>
<td>Youth &amp; Sexuality in Egypt</td>
<td>where we stand and what we want ...</td>
</tr>
<tr>
<td>10</td>
<td>Antibiotic Resistance</td>
<td>Time to Act!</td>
</tr>
<tr>
<td>11</td>
<td>The Behavior of Young People in Social Networks of The Internet and HIV</td>
<td>an interrelationship that requires new ways of Health Promotion and Prevention policies</td>
</tr>
<tr>
<td>11</td>
<td>Problems of Global Youth</td>
<td>Burn borders, not cars. Break chains, not glass.</td>
</tr>
<tr>
<td>12</td>
<td>After Rio, where to?</td>
<td>Commentary on World Conference on Social Determinants of Health held October 19-21, 2011 in Rio de Janeiro, Brazil</td>
</tr>
<tr>
<td>16</td>
<td>Social determinants of health in two community settings</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Social determinants of health</td>
<td>a personal journey of joining the dots and turning frustration into action</td>
</tr>
<tr>
<td>20</td>
<td>Lifestyle Choices made by Medical Students attending an IFMSA General Assembly</td>
<td>A Survey</td>
</tr>
<tr>
<td>23</td>
<td>“THE EVIL WHICH MUST NOT BE NAMED”</td>
<td>Some aspects related to the taboo of child sexual abuse in Pakistan</td>
</tr>
</tbody>
</table>
Dear reader,

**MSI25** is focusing on the broad field of Social Determinants of Health (SDH), a subject that has been getting more and more attention worldwide in the last few years.

As defined by the World Health Organization (WHO), Social determinants of Health are “conditions in which people are born, grow, live, work and age, including the health system,”[1] which also includes the policies and mechanisms behind Health Care funding and decision making.

Following the uprisings taking place in many areas of the world calling for better life for people, I can say that the lack of attention to Social Determinants of Health (as defined before) is one of the major causes for it. People are calling for the right of everybody in better life, better educations, housing and the basic right of everybody being treated equally.

In these event, youth has always been the ones in the front lines, offering help and addressing the needs of their society and inspiring others to do more and to keep fighting for a better life where all people are treated equally.

**MSI25** will reflect various medical students’ opinions, thoughts and analyses on this topic of increasing importance. As future Physicians it’s our mission to keep fighting for a better world for all people, a world where we can all be treated equally. And I’m sure that, we -youth- will achieve victory at the end it.

Finally I want to thank my whole team for their efforts for making this happening.

Enjoy reading!
Omar Safa, Editor in Chief

References

Social Change, what we should do!!

Message from the IFMSA President

Christopher Pleyer, IFMSA President 2011-2012

Dear friends,

Social change—the process by which individuals organize based upon a common set of beliefs and values to impact and move society toward a more progressive, cohesive, and visionary place.

Around the world this year, social change has taken on an even more impactful course—with governments collapsing, policies challenged and redefined, structural changes in some of the most revered international organizations, social issues brought to the forefront by the people—and at the heart of all these socially driven actions around the world are inequalities.

Inequalities are an ongoing challenge that humanity faces. However, notable are the periods in history where inequalities cannot be denied, ignored, and put at the back burner. We are in such a period of history, as we are in the second decade of the 21st century. Especially for health, development and equality, this decade is marked by goals and promises to achieve a universal improvement in health and quality of life through international and multi-sectorial collaboration.

I encourage us to contemplate about social change and how we, as aspiring physicians, leaders, public health activists, are partaking in redefining social and health issues and leading social change.

At the IFMSA March Meeting 2012, students, health professionals, physicians, public health experts will engage in knowledge and skill sharing, inspiration exchanging, building capacity, increasing opportunities and expanding the IFMSA and health network, and most importantly, creating a snowball effect on our motivation to take on social and health challenges around the globe. It is important for us to not only think out of the box, but as well defining the next steps on how together, as being part of IFMSA, we can further drive social changes on the issues that are the most important ones for those in our communities and ourselves.

Promoting and implementing change and innovation is often a long, enduring process requiring years of preparation and follow-up. The work that has been carried out in previous years has reached a critical point and today provides us with an immense momentum to take the next big leap in IFMSA. Now, we have the chance to translate this opportunity into concrete actions and measures to strengthen the ties of our federation and set a path for the future.

IFMSA as the leading professional, student network and voice on health related issues worldwide, not only has the ability to lead social change, but realize we are leading social change around the globe—in our communities, nationally and internationally.

It is also a very special moment for IFMSA to have our General Assembly in Africa and provide this opportunity to our members and to the region. Many of the largest battles in health and social inequities are taking place in Africa, and we have this unique opportunity to being medical students from around the world to the front line.
World Health Organization (WHO) defines social determinants of Health as "conditions in which people are born, grow, live, work and age, including the health system." [1] The definition further elaborates that the underlying gear mechanism spinning the wheel of social determinants is “money [and] power” [1] and resource allocation (global, national and local) - all of these inequities being sustained and enabled by policies.

One of the initiatives to rectify current policies is aimed to correct the wrongs within Canadian society by focusing on poverty reduction. It is no surprise that poverty leads to a myriad of health complications (physiological, social and mental) that can be avoided. Poverty is also at the cornerstone of social determinants stated by the WHO definition earlier. Individuals from low socio-economic environments are at a much higher risk of developing chronic diseases including: diabetes, heart and circulatory conditions, chronic respiratory diseases and cancer. [2] Furthermore, a much more problematic issue demanding urgent attention is child poverty.

A recent research study done by United Nations Children’s Fund (UNICEF) in 2011, compared different western countries and their ability “to meet the needs of their children” [3]. They examined the nation specific relative measure of poverty - defined as the difference between top and bottom 20% of incomes and Gross Domestic Product Health Expenditure (GDPHE). In simpler terms, GDPHE is the dollar amount a nation spends of its total Gross Domestic Product (GDP) to maintain and promote health of its citizens. The results of this study were incredible.

The study showed that the highest child mortality rates among the western nations were that of USA (2436 per million), New Zealand (2105 per million), Portugal (1929 per million) and Canada (1877 per million). The lowest rates were that of Japan (1073 per million) and Sweden (1075 per million). [3]

What was interesting about this study was that when they analysed GDPHE spending to child mortality, there was no significant correlation. For their data, they looked at the years 1979 till 1981 and from the years 2003 till 2005. In those years there was no relationship between GDPHE and child mortality. In other words, the dollar amounts a western nation spent out of its total GDP to preserve and maintain health did not significantly correlate with the child mortality levels noticed [3].

However another correlation was profound. The same study examined children’s death and income inequalities. The results suggested a significant increase in child mortality associated with an increase in income inequalities. In this study, income inequality was defined as the gap between the highest and lowest 20% of incomes. [3]

Yet, there was still another enlightening conclusion. Countries with the widest gap between the highest and lowest income earners had the highest child mortality rates. Similarly, in countries where the gap between the rich and the poor was narrow, the child mortality was lower. [5]

As Canada was named one of the countries with the highest child mortality rate among the western nations, the only logical conclusion is that the Canadian healthcare system is not efficiently and effectively meeting the demands of its children.

Similar results are present in other research literature as well. A report by Children’s Aid Society labelled Toronto as the child poverty capital of Ontario. It said that “more than 500,000 kids” [6] which is about “50% of Ontario’s children living in poverty” [6] reside
World Health Organization (WHO) defines social determinants of Health as "conditions in which people are born, grow, live, work and age, including the health system." [1]

Countries with the widest gap between the highest and lowest income earners had the highest child mortality rates. Similarly, in countries where the gap between the rich and the poor was narrow, the child mortality was lower.[3]

in Toronto. The number of children living in poverty is up by 44% since 1997. [4]

While the numbers are quite astonishing for a developed country such as Canada, interventions - mostly political - have not proved to be as successful as once envisioned. The parliamentary pledge in 1989 aimed to eliminate child poverty by the year 2000 has failed. The margin between the rich and the poor since then has only increased along with child poverty.

But a lot has been learned since 1989. With deeper insights into obstacles preventing individuals to break free from the poverty cycle and better understanding the "roots of poverty [which] are complex"[5] and "multi-faceted and challenging".[5] Ontario’s government is following a comprehensive action plan. Current main focus of poverty reduction strategy is on three primary objectives.

The first objective is to invest in the child’s future by providing high quality early learning and educational opportunities for achievement. The second objective is to provide support for parents to enable their children to succeed by assigning tax relief and reform, job accessibility, path out of unemployment, fair minimum wages and working conditions. The third objective is to have critical community partnerships and programs to amplify the effects of political policies.[5]

However a small-group community approach that has been ignored is the role of religious faith groups in combating poverty. In all of the Abrahamic faiths (Judaism, Christianity, and Islam) there has been a strong focus on helping those in need and eradicating poverty. In fact, these faiths can be summed up in two statements: Loving God with all your heart and loving your neighbour as yourself. From that strong origin of belief, members of these faith groups can have monumental and profound impact on their local communities. A working example of different faith groups coming together to combat child poverty is taking place in London, Ontario. The response has been immensely positive. It is these grassroots organizations that are needed on top of political reform that can bring equity to different marginalized low-resource communities within our society.

Poverty affects us all and poverty reduction is beneficial to us all. From the founding principles of our Canadian constitution, it is imperative that all Canadians play their role and do what they can to eventually eradicate poverty. It is through addressing the poverty problem that many of the social determinants to youth health can be addressed. Help for youth starts with a single will to better the life of others by caring for them as you would like to care for yourself.

References
Youth & Sexuality in Egypt

where we stand and what we want ...

Sherif Tarek Erfan

Middle East & North Africa (MENA) region has the second youngest population, with half the population under the age of 25 [1]. Egypt itself is home to 16 million people from ages 15-24 years old [1]. More than half of these youth live in rural areas, home to most of the country’s illiterates [2]. In these communities, anything related to sexuality is a taboo, even if it's about sexual and reproductive health.

In 1994, the international conference on population and development (ICPD) held in Cairo, developed a new common understanding of reproductive health. The ICPD program of action defined reproductive health as:

“A state of complete physical, mental and social well-being in all matters related to reproduction, including sexual health. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so”

Consequently, reproductive health care should include family planning, maternal health, safe pregnancy, youth health services and prevention and treatment of STIs including HIV [3].

This all leads us to only one conclusion; which is the right of our youth to have access to sexual health education, services and most importantly social support. We must eliminate the stigma and the taboo related to sexuality in our society.

Where do we stand?

In 2009, a survey of 15,000 people aged from 10 to 29 all over Egypt showed that only 15% of the boys and 5% of the girls received information about puberty from school, while the others got their knowledge from their mothers and relatives [4]. When the teachers were questioned about this, their reasoning was that it's a sensitive issue plus it's not socially acceptable.

So it's obvious that most of youth get their information from unreliable sources. As mentioned before, more than half of the nation's youth live in rural areas, where superstitions are considered as facts. These superstitions affect the youth sexual life badly and have a very negative effect on their usage of the available reproductive health care services. For example, the recent increase in VCCT (Voluntary Confidential Counselling and Testing) services has not been translated into a corresponding increase in number of people receiving these services. The main reasons for such phenomenon are: fear about lack of confidentiality, fear of knowing their status (for example, AIDS is always linked to death and misbehaviour in their minds) and the negative attitude of the service providers (which is also because of linking AIDS to misbehaviour and socially unacceptable attitude).

Sexuality and life quality

The lack of sexual education and services was found to be related to the social background. For example, lack of education on risks of early marriage and pregnancy is because that a girl in a rural community is expected to get married at the age of 18. As a consequence, Egypt demographic and health survey in 2008 shows that 24% of 19 year old girls have begun child bearing [5]. Early child bearing poses serious risks to the health of the mother and the child. Same goes for HIV and AIDS, where the incidence is on rise because of the social fear of the disease; even though the risk of getting infected with HIV is much less than other diseases like hepatitis B. The society interference strikes again in the form of gender inequality, which is obvious from the big difference in knowledge between men and women on sexual matters [4]. It's more socially acceptable for a man to seek sexual information and discuss sexuality than it is for a woman, leaving women more susceptible to risks related to sexual life.

Speak out loud. Break the silence.

In Egypt, family values are the main guidelines of behaviour. Regarding sexuality, parents seem to deprive their children from information. Even though this is done with good intention, as parents think they are protecting them, it’s obvious that limiting youth access to sexual information leaves them more vulnerable to health problems. On the contrary, better informed young men and women are more empowered to avoid sexual health risks. Therefore, any attempt to
introduce sexuality education must incorporate the family values. Involvement of parents in sexual and reproductive health education can be very useful.

One of the main routes of any sexuality education is done by approaching preparatory and secondary schools. With the increasing enrolment rate in schools, schools represent a potential and effective means of communicating information on sexual and reproductive health. Introducing curricula on sexual and reproductive health is a must. Such curricula can vary from biological content on the physiology and anatomy of male and female genital systems and STIs; to social content on gender equality, fighting stigma and discrimination which accompany HIV and AIDS and family planning.

To fill the gap between youth needs and actual reproductive health content in school curricula, NGOs must take the initiative of introducing peer-to-peer education programs. Such programs include awareness campaigns, seminars for school students and parents. Furthermore, NGOs have a role in promoting and providing sexual and reproductive health services, sensitizing the society towards sexuality and pushing for change in the country’s policies.

A society that seeks progress needs its youth healthy and satisfied in all aspects of life. We can’t let superstitions, illiteracy and negative attitude hold us back from our dreams. We must make big steps into the future.

References
Antibiotic Resistance

Time to Act!

Cecilia Källberg

About seventy years ago one of the world’s greatest inventions was introduced to the global society. The man who discovered it was named Alexander Fleming, and the item that was discovered was antibiotics. Antibiotics revolutionized the world of medicine when it was first introduced in the 1940s, transforming previously deadly diseases into manageable infections. Due to increased antibiotic prescribing practices as well as the lack of compliance to antibiotic prescriptions, this valuable resource has slowly been losing the battle against bacteria. This has become known as antibiotic resistance (AR).

The World Health Organization (WHO) Director-General, Dr. Margaret Chan, stated in her speech on World Health Day 2010: “The emergence and spread of drug-resistant pathogens has accelerated. More and more essential medicines are failing. The therapeutic arsenal is shrinking. The speed with which these drugs are being lost far outpaces the development of replacement drugs. In fact, the R&D pipeline for new antimicrobials has practically run dry.” In short, it is time to act.

The importance of antibiotics to infectious diseases is hard to deny. However, antibiotics have proven to also play a great role in other fields of medicine, such as surgical procedures and transplantations in addition to treating immune deficient patients, such as cancer patients undergoing chemotherapy, preterm babies and HIV-positive persons [1,2]. Research on the effects of non-functional antibiotics is pointing towards an increased risk for secondary complications, mortality rates and economical costs, causing great strain on global health care systems [3,4,5]. Therefore, it should be a top priority for everybody affected - patients, general population, health care professional and students, politicians and governments - that the AR dilemma is addressed.

All medical students across the world will enter the global health work force and become influential stakeholders in the medical field. We will inherit the modern medical technology, as well as associated global health problems or challenges, including AR. To manage this task, medical students and residents should be educated and trained on how to manage AR. It is crucial that medical school curricula addresses the problems related to AR and that the education will continue in their years of clinical training in hospitals. However, the reality is that medical education has not yet been incorporated AR into the curricula. This poses a great risk for the repetition of mistakes in health care across the globe, where antibiotics will continue to be overprescribed and used improperly, contributing to new resistant strains without any proper treatment.

The Standing Committee on Public Health (SCOPH) is now organizing a permanent Small Working Group (SWG) that aims at raising awareness about AR. The main goal is to design campaigns, collect and distribute educational material and form collaborations with partner organizations. For project success, we motivate all countries and regions to participate.

If you are interested or already working with AR projects, please email me at: antibioticresistance.timetoact@gmail.com

References
The Behavior of Young People in Social Networks of The Internet and HIV: an interrelationship that requires new ways of Health Promotion and Prevention policies

Bruna Alonso Saade , Laura Alves de Azevedo, Malek Mounir Imad (3rd year medical students at the University Lusiada, Santos, Sao Paulo Brazil)

In December 2010, the Brazilian Ministry of Health published a recent Epidemiological Bulletin that showed an increased incidence of the Human Immunodeficiency Virus (HIV) in young males between the ages of 13 and 24 years [1]. This increase may be due to several controversial prevention campaigns against HIV, supported by public health politics and social programs, including the general media and non-governmental organizations.

However, we must also define the reasons and the main failures of prevention programs. Do the young men no longer fear the HIV virus due to treatment advancements? Are the health promoting messages reaching the newly teenage children? Does the Internet have the power to reach the majority of young citizens and to educate them on how to avoid contracting the HIV virus?

Currently, social networks have a major influence on youth behavior. “Sites”, “blogs” and chat rooms have emerged recently as key modern tools that facilitate contact between people who previously did not know each other. Among these networks, some are focused on effective relationships and even sexual relationships. With increased familiarity with Internet navigation and increased curiosity, young people are seeking intimate virtual relationships. However, they often do not necessarily take this situation with responsibility and use caution, having dates and sexual relations without using condoms.

A sexual relation with a known partner is considered to present lower risks for HIV contraction than a sexual relationship with an unknown partner [2]. Besides that, despite the increased condom use among the young [3,4,5,6], the prevalence of using condoms among internet youths is not over 55% [7]. Therefore, it is necessary to investigate the interrelationship between the ease of obtaining sexual dates via the internet and HIV transmission. Also, it is important to establish prevention advertisements for such networks, since the main social networks do not seem to be concerned about the risk of the Acquired Immunodeficiency Syndrome (AIDS). Reaching young people and guiding them is a difficult task. Society must update methods for health promotion to prevent HIV/AIDS and adapt to the changing world, reaching out to social networks on the Internet.

References

[1] Epidemiological Bulletin. (2010). Table 1 - AIDS Cases (number and detection rate per 100,000 inhabitants) among youths 13 to 24 years of age in SINAN, declared in the SIM and SISCEL / SICLOM.
[7] Brazilian Center of Analysis and Planning. (2010). Table 1 - AIDS Cases (number and detection rate per 100,000 inhabitants) among youths 13 to 24 years of age in SINAN, declared in the SIM and SISCEL / SICLOM.
The road, or rather, the flight to Rio de Janeiro, Brazil is the longest I ever took. Two days to the destination, two days on the way back, but at the end of the nine-day sojourn, I can say it was all worth it. As someone who lives in Asia, you only get to South America once in a blue moon. I feel blessed because this trip was not just my first to the continent, but the main objective was historic and inspirational.

For three days, more than a thousand public health experts coming from governments, UN agencies, academia, and civil society gathered at the World Conference on Social Determinants of Health to discuss how global health equity can be achieved. Unfortunately, the road towards it is not as smooth as my flight to the land of samba.

To illustrate the gravity of the situation, I turned to my reference materials. In Southeast Asia alone, glaring inequalities in maternal mortality rates can be noted: 339 out of 100,000 mothers in Laos, 229 in Indonesia, 84 in the Philippines, and only 16 in Singapore [1]. On the other hand, when referring to inequities within countries, the classic example in social determinants literature is that of Glasgow in Scotland. Despite it being a city in a rich industrialised country, there exists a 30-year gap in life expectancy between the city’s most and least advantaged communities [2].

Clearly, there are many external forces that shape these inequities, and biomedicine has realized that genetic and other individual factors have little to do with these gross inequalities at the population level. Two hundred years ago, the German physician Rudolf Virchow [3], who is regarded as the Father of Social Medicine, had already hit the nail at the head when he asked: “Do we not always find the diseases of the populace traceable to defects in society?”

It is therefore with this background that the World Conference was organised, with the intent of engaging “high level political support to make progress on national policies to address social determinants of health to reduce health inequities” [4]. Moreover, the conference is an off-shoot of the 2008 report of the World Health Organization (WHO) Commission on Social Determinants of Health [5], which synthesised evidence from around the world illustrating how social determinants of health (SDH) – the conditions in which people are born, grow, live, work and age – bring about avoidable health inequities within and between countries.

The Commission, headed by renowned British social epidemiologist Professor Sir Michael Marmot, also listed down proposals for action on social determinants, which were summarised into three overarching recommendations: 1) the improvement of daily living conditions; 2) tackling the inequitable distribution of money, power, and resources; and 3) measuring and understanding the problem and assessing the impact of action.

Mixed views

The overall outcome of the conference itself can be described as equivocal, as it has drawn mixed views from different sectors. Some saw the conference as a major step towards renewing the global health equity debate; even being tagged as the new “Alma Ata,” in reference to the landmark 1978 Alma Ata Declaration on Primary Health Care [6]. Although not explicitly using the phrase “social determinants of health,” the Declaration was the first international document that recognised gross health inequities as “politically, socially, and economically unacceptable” and which had called for inter-sectoral action and international collaboration towards the achievement of “health for all by the year 2000.”

However, others noted the diminished ambition of this event, especially of its main product – the Rio Political Declaration on Social Determinants of Health [7]. This new document laid out commitments and recommendations from the over 100 governments present, capturing the five themes of the conference – governance, participation, the role of the health sector, alignment of global priorities, and monitoring of progress [8]. However, other groups, especially civil society, criticised the document as being silent about some fundamental and crucial subjects such as trade as a social determinant of health, the links between social determinants of health, climate change, and...
sustainable development, and ultimately the redistribution of power, money, and resources, which has been the clarion call of the Commission's Report since its publication.

Despite the document stepping on middle ground, there are still reasons to celebrate. The World Conference provided a venue for academics and civil society to gather and combine their voices for the revival of the health equity debate. In recent years, especially since the failure of Alma Ata in 2000, international networks such as the People's Health Movement have created their own platforms for global discussion on health equity and social justice, but none of these are either initiated or actively participated in by the WHO or any other intergovernmental agency.

The Rio conference, on the other hand, was the brainchild of WHO as requested by Member States through a World Health Assembly resolution in 2008. Thus, this event served as an opportunity for meaningful dialogue between governments and UN agencies on one hand and civil society and academia on the other. Civil society groups were even allowed to organise their own side events, which further contributed to the solidifying of existing international and regional networks.

The People's Health Movement (PHM) in particular also made use of this rare chance to concretize their dismay towards the Rio Political Declaration. Considered as the largest network of health activists calling for the revival of Alma Ata principles and of the vision of “health for all,” PHM came up with its own “Alternative Rio Declaration.” In this document, PHM listed down specific and concrete measures to address global health inequities such as the use of progressive taxation, reducing the clout of financial capital, use of health impact assessments in trade agreements, reconceptualisation of development aid as an international obligation, and democratisation of global governance, to name a few. The group’s statement somehow reflects the dissatisfaction towards the status quo, embodied by the ongoing Occupy protests which have spread from Wall Street to across the globe.

PHM and civil society at large even infiltrated the closing panel of the conference in a grand manner. One of its members, Dr. David Sanders from the University of Western Cape in South Africa, lambasted the Rio Declaration’s silence on unfair trade in food production and the “brain robbery” of health workers by Northern countries. Such fearless statements triggered the only standing ovation during the three-day conference.

Speaking the SDH Language

Another positive sign that we observed during the conference is that some governments are now starting to speak the language of social determinants. Before the World Conference, I have previously attended a few meetings on social determinants. It is evident that despite the publication of the Commission’s Report and the wide availability of resources on social determinants, there remains diversity in understanding of the concept, ranging from promoting healthy lifestyle amongst local politicians (hoping that their good health will translate into good policies) to addressing global determinants such as climate change and the financial crisis.

In Rio, it seemed that some countries have already grasped the idea, while a few were actually fairly advanced in their understanding and implementation of action on social determinants. For example, South Australia boasts its “Health in all Policies” approach which enables other departments beyond the health sector to apply a “health lens analysis” to their policies and projects. Thailand instituted a National Health Assembly in an attempt to democratise health governance and allow participation from all sectors in priority setting and decision making. Finland even went on by declaring the welfare state as the best medi-
cine against growing health inequities [13].

Despite this, albeit minor, victory, it is important to keep in mind that no matter what ministers of health declare in international conferences like this; most of the crucial decisions governing social determinants of health are under the jurisdiction of other domestic leaders, such as ministers of finance or labour or even the prime ministers and presidents themselves, none of whom were present at the conference [16]. The same can be said of the international arena – key actors such as the United Nations, World Bank, and World Trade Organization were also absent in Rio. Expressing a commitment during the World Conference is just half the battle – advocating for action to other sectors at home still remains the major formidable task.

Consistency is key

Even after the World Conference, health equity activists should keep an eye on the World Health Organization. Observers of global health history clearly understand WHO’s tendency to switch themes from time to time, depending on the tune of some donor countries, influential NGOs and academic think tanks, and even private donors. If WHO is really serious about “closing the gap in our generation” as the Commission’s Report’s title says, then the organisation should remain consistent in its policy pronouncements from the Director-General to its country offices, and the SDH framework should be reflected in all its implemented programmes, whether on HIV-AIDS or on NCDs.

It is saddening that “social determinants” or “health equity” is not mentioned in the candidature of the current WHO Director-General Dr. Margaret Chan, who is now seeking another five-year term [17]. Surely, as the only candidate for the post, she will be given another chance to lead WHO and to push forward the health equity agenda. Not only will it complement her agenda towards stronger health systems and a reformed WHO, this work on social determinants, and not her present focus on NCDs or any other vertical disease-oriented programme, could also become her enduring legacy to global health.

Finally, again speaking of consistency, governments should start realising – and realising through the hard way – that business as usual is not an option for our global health future.

Health equity at the heart of IFMSA

Finally, this commentary will not end without looking at the role of the International Federation of Medical Students’ Associations (IFMSA) in this ongoing global debate. In 2011, IFMSA made health equity and social determinants of health a key policy focus [16], commencing with the passing of a policy statement on the matter in Jakarta [18]. For months, the Small Working Group on Health Inequities under the Standing Committee on Public Health energised the discussions, both online and in actual meetings and consultations, which then culminated in a magnetic presence in all standing committee and regional sessions, and an overwhelmingly-attended forum with Sir Michael Marmot during our 60th anniversary conference. Since that week “SDH” has been the mantra of Copenhagen.

Now, after Rio comes Accra, Ghana, which hosts IFMSA’s March Meeting this 2012, revolving around the theme of social determinants of health. This assembly is accompanied with a pre-General Assembly on SDH and a presentation to the plenary on the proposed Global Health Equity Initiative. All these, I believe, will set the tone for IFMSA’s future.

This “SDH” capital that has been amassed in 2011 should not be put to waste, and I hope the future generations of IFMSA leaders and members will not cease talking about it and doing something about it. I recall someone telling me, “There should be no SDH-related activity in future meetings after Ghana.” I beg to disagree – the discussions should continue beyond Accra – as we already triumphantly did from Jakarta to Copenhagen to Rio.

We should remember that for every missed opportunity to discuss and to act on this crucial issue of our times, someone has to pay the price. Global health equity is not merely a theme for a conference, but a real global challenge that a truly global and truly health-committed organisation should tackle in the 21st century.

Our aim is to create a global movement, not to make it a topic for a session. Every General Assembly has a new breed emerging, and therefore every General Assembly should not stop sowing the seeds of health equity into each IFMSA generation.

Medical students as social determinants of health

Looking at particular social determinants, I hope to see IFMSA spark a discussion about the management of human resources for health, including medical students who will soon become physicians, as an important global social determinant of health [19]. I already mentioned about the “brain robbery” of health workers by developed countries from developing countries being a hot topic in Rio. It cannot be denied that medical students and young doctors play a vital part in this ongoing process.

As an international federation of medical students, it is our obligation to look into this issue, not just in medical education, which is only one segment of the whole health human resource production process, but also in the recruitment, certification, deployment, quality assurance, and compensation of physicians and health workers. These processes, in turn, are inextricably intertwined with issues concerning global trade, human migration, and global health governance, to name a few.

For example, a closer look into our professional exchange programmes would enable us to understand if such programmes actually promote global
health learning for meeting local needs, or instead lead to global health inequalities by encouraging young physicians to move from their places of origin and training to new locations, which are often more lucrative but where they are needed least. I am sure many of our members will feel uncomfortable about this matter, but if we truly want to close the health gap, this one cannot be ignored.

Time to Become Revolutionary Doctors

Sometimes, no matter how well-informed, updated, and passionate I am about the issue of social determinants and health equity, I feel that I still do not have the exact answers. But also I think what is important now is that we, medical students, have already started talking about it – that we condemn the inequalities in health, that we understand the root causes of ill health and health inequities, and that we seek for ways to change the status quo. The members of the IFMSA delegation even expressed this desire in a statement distributed during the final day of the World Conference:

“We medical students commit ourselves to continue engaging with all sectors involved in the work towards global health equity, spreading awareness of the social dimensions of health to our fellow young people, mobilising them to take action in their respective communities and countries, doing our part, little by little, but with courage, constancy, and conviction.”[20]

We therefore invite every member of this Federation to embrace this commitment, now as medical students, and beyond, when we become doctors of the future, until we see the day when, in the words of former UN secretary-general Kofi Anan, “health will finally be seen not as a blessing to be wished for, but as a human right to be fought for.”

This year and beyond, we, IFMSA, must keep reminding the global health world that we, medical students and young people at large, are not mere observers or beneficiaries, but are key players in this global movement. We will inherit this current global health regime sooner rather than later, and so we must exhaust all the platforms within our reach not tomorrow but now.

So, after Rio, where to? For IFMSA and medical students worldwide, it is time to, quoting from a new book entitled Revolutionary Doctors, “combine the humanitarian mission of medicine with the creation of a just society” [20]. Realising this requires an unwavering commitment to social determinants and “health for all.”

References

Social determinants of health include the impact of socioeconomic factors as well as the physical and social contexts of the levels of education, living conditions and access to health care services\[^{1,2,3}\]. Differences in health status, called health inequalities, are prevalent in communities across all countries\[^{3}\]. For example, rural communities that are dedicated to the agricultural industry may be isolated and have limited economic resources and access to health care services. Also, if community members have low levels of education, they may not understand the meaning of the health message or have adequate motivation to adhere to recommended prevention practices\[^{4}\].

Changing socioeconomic factors requires health interventions that impact the entire community, including programs to improve the water and food quality, public roads and education system. However, although health education campaigns may be the first line of defence against disease for at-need communities, only sustainable community health programs remain critical to instil behaviour change\[^{5}\].

In November 2011, medical students from the Iberoamerican University (UNIBE) School of Medicine in Santo Domingo, Dominican Republic, organized two health projects to educate young community members of disadvantaged communities about critical health topics.

**PROJECT #1: “I am a leader in my health!”**

The purpose of this project was to organize health education seminars as a part of the primary prevention initiatives for 225 children and adolescents of the Batey La Lechería in the Manoguayabo community. Bateys in the Dominican Republic are sugarcane plantations, where the majority of residents are Haitian descendants, living and working in impoverished socioeconomic conditions\[^{6}\].

On November 26, four medical students organized preventive health seminars for small groups of children and adolescents that focused on the importance of improved sanitation and hygiene to reduce the risk of diarrheal (cholera) disease. This seminar was followed by an interactive practicum that taught youth how to prepare a basic oral rehydration solution with common materials within their homes. To complement the seminar and activities to improve sanitation, soap was distributed to each youth member. In addition, we measured blood pressure (BP) and calculated body mass index (BMI) to accompanying adults in efforts to counsel individuals on optimal BP and BMI values.

**PROJECT #2: “Positive Health Message for Christmas”**

The purpose of this project was to organize donation efforts of school materials, where positive health messages could be decorated in school notebooks for the female children and adolescents at the Hogar Niñas de Dios orphanage in Santiago, Dominican Republic.

During the month of November, twenty-two medical students promoted the donation campaign of school materials for this health activity. They developed positive health messages that were focused...
on female child and adolescent health, including the importance for eating healthy, exercising, sleeping nine hours per day and reflecting on their own internal beauty. These positive health messages were integrated into bookmark designs as well as decorations in the front and back covers of school notebooks.

Conclusions
UNIBE medical students offered health outreach education programs for at-need communities – Batey La Lechería and the Hogar Niñas de Dios orphanage – in the Dominican Republic. Medical students gained insight on how to utilize communication strategies for increased awareness among youth community members regarding the health message in preventive health seminars and in donated materials as educational tools. These innovative methods, that present health education information, will be beneficial for these medical students in their future careers in health education and medicine. At the same time as young and adolescent community members were exposed to the positive role models, they learned the importance of developing healthy lifestyle habits to have a positive impact on physical and mental health outcomes.

References

Project 2: UNIBE medical students organized school material donations for the Hogar Niñas de Dios orphanage in November 2011

Project 3: Donated school materials were collected in a decorated box under the UNIBE School of Medicine Christmas tree in November 2011
Social determinants of health

a personal journey of joining the dots and turning frustration into action

Waruguru Wanjau

My first clinical rotation in my junior clerkship was orthopaedics. After my first few patients, I was able to predict what the history of the presenting complaint was before I even asking the patient, as most patients had the same history. The patients would say “nilikuwa nikitembea na gari ikanigonga” (I was walking and a car hit me). That does not make much grammatical sense and is not well supported by any laws learnt in a Physics class so allow me to put it in context. In some areas of Nairobi, there are no clearly defined sidewalks so, during the rush hour arbitrary paths are made and the demarcation with the main roads used by cars is not clear. In all the commotion, it is possible that a car can hit a hardworking Kenyan trying to make his way home after an honest day’s work.

In addition to jotting down the injuries sustained and the orthopaedic topics I needed to read that evening, I was always left with a lingering question. Why can’t we identify the areas with the largest human traffic and build sidewalks? In my opinion, it’s a simple question that seems to solve an obvious problem. This simple measure would probably reduce the number of patients in the orthopaedic hospitals of our country by at least a third, in my estimation. In medical school, I am taught the types of fractures, the steps in callus formation and different approaches to repairing the fracture. The city council official is aware of the sidewalk problem and plans to eventually do something about it. He however does not know the direct impact of this lack of sidewalk on the orthopaedic health on his citzenry. Somebody needs to connect the fractured femurs to the absent side walk. I finished my orthopaedic rotation, but the question still lingered …. 

Two rotations and many frustrations later, I had a major ward round in the Internal medicine department. While in the female section of a particular ward we came across numerous cases of end stage Kidney disease. The consultants’ remarks were constantly:
1. Can her relatives afford to pay for the dialysis
   If not…
2. We have done everything we can, we can now discharge her

The reason why this stood out for me is because earlier that week I had watched a television series called “Undercover Bosses”. I’m sure you are asking: What is the connection between a television series and the kidney patients? The connection is that, in the series there were two employees both over forty and were on dialysis. These two individuals were well built and until they mentioned it, I could not tell they were on dialysis. In addition to that, they were featured on the programme because they were some of the most hardworking people in their respective companies.

I then compared those two individuals to the wasted women who we were being discharged and the only difference between them was their socio-economic conditions. As these patients could not afford to pay for dialysis, they were being sent home to spend their last moments with their family instead of being the best workers in a company. I knew something was wrong. I knew it wasn’t right. I knew those patients could go on to live full and healthy lives with the correct treatment.

Later on, I had the privilege of reading extensively through some documents on Social Determinants of Health as part of my IFMSA work and then representing the federation at the World Conference on Social Determinants of Health. These two events finally connected these dots for me and answered all the questions that had been brought about by my frustrations. That it was the socio-economic situation of these individuals that was determining the life expectancy of the kidney patients and the quality of life of the orthopaedic patients. These discrepancies fall under Social determinants of Health and this is what the decision-makers and the masses need to be made aware of. As governance is a key area in determining Social Determinants of Health, the decision makers in all sectors of government, such as city council officials, need to be made aware that their decisions in other sectors directly affect the health of their population. The general population need to be made aware that as long as they have the same biology and genetics, their life expectancy and quality of health should be equal to other citizens in the same region/city/country. Any factor that leads to disparity in health should be addressed by the government to ensure health equity and this is a right they should demand from their government.

It made me realize that I do not need to be frus-
trated during my next ward round when we discharge patients with end stage Kidney disease or when I can predict the cause of a broken femur in the orthopaedics ward because I know that these Kenyans have the same Biology and Genetics as other Kenyans who do not have unnecessary broken bones and who live full lives with kidney disease. Their health is only determined by socio-economic factors. I can now turn the frustration into a movement. A movement, in which I can raise awareness of Social determinants of health, educate anyone who is interested and hopefully make SDH a common language.

In the same year, the doctors in Kenya went on strike. The reasons behind the strike are many but the one that affected me the most was the budget allocation to health which in the last financial year was about 5%. In a developing country, where we have people dying of preventable disease, this is unacceptable and contributes to the health disparity that underlies social determinants of health. Due to my exposure to the concept of Social Determinants of Health, I knew I could not just sit back. I decided that social media would be my tool of choice. I informed the doctors’ union through their Facebook group about SDH, because this is part of what they were fighting for but, were not yet informed of the concept of SDH. I engaged the Minister of Medical Services in a twitter conversation asking him about SDH and my country’s participation in writing the Rio declaration and yet our budget allocation to health did not mirror that. The response was not as robust as I would have liked, but I was turning my frustration into action keeping in mind the orthopaedic patient and the wasted women at the back of my mind.

Social Determinants of Health are all around us in our communities; in some it is increased alcoholism and injuries caused by violence, in others it could be maternal mortality discrepancies in different regions of the same country. Whatever the social determinant of health is in your country, be ready to join the dots, be ready to go to a meeting in your public health department and have a voice.

Root out, reach out! Root out the causes in your city, region or hospital that do not promote health equity, then reach out to all the policy makers, the health care providers, the decision makers whose choices affect the health of the your community.
Lifestyle Choices made by Medical Students attending an IFMSA General Assembly

A Survey

Background

As medical students and junior doctors, we find that we are subjected to high rates of stress and degrading situations. This subjects all health professionals to psychological morbidity due to their work and study environment \cite{1,2}. It has been found that medical students are initially quite similar to the general student population prior to commencing their medical course \cite{3}, but this slowly changes as training progresses, resulting in changes in psychological well-being\cite{4}. Stress may be a contributing factor for unhealthy behaviours and co-morbidities. Previous research has estimated that up to half of medical students reportedly abused alcohol and illicit substances (marijuana)\cite{5}, have reduced physical activity and poor diet, and suffered from an increased workload\cite{6}.

With increases in obesity levels \cite{7}, fast-food consumption \cite{8}, smoking rates \cite{9}, alcohol consumption \cite{10}, and illicit drug use \cite{11}, it is uncertain what the increase of these socio-economic factors will cause over the coming decades. However, it is inevitable that our future physicians must manage these infectious and chronic diseases that develop from poor lifestyle choices (smoking, poor nutrition and lack of physical activity). Current medical students must become global leaders in dealing with the poor lifestyle choices of today's population.

Where, Why and How

Aware of this situation, we decided to investigate this topic further by conducting a survey study of the IFMSA General Assembly participants of the AM2009 in Macedonia. The survey was given as a 21-question survey to all participants of the congress (n=481) over a two-day period (days 4 and 5 of the General Assembly). A pre-tested structured questionnaire was self-administered with the participants’ consent. The socio-demographic data were collected on lifestyle choices, tobacco consumption (cigarette, pipe tobacco and tobacco use in any other form), exercise that lasted for 30 minutes or longer, dietary habits (fruit, vegetable and fast food consumption), alcohol consumption and sexual activity.

Findings

Demographics. The survey had a response rate of 60.9% (n=293), and the study subjects included 56.3% females and 43.7% males. Most students were undergraduate students (89.0%), while the remaining subjects were at the postgraduate level (11.0%). The mean student age was 22.45 years, with the ages of the subjects ranging between 18 and 29 years. The study subjects were then divided into five regions, similar to those maintained by the World Health Organisation, representing European countries (62.3%), Eastern Mediterranean Region (12.3%), Asia (12.0%), the Americas (11.6%) and Africa (1.7%).

Physical activity. Unsurprisingly, less than 20% of participants reported exercising regularly, with approximately 60% reporting occasional exercise and 5% reporting never exercising. There were no significant differences in the physical activity carried out between the gender groups in the study population.

Nutrition. The majority of students do appear to attempt on following a healthy lifestyle with more than half of the students consuming vegetables and fruit on a daily basis. However, fast food was reported to be consumed regularly by around one-third of the respondents, which may be an indication as to the time available for cooking and preparing healthier meals during study periods or working hours. Chi square analysis showed that females were significantly healthier in their nutritional choices with higher con-

<table>
<thead>
<tr>
<th>Study Demographic</th>
<th>Males (%)</th>
<th>Females (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study Group Gender</td>
<td>128 (43.7)</td>
<td>165 (56.3)</td>
</tr>
<tr>
<td>Regular Physical Activity</td>
<td>102 (80.4)</td>
<td>128 (77.6)</td>
</tr>
<tr>
<td>Regular Smokers</td>
<td>35 (27.6)</td>
<td>30 (18.2)</td>
</tr>
<tr>
<td>Sexually Active</td>
<td>104 (82.5)</td>
<td>118 (72)</td>
</tr>
<tr>
<td>Sexual Partners (Mean)</td>
<td>2.44</td>
<td>1.16</td>
</tr>
<tr>
<td>Always Use Contraception</td>
<td>83 (65.9)</td>
<td>99 (60.4)</td>
</tr>
<tr>
<td>Regular Alcohol Drinkers</td>
<td>63 (49.5)</td>
<td>63 (38.2)</td>
</tr>
<tr>
<td>Regular Fruit Consumption</td>
<td>72 (56.2)</td>
<td>114 (70.4)</td>
</tr>
<tr>
<td>Regular Vegetable Consumption</td>
<td>91 (71.0)</td>
<td>141 (86.5)</td>
</tr>
<tr>
<td>Regular Fast Food Consumption</td>
<td>56 (43.7)</td>
<td>53 (32.5)</td>
</tr>
</tbody>
</table>

Table 1: Study Demographics of the Surveyed Student Population
smothing of fruit and vegetables than that of their male counterparts (p<0.05). No significant difference was seen, however, in the consumption of fast foods, where it appears that males and females both have high rates of ordering fast food on a regular basis.

Smoking. Just under a quarter of the respondent population reported smoking (marijuana, smoking cigarettes, pipe tobacco and any other forms of tobacco) on a regular basis. Only three-quarters of the students reported abstaining from any form of tobacco. The Eastern Mediterranean had the greatest number of smokers, with approximately one-third of the study population. European and American subjects were not far behind with around 20-25% in each region. When comparing genders, male students were significantly more likely to be smokers than female students (p<0.05).

Sexual activity. More than three-quarters of the study population reported being sexually active. Age at first intercourse in this sample ranged between 13 to 25 years with a mean age of 18 years. With regards to sexual orientation, the majority reported being heterosexual, with some reports of being homosexual (<2%) or bisexual (<4%). An overwhelming majority stated regular contraceptive use, with more than four-fifths of the sexually active cohort stating always to use contraception and a majority of the remainder stating regular use. The most popular reported methods of contraception were the condom (two-thirds of the active males) and the oral contraceptive pill (two-fifths of the active females). Ten percent of the study population also reported using other forms of contraception, such as withdrawal, intra-uterine devices, contraceptive patches and the diaphragm. Almost half of the sexually active respondents reported using more than one form of contraception. In particular, one-third of the sexually active female population used condoms and the oral contraceptive pill during sexual intercourse.

Over half of the sexually active respondents reported having just one sexual partner over the previous twelve months. Of the sexually active respondents, two-fifths of the active group reported having between two and four sexual partners over the previous twelve months, whereas ten percent reported having five or more sexual partners over the same time period. Over the previous twelve months, sexually active males had an average of 2.44 partners and females had an average of 1.16 partners. Respondents from the European and the American regions reported the highest proportion of sexual activity, whereas respondents from the Eastern Mediterranean and Asia had the lowest proportion (approximately one-third of respondents for each). Males were found to be more sexually active than females and were more likely to have multiple partners. However, there was no significant difference in the age at first intercourse between gender groups.

Alcohol consumption. Almost half of medical students reportedly consume alcoholic beverages one or more times per week. A small proportion of the respondents (just under one-fifth) reportedly binge drinks on a regular basis with a small percentage (<3%) reporting daily alcohol consumption. Less than 20% of the respondents reportedly did not consume alcohol. Less than 5% reported in having consumed alcohol before the age of 12 years although the majority claimed to first consume alcohol between the ages of 15 and 18 years. Statistical analysis did not elicit any difference between genders with regards to prevalence of alcohol consumption and age at first alcohol consumption.

What does this mean

This study assessed the dietary habits and lifestyle choices of medical students, who comprise the significant community of future health care practitioners. If correct lifestyle choices are made early on during the medical education period then it is believed that this would produce physicians practising and promoting a healthy lifestyle. There is a visible need for improvement in some of the lifestyle choices made by medical students.

Studies conducted in Pakistan [12] and the United Arab Emirates [13] have shown similar findings with poor lifestyle choices made by medical students. Nisar et al. [13] found a very low smoking prevalence which correlates with our study’s regional results described for smoking. A number of American studies [14-17] also found a relatively low prevalence of smoking among medical students as we did in our survey. As a well known fact that health providers (including medical students) smoke, in 2005 the World Health Organization (WHO) Center for Disease Prevention and the Canadian Public Health Association developed the Global Health Professionals Survey [18] to investigate smoking habits of medical, nursing, dental and pharmacy students in a variety of WHO member states and published their results in 2005. Although a large number of medical students smoke regularly, there is also evidence to support the fact that the same subset of health care students know and understand the health risks of smoking and are ready to promote smoking cessation to their patients [19]. In a recent review of smoking in medical students [20], the rates of smoking were described to increase incrementally with each year of study. It was also suggested that smoking cessation strategies should be identified and implemented by the medical schools themselves. However, there is no mention in the literature that any strategy has been implemented.

Another study [21] found low levels of physical activity, whereas the surveyed international community does not appear to portray these poor levels. A high prevalence of fast food consumption was once again confirmed in other studies. Poor diet has been documented [22,23] in medical students with even worse nutritional intake documented closer to exam periods. British and Greek studies [24,25] found similar results when reviewing the amount of fruit consumed by medical students, reporting that the majority ate fruit regularly, but few consumed the recommended five daily portions of fruit a day advised by health authorities.

Studies on sexual activity [26-27] in medical students have found similar results as found in our survey with similar mean ages for first intercourse as well as similar preferences of contraceptive methods. It may be possible that the two studies carried out [12,13] did not include this variable due to social constraints. The results of the international survey show a high prevalence of sexual activity and an equally high prevalence of contraceptive use with a proportion of the subjects reportedly using two or more forms of contraception, where the male condom and the oral contraceptive pill being the most common forms used. Same-sex behaviour described in the literature [28] correlates well with the low levels of homosexual or bisexual activity reported by the medical student international community.

The Summarised Conclusions

The self-reported lifestyle choices and habits of international medical students displayed healthy and unhealthy choices with a predominance of high proportions of consumption of tobacco, fast food and alcohol. The healthy choices made by the study group displayed that some aspects of health promotion do permeate into the lifestyle choices made by medical students, as was shown by the high prevalence of contraccep-
tive use. Other positive behaviours included the high rates of exercise and the clearly demonstrated levels of fruit and vegetable consumption. It is possible that the lifestyle choices made by medical students may be inevitable due to the academic schedule, as many students live far away from home. It is possible that more directed dietary and tobacco advice may be required as a preventive strategy for this study group. Our study findings as well as findings from other studies 19 suggest the need for a larger study across more countries so that adequate arrangements can be made to improve current student health care issues.

The International Federation of Medical Students Associations (IFMSA) is involved in numerous projects which have a direct effect on student health care choices, including participants, organizers and directors of these projects. The IFMSA once had a standing committee whose sole purpose was to direct projects towards the health care of medical students. The literature and survey have raised various issues, which indicate the need for further investigation. There is an obvious need for the international student community to address issues of medical student health care, not necessarily in the form of an international standing committee, but most importantly within local and national committees in the very near future.

References

"THE EVIL WHICH MUST NOT BE NAMED"

Some aspects related to the taboo of child sexual abuse in Pakistan

Hamza Zahidullah Mohammad Zai and Arslan Inayat

Pakistan is a country where many cultural and ethical restraints do not allow topics such as Child Sexual Abuse (CSA) to be discussed openly in the public. In fact, any topic related to sex is deemed shameful and taboo. And yet, the point to be understood is that ignorance is the worst enemy of children who are exploited by these abusers.

What is Child Sexual Abuse? [1,2,4,5]
Child Sexual Abuse (CSA) is the act of using a young child, irrespective of gender, in any sort of sexual behavior by an adult or an older child. The sexual acts includes:
1. Kissing and touching in a way that makes the child feel uncomfortable.
2. Fondling.
3. Looking at a child's private parts.
5. Verbal sexual abuse.
7. Rape and Sodomy.

Statistics of CSA in Pakistan
Statistics conducted by Sahil (An organization in Pakistan for children rights) has confirmed that there have been 2595 confirmed cases of child sexual abuse reported in newspapers in the year 2010[1]. This shows a rise of 11.9 % in the number of cases reported in the year 2009 which was 2012 cases[1]. The statistics of 2010 show that 7 children are sexually abused per day[1]. However, these figures do not show the whole magnitude of the problem considering the fact that most cases are not reported in Pakistan because having a child who has been sexually abused is a matter of shame and dishonor for the family.

Facts about Child Sexual Abuse
Distribution: Child Sexual is not restricted to an uneducated class of people or to underdeveloped areas. It is spread over a range of socio economic classes of people[3,4,5]. Child Sexual Abuse is mostly prevalent in the rural areas (67%) than in urban areas (33%)[1] due to the fact that 70% of the population of Pakistan lives in rural areas[1].

The Victims: Child Sexual Abuse is not restricted to girls. Boys are as vulnerable as girls. In 2010, out of the 2595 cases, 657 of them have been boys dispelling the myth that boys are not sexually abused[1]. Girls are exposed to sexual abuse at the ages from 6 -8 years[2]. On the other hand, boys are first sexually abused mostly at the age from 9 -12 years because boys become more independent as they grow older and their vulnerability also increases[2]. It is thought that children who reach the stage of adolescence are more vulnerable. However, it has been found out that children as young as 2 months have been sexually abused[3].

The Abuser: It is a common belief that child sexual abuse is only performed by strangers[4]. However, most of the abusers are people who are known to the victims either in the form of acquaintances or family members. The acquaintances may include neighbors, teachers, shopkeepers, etc[1]. In the year 2010, there have been 4543 abusers who have abused children 81% of them are acquaintances, 16% are strangers and the rest are people within the family[1].

Effects on the children: The effects of child sexual abuse are diverse, ranging from psychological and behavioral problems to physical problems[4,5]. Depending on the severity of the incident, victims of sexual abuse may also develop fear and anxiety regarding the opposite sex or sexual issues[5].

The negative effects can be short term or long term. The child may have sleeping problems, appetite problems and deviation from their normal behavior. Their performance at school may drop and they may not take part in activities which they normally used to do[5].

The long term effects of child sexual abuse can continue on to adulthood as well. Adults who were abused in their childhood may suffer from depression, anxiety attacks, situation specific anxiety disorders and insomnia[5].

Physically, the victim might suffer the infections due to sexual penetration. It could also lead to vaginal and anal bleeding. There is also a risk of pregnancy in female victims who have reached puberty. Pregnancy at such a young age is itself a very hard time to go through. The risk of contracting a sexually transmitted disease should not be undermined either[6].

Conclusion
Child Sexual Abuse is a global problem made worse by unawareness not just among the children but also among the adults. In a conservative country like Pakistan, where talking of sex openly in the public is taboo, many child sexual abuse cases can be prevented by awareness among the masses. Only then can we think of a safe and better future of our children.

References
Algeria (Le Souk)  Algeria (Le Souk)  Kuwait (KuMSA)
Argentina (IFMSA-Argentina)  Kyrgyzstan (MSPA Kyrgyzstan)  Argentina (IFMSA-Argentina)  Lebanon (LeMSIC)
Armenia (AMSP)  Latvia (LaMSA Latvia)  Armenia (AMSP)  Libya (LMSA)
Australia (AMSA)  Lebanon (LeMSIC)  Australia (AMSA)  Lithuania (LiMSA)
Austria (AMSA)  Libya (LMSA)  Austria (AMSA)  Luxembourg (ALEM)
Azerbaijan (AzerMDS)  Lithuania (LiMSA)  Azerbaijan (AzerMDS)  Malaysia (SMAMMS)
Bahrain (IFMSA-BH)  Luxembourg (ALEM)  Bahrain (IFMSA-BH)  Malawi (APS)
Bangladesh (BMSS)  Malaysia (SMAMMS)  Bangladesh (BMSS)  Malawi (APS)
Bolivia (IFMSA Bolivia)  Mauritania (MMSA)  Bolivia (IFMSA Bolivia)  Mongolia (MMLA)
Bosnia and Herzegovina (BoHeMSA)  Mexico (IFMSA-Mexico)  Bosnia and Herzegovina - Rep. of Srpska (SaMSIC)  Mongolia (MMLA)
Brazil (DENEM)  Mozambique (IFMSA-Mozambique)  Brazil (IFMSA Brazil)  Mozambique (IFMSA-Mozambique)
Bulgaria (AMSB)  Nepal (NMSS)  Bulgaria (AMSB)  Nepal (NMSS)
Burkina Faso (AEM)  New Zealand (NZMSA)  Burkina Faso (AEM)  New Zealand (NZMSA)
Burundi (ABEM)  Nigeria (NiMSA)  Burundi (ABEM)  Nigeria (NiMSA)
Canada (CFMS)  Norway (NMSA)  Canada (CFMS)  Norway (NMSA)
Canada-Quebec (IFMSA-Quebec)  Oman (SQU-MSG)  Canada-Quebec (IFMSA-Quebec)  Pakistan (IFMSA-Pakistan)
Catalonia - Spain (AECS)  Palestine (IFMSA-Palestine)  Catalonia - Spain (AECS)  Palestine (IFMSA-Palestine)
Chile (IFMSA-Chile)  Panama (IFMSA-Panama)  Chile (IFMSA-Chile)  Panama (IFMSA-Panama)
China (IFMSA-China)  Paraguay (IFMSA-Paraguay)  China (IFMSA-China)  Paraguay (IFMSA-Paraguay)
Colombia (ASCEMCOL)  Peru (APEMH)  Colombia (ASCEMCOL)  Peru (APEMH)
Costa Rica (ACEM)  Peru (IFMSA Peru)  Costa Rica (ACEM)  Peru (IFMSA Peru)
Croatia (CroMSIC)  Philippines (AMSA-Philippines)  Croatia (CroMSIC)  Philippines (AMSA-Philippines)
Czech Republic (IFMSA CZ)  Poland (IFMSA-Poland)  Czech Republic (IFMSA CZ)  Poland (IFMSA-Poland)
Denmark (IMCC)  Portugal (PorMSCIC)  Denmark (IMCC)  Portugal (PorMSCIC)
Ecuador (IFMSA-Ecuador)  Russian Federation (HCCM)  Ecuador (IFMSA-Ecuador)  Russian Federation (HCCM)
Egypt (EMSA)  Romania (FASMIR)  Egypt (EMSA)  Romania (FASMIR)
Egypt (IFMSA-Egypt)  Russian Federation (HCCM)  Egypt (IFMSA-Egypt)  Russian Federation (HCCM)
El Salvador (IFMSA El Salvador)  Rwanda (MEDSAR)  El Salvador (IFMSA El Salvador)  Rwanda (MEDSAR)
Estonia (EstMSA)  Saudi Arabia (IFMSA-Saudi Arabia)  Estonia (EstMSA)  Saudi Arabia (IFMSA-Saudi Arabia)
Ethiopia (EMSA)  Serbia (IFMSA-Serbia)  Ethiopia (EMSA)  Serbia (IFMSA-Serbia)
Finland (FiMSIC)  Slovakia (SloMSA)  Finland (FiMSIC)  Slovakia (SloMSA)
France (ANEMF)  Slovenia (SloMSIC)  France (ANEMF)  Slovenia (SloMSIC)
Georgia (GYMU)  South Africa (SAMSA)  Georgia (GYMU)  South Africa (SAMSA)
Germany (BVMD)  Spain (IFMSA-Spain)  Germany (BVMD)  Spain (IFMSA-Spain)
Ghana (FGMSA)  Sudan (MedSIN-Sudan)  Ghana (FGMSA)  Sudan (MedSIN-Sudan)
Greece (HelMSCIC)  Sweden (IFMSA-Sweden)  Greece (HelMSCIC)  Sweden (IFMSA-Sweden)
Grenada (IFMSA-Grenada)  Switzerland (SwiMSA)  Grenada (IFMSA-Grenada)  Switzerland (SwiMSA)
Hong Kong (AMSAHK)  Taiwan (IFMSA-Taiwan)  Hong Kong (AMSAHK)  Taiwan (IFMSA-Taiwan)
Hungary (HuMSIRC)  Tanzania (TAMSA)  Hungary (HuMSIRC)  Tanzania (TAMSA)
Iceland (IMSIC)  Tatranstan-Russia (TatMSA-Tatarstan)  Iceland (IMSIC)  Tatranstan-Russia (TatMSA-Tatarstan)
Indonesia (CIMSA-ISMKI)  Thailand (IFMSA-Thailand)  Indonesia (CIMSA-ISMKI)  Thailand (IFMSA-Thailand)
Iran (IFMSA-Iran)  The former Yugoslav Republic of Macedonia (MMSA-Macedonia)  Iran (IFMSA-Iran)  The former Yugoslav Republic of Macedonia (MMSA-Macedonia)
Israel (FIMS)  The Netherlands (IFMSA-The Netherlands)  Israel (FIMS)  The Netherlands (IFMSA-The Netherlands)
Italy (SISM)  Tunisia (ASSOIA-MED)  Italy (SISM)  Tunisia (ASSOIA-MED)
Jamaica (JAMSA)  Turkey (TurkMSCIC)  Jamaica (JAMSA)  Turkey (TurkMSCIC)
Japan (IFMSA-Japan)  Uganda (UFSMA)  Japan (IFMSA-Japan)  Uganda (UFSMA)
Jordan (IFMSA-Jo)  United Arab Emirates (EMSS)  Jordan (IFMSA-Jo)  United Arab Emirates (EMSS)
Kenya (MSAKE) United Kingdom of Great Britain and Northern Ireland (Medsin-UK) Kenya (MSAKE) United Kingdom of Great Britain and Northern Ireland (Medsin-UK)
Korea (KMSA)  United States of America (AMSA-USA)  Korea (KMSA)  United States of America (AMSA-USA)
Kurdistan - Iraq (IFMSA-Kurdistan/Iraq)  Venezuela (FEVESOCHEM)  Kurdistan - Iraq (IFMSA-Kurdistan/Iraq)  Venezuela (FEVESOCHEM)