IFMSA

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 115 National Member Organizations from more than 100 countries across six continents with over 1.3 million students represented worldwide. IFMSA is recognized as a non-governmental organization within the United Nations system and the World Health Organization, and is a student chapter of the World Medical Association. For more than 60 years, IFMSA has existed to bring together the global medical student community at the local, national and international levels on social and health issues.

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Dear IFMSA Family,

It is hard to believe August is already upon us. Wasn’t it just yesterday that our March MSI magazine was being released?! In keeping with our information technology theme, does anyone want to create a time-machine for me? I’m sure the instructions for this are floating around somewhere on the World Wide Web.

Ok, lame jokes aside, welcome back to another edition of the MSI! In this very special publication (our last of the term), you will find a plethora of information related to IFMSA and its activities in the Standing Committee and Projects Division sections; as well as health stories from the era of high-tech and space-age in our “i-health” section. We also have a surprise in the form of an address from none other than the Director-General of the World Health Organisation herself, Dr Margaret Chan, for you to appreciate! It is my sincere hope that you will enjoy your reading experience!

As always, a great deal of work has gone into this magazine to make it a reality. I would be nowhere without the help of the Awesome team working with me. A special mention has to go to Mr Omar Safa, our Publications Director of 2011 to 2012, who has been so kind as to oversee the co-ordination of the design process for our magazine; and Dr Helena Chapman, Dr Mariam Parwaiz and Dr Ebraheem Mousa, our International Publications Team members, who have all worked incredibly hard to produce what you see now.

And finally, in my best HTML-speak: <p>Thankyou for everything; it’s been a journey and I’ve enjoyed the ride<br /></p>

With my love and best wishes always,
Bronwyn :O)
Dear IFMSA members and associates,

It is with great pleasure I write to you on this occasion for the 62nd IFMSA General Assembly, August Meeting 2013 in Santiago, Chile.

The IFMSA We Want – Reform

IFMSA over the years has brought together medical students from around the world to exchange ideas, capacity build, and create projects and campaigns. As we complete our 62nd year, IFMSA is entering uncharted territory, with record-high membership and a growing interest on addressing global health issues.

This GA will be unique, as it will focus on IFMSA Reform. Our discussions will concern how we can improve the operation, strategy and long-term development of our Federation to address the growing challenges. We will also have the chance to redefine our mission and vision in preparation for the next decade.

IFMSA has not only been a source of inspiration and knowledge, but one where medical students are connected to health leaders worldwide, so their voice is heard among the most influential political leaders. IFMSA has directly contributed to discussions on the Post-2015 Development Agenda; sustainable development and its link to health; gender equality; mental health; universal health care; health in all policies; addressing global health inequities and much more.

As we grow outwardly, we also require a great deal of investment in our internal operations—to create a more sustainable model for IFMSA’s development.

So I encourage all of you to think beyond the “box” and put on your innovation hats to make this the most defining GA in creating the IFMSA WE WANT!

IFMSA-Chile

IFMSA-Chile has a legacy of being one of the most active national member organizations in the Americas by bringing IFMSA opportunities to the region and linking medical students from the Americas to the broader international community. It is with great pleasure that we will be hosted by IFMSA-Chile during our 62nd General Assembly which will focus on the important topic of i-health.

i-health

Technology linked to globalization has changed the outlook on health issues worldwide and the impact health professionals have—in the prevention, detection and treatment of diseases. By glancing at the past decade, whether in the classroom setting or in the doctor’s office or even in the political arena, there has been a change in the approach of health professionals, their education, the tools utilized, and most importantly, the focus in addressing the health of vulnerable people through technological advances. Indeed, the use of iHealth has furthered the reach of knowledge and medicine. Moreover, for patients, the advancement of this technology has empowered them to actively participate in their care.

This GA will afford you the opportunity to explore the topic of i-health. You will hear from experts as well as your peers about i-health and how it is transforming the practice of medicine and delivery of care.

Acknowledgements

I would like to give a sincere thanks to our guests and externals for attending our GA; we are honored to host you and appreciate you taking the time to join us.

As well, thankyou to all – IFMSA Chile and the OC, IFMSA Team of Officials, coordinators, support people, assistants, publications team – that have spent a great deal of time and effort to create a fantastic program for our August Meeting 2013.

I wish all of you a wonderful meeting and may we all continue to take on the health challenges of the 21st century, as leaders, together!

Sincerely,
Roopa Dhatt
IFMSA President, 2012-2013
Address by the Director-General of the World Health Organization

Officers of the International Federation of Medical Students’ Associations frequently intervene during sessions of the WHO Executive Board and the World Health Assembly. I always listen closely, as I know I will hear something sharp, fresh, inspiring and not yet hardened by a world that produces so many reasons for international outrage.

You are studying medicine at a time and in a world that is characterized by inequality and insecurity—financial insecurity, food insecurity, job insecurity and political insecurity—as well as financial austerity. Our times are also marred by armed conflicts, terrorism and violence, particularly against women and children. These threats are endangering the health and welfare of large populations.

In such a world, it is more important than ever to strive for equity and social justice. In health, this means maximizing good health outcomes for everyone. Good outcomes result from quality care. All people, irrespective of their ability to pay, should have access to the quality health care they need, without risking financial ruin.

These convictions are the foundation of universal health coverage. I believe that universal health coverage is the single most powerful concept that public health has to offer. It is inclusive. It unifies services and delivers them in a comprehensive and integrated way, based on primary health care. And it is a powerful social equalizer.

This kind of comprehensive care is increasingly vital, especially to deal with the rise of non-communicable diseases. Chronic non-communicable diseases, including cardiovascular diseases, cancers, diabetes and respiratory diseases, have now overtaken infectious diseases as the leading cause of death worldwide. These diseases share common risk factors—tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diets—so prevention is a clear priority. But effective clinical care that is cost-effective and financially sustainable is also urgently needed, now and for long-term management.

The adoption of the Millennium Development Goals in 2000 represented the most ambitious attack on human misery in history, including the misery caused by disease. Those goals focused development efforts and stimulated innovation. Although not all countries will meet their 2015 targets, considerable progress has been made in the health-related MDGs.

Health clearly deserves a high priority on the post-2015 development agenda, not only because of its own intrinsic worth, but also because changes in health indicators are a good way to gauge the effectiveness of policies in other sectors.

But finding the right place for health on this agenda is challenging. We need to address a complex global situation that is vastly different from that of 2000.

On top of enduring financial crisis and the rise of non-communicable diseases, the challenges of climate change, emerging and epidemic-prone diseases, ageing populations, bulging cities, mental disorders, disabilities, and rapidly rising health care costs will certainly aggravate inequities in both health determinants and outcomes within and between countries.

A continuation of the development agenda beyond 2015 requires measurable goals. These goals should restore some balance to this world, create greater fairness in the way benefits are distributed, and contribute to social cohesion and stability.

Studying medicine is a privilege, and with privilege comes responsibility. My hope is that you, with your energy and enthusiasm, will accept your responsibility to work to improve the plight of the poor and vulnerable. You are in a position to help them. The poor deserve the very best health care because they have been given so little else in life. Where there is health, there is hope.

You are the future of health care. I believe the best days for health are still ahead of us. Turning that prediction into a reality lies squarely on your shoulders.
Technology: A vehicle to achieving universality post-2015?

Nathan Cantley

The international community is awash with chatter about what will be the next big thing in international policy and development with the expiration of the 8 Millennium Development Goals (MDGs) in 2015. Implemented alongside the Millennium Declaration in 2000, the goals - ranging from improving access to education, combating diseases such as HIV/AIDS and ending global poverty - have been the focus of many charities and civil society movements for over a decade. After seeing their varying degrees of success, thoughts now turn to what will happen “post-2015”.

As I write this, the final report on the post-2015 development agenda, from the High-Level Panel (HLP) of the United Nations (UN) appointed by Ban-Ki Moon last year, has just been released [1]. Contained within the 80 or so page document is the culmination of conclusions from consultations between the governments and people of the world spanning the best part of a year. The IFMSA and its national member organisations from across the world have played their part both in contributing to consultation papers and being involved with the dialogue that has taken place [2]. I won’t go into the findings of the HLP report too much here, but one thing that strikes me is how technology has played its part in bringing us to this stage in the writing of the post-2015 agenda.

A lot has changed since 2000. Thoughts of “the millennium bug” are long gone and the internet has exploded worldwide with more people able to access it than able to access clean sanitation. From a post-2015 perspective, the internet has been instrumental to the dialogue and consultation process. In particular, two initiatives stand out from the rest. The “World We Want” online platform has been the central compendium for the worldwide thematic consultations [3]. The second initiative is the “My World” survey, initiated again by the UN and big partners like the Overseas Development Institute (ODI). This simple survey asks you to choose 6 things from a list of 16 that you would prioritise to be seen in the post-2015 agenda [4]. “My World” is an incredibly simple initiative and one which the website claims, “captures people’s voices, priorities and views, so world leaders can be informed”. As of the end of May this year, nearly 600,000 people from over 180 countries had responded to the survey. I would encourage you to do the same as the website is collecting results until 2015 and is an easy way for you to reflect on what you think could be important in the future.

When looking at the consultative process, many have applauded the use of technology and the internet to allow for inclusive engagement. Others are not so sure. Let me explain. Whilst writing this, I accessed an image representing the geographical distribution of responses from the My World survey so far (you can see it as Image 1 in this article) [5]. Upon viewing, I hope you agree that there are two countries that are particularly prominent for achieving a high response rate, namely Nigeria and India (157,872 and 80,646 votes respectively as of the 31st of May). These two countries alone account for over a third of the total responses so far. The website claims that it would like “citizens of all ages, genders and backgrounds, and particularly the world’s poor and marginalized communities” to contribute. Yet, whilst I applaud these two countries unexpectedly coming up top on response rate, it strikes me whether celebrations are premature. Especially so when you consider that Niger, the country that is literally next door to Nigeria, has achieved at the time of writing, a response rate of only 47 (not 47,000 or 4,700, just 47) [5]. I therefore can’t help but wonder whether the idea of reaching the most marginalised countries has truly been achieved by this supposedly “novel use of technology and the internet”. Furthermore, if you look at the submissions of position papers to the World We Want platform you will see the majority of them coming from huge international Civil Society Organisations (CSOs) and NGOs rather than your average Joe from a remote village somewhere in the world.

Why do I focus on this you may ask? Why does this even matter you may wonder? Surely this is a marked and welcomed improvement from the closed doors and hushed discussions that led to the creation of the Millennium Development Goals 13 years ago? Whilst I agree from one respect, everything comes back to a key message that
has run through everything I have seen so far with the post-2015 consultations; the idea of universality.

Be it universal access to healthcare, to education, to sanitation or to rights, the idea that everyone should be able to use it makes me reflect on whether we will see universal access to the internet become a formalised human right. In May 2011, the Special Rapporteur for the UN Human Rights Council actually took a bold step in a special report published then that stated the use of the internet as a vehicle by which people could express their human right of freedom of speech and of opinion [6]. However, as of yet, access to the internet has not formally become “a human right”.

On a different note, attempts have already been made in the MDG era to create more equal access to cheap technology through initiatives such as “One Laptop per Child” (OLPC), pioneered by Nicholas Negroponte and backed by the UN Development Programme in the mid-2000s [7]. Yet, this project also stands as a testament to how a project with great ideas and aspirations can so easily falter without a proper framework behind it as OLPC failed to deliver on its original promises of 150 million laptops by the end of 2007 [8].

So, with post-2015 looming and people champing at the bit to find some way to criticise the new development agenda before it has even been written, what hope is there that technology can be included in this plan being master-minded by the UN? A quick scan through the UN HLP Final Consultation Report published on the 30th of May shows promise that it could be used to good effect [11]. Whilst it doesn’t outline a single goal strictly for improved access to either the internet or technology, there are several mentions of using technology and science as a vehicle to achieving targets on things such as sustainability, obliteration of poverty and access to healthcare, amongst others.

Yet (spoiler alert by the way in case you haven’t read the HLP report), what is interesting is a target on the promotion of partnership and access to “science, technology and innovation” in the proposed 12th goal in the report. This goal, in general, very much mirrors the 8th MDG on partnership that is widely regarded to be a failure [9]. This makes it all the more interesting to see how this explicit inclusion develops as the “nitty gritty” is discussed and finalised.

In conclusion, a huge criticism of the MDGs has been the way we measure the success of “aspirational” goals such as MDG8 or the 12th post-2015 goal mentioned above. Can we continue to simply use technology as a vehicle for development and partnership instead of tackling the access of it head on with a specific target and goal? If we do, will we ever be able to achieve true universal access to services and rights or a response to global discussions that initiatives such as “My World” aim to achieve?

References

The six-year-old in me is never far from my thoughts. I grew up always making comparisons with my childhood years, as they shed light on how life has changed, how I have changed. I understand that most of my interpretation is subjective at core; however, there are some undeniable truths. The world is not the same place it was fifteen years ago - there are fewer resources for more people, greater distractions dwindling our focus, less page flips and more mouse clicks. Everything is now, instant and express. Don’t get me wrong, I’m not against the ever-increasing mouse clicks - what I am against is maintaining conventional thought patterns, and not adapting and tapping the potential this new scheme of lifestyle holds in promise.

It is estimated that around 80% of the world’s population has a mobile phone, one in five being a smart phone which currently add up to over a billion units[1]. It is needless to say how electronic tablet and personal computer usage have spiked as well. In essence, we live in a world ever stirring with a volume of information exchange greater than ever before. Information Technology (IT) has forever shifted and molded our everyday lives. Discussing the various ways in which it has done so surpasses the scope of this article. However, having touched on numerous aspects of our lives, its touch is yet to be strongly felt when the health care sector is in regard.

Nevertheless, there is growing awareness when it comes to realizing the promise of the innate potential that IT integration possesses. With it, an increasing number of medical initiatives utilizing an IT system at their core are starting to emerge. EyeWire is a case in point. This online computation game was developed by the Max Planck Institute of Medical Research and is led by Dr Sebastian Seung. The project aims to map and trace neuronal patterns and connections of the human retina in order to determine how vision works. Players are made to select and highlight parts of neuronal circuitry to ultimately reconstruct a three-dimensional shape of the neurons from two-dimensional images [2]. Foldit is a similar project in construct; however, it differs in that its theme is centered on the players folding different proteins into the correct shape. The idea of such initiatives is that an in-depth understanding acquired by the players’ collective inputs should lead to a multitude of scientific breakthroughs. In this way the parameters of research are fundamentally re-defined, thereby surpassing limitations of our current conventional methods. Furthermore, implementation of IT in medical care appears to bear as much fruit as it does in medical research.

There are several key points to acknowledge when discussing health care in light of IT integration, first and foremost is information availability. Creating an interconnected system in which the patient’s health-related information is readily accessible to others, including doctors and hospitals that are a part of other health systems, would be of particular importance in emergency settings and in tracking the status of patients with chronic illnesses [3]. Second, there must be an efficient synchronization process, so that patients can have access to their most recent health records, whether by smartphone, tablet, etc., allowing them the freedom to share such information with a health care provider of their choice. Last but not least is the concept of unification. Having a standardized system through which physicians obtain patient information, would greatly enhance and harmonize the process of consultation within the circle of physicians, whether it is on a local, national, or an international level.

In 2005 a team of researchers at the Research and Development Organization (RAND) published a study analyzing the effect IT system adoption would have on the health care system. It estimated that such an adoption would eventually save the United States more than $81 billion dollars annually in medical expenses, whilst improving the delivery and efficiency of health care [4]. The economic trajectory of such expenditure savings alone is reason enough to pursue a widespread shift. Such funds generated would go
to serve a greater portion of the public with better quality health care.

Let it be noted though, that the case for IT system integration does not require the blessing of an economically rewarding scenario for its implementation to be viable. Already-established IT systems within health care facilities have proven to be efficient and advantageous on a number of levels. A study published in the Journal of Political Economy found that a mere 10% increase in the use of electronic medical records (EMR; also known as EHR or electronic health records) had substantially reduced infant mortality, and that a complete transition would save 6,400 infants a year, in the United States [5]. This can be achieved because EMRs make it easy to identify high risk pregnancies as well as co-ordinate health care efforts [5]. Within the grand scheme of things, there is existing consensus that the use of EMRs significantly cuts down on errors related to drug prescriptions, tests and procedures; and creates a significantly more stable setup for establishing efficient preventative care [6].

Under the umbrella of IT, innovation becomes a vertex, for it is the only means by which underlying potential is exploited. Yanko Design, a web-based magazine, recently showcased the “GP Toilet” designed by Lucy Jung, capable of performing urine analysis and recording results [7]. Besides being aimed at patients who have to deal with repeated testing, the unit could provide means of efficient monitoring and early diagnosis, especially when utilized under the scheme of EMRs, smartphones and other technologies.

“The failure of health information technology to quickly deliver on its promise is not caused by its lack of potential, but rather because of the shortcomings in the design of the IT systems that are currently in place”, said Dr Art Kellermann of the RAND organization [3]. With the slow fading of the conventional paradigm and the emergence of a more “in-tune” generation, I see the road being paved towards utilizing IT as a means to provide satisfactory medical care with higher efficiency, at a lower cost and incurring less errors.

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Strengthening health information systems to achieve universal health coverage: lessons from community-based efforts in the Philippines

Ramon Lorenzo Luis Guinto

Global and national context: the call for universal health coverage

Today, nearly a hundred countries are racing towards the end goal of universal health coverage (UHC), championed by the World Health Organisation as the “single most powerful concept that public health has to offer” [1]. While most efforts nowadays have been devoted to ensuring financial risk protection, strengthening health systems requires attention to all six building blocks of the health system as conceptualized by WHO – leadership and governance, service delivery, health workforce, medical products and technologies, health financing, and health information systems. After all, WHO defines a health system as consisting of “all organizations, people and actions whose primary intent is to promote, restore or maintain health” [2].

Such a strong, efficient, and equitable health system necessitates a health information system that provides timely and useful data for evidence-based planning and decision-making; reliable disease surveillance and forecasting; and systematic monitoring and evaluation of health determinants, health system performance and health outcomes. It is unfortunate that this building block is oftentimes the neglected part of the whole health system equation.

Health information in the Philippines

In my previous article in the Medical Student International magazine, I discussed the universal health care program that is now embarked on by the current Philippine government [3]. Unfortunately, while the process has been ongoing for years, strengthening the Philippine health information system is not explicitly indicated as a national priority. Reliable and useful health data both at the health facility and high policy level is critical in achieving the ultimate goal of the Philippines’ universal health care agenda: “the provision to every Filipino of the highest possible quality of health care that is accessible, efficient, equitably distributed, adequately funded, fairly financed, and appropriately used by an informed and empowered public” [4].

Despite numerous efforts to improve the health information system in the Philippines, it has remained antiquated and inadequate for addressing the needs of the health sector, particularly for effective policy formulation. Reporting is still paper-based and manually completed by already overworked and underpaid health workers. Each vertical program of the Department of Health (DOH) has its own set of forms that need to be filled out. Due to the time expended, the information that reaches the topmost level is not useful anymore for timely and relevant decision-making [3].

Currently, the DOH utilizes an information architecture called the Field Health Service Information System (FHSIS), which is intended to address the short-term data needs of the department for priority public health programs. Utilizing four paper reporting forms to represent each stage of the health service delivery, data is collected at the local health center and later aggregated and submitted successively to higher levels until information ultimately reaches the national DOH [5]. Recently, the DOH launched an e-FHSIS, which is the electronic version of the FHSIS but is only currently used from the level of the municipal/city health office up to the national level. Information gathered at the local health center level is recorded in paper and copied by volunteer health workers into the electronic system at the municipal level. Given this present set-up, in which data at the point of care is still collected manually and recorded on paper, evidence-based decision-making at the local level remains to be elusive. It was noted that in developing countries, healthcare information systems have been driven mainly by the need to report aggregate statistics for government or funding agencies [3]. Health workers are then encouraged to actively engage in the fabrication of data, and therefore there is no value placed on data collection or, more so, policy implementation at the local level [6]. Therefore, in the past decade, there has been an ongoing push worldwide to shift towards electronic health information systems (e-HIS), particularly electronic medical records (EMR), which will enable easy retrieval and summarization of data for local decision-making.

Community Health Information Tracking System

While reforms at the national level have been moving gradually, independent institutions in the Philippines have

References

developed small-scale technologies that hope to address the problem of data collection and usability. In 2004, a team from the University of the Philippines developed the “Community Health Information Tracking System” or CHITS - a low-cost computerized initiative whose ultimate aim is to increase efficiency in patient care and to provide aid in health decision making at the local level [9].

Originally developed as a community-based child injury surveillance system, CHITS was then later expanded to store and sort various kinds of health information at the health center level using open source software. An outstanding feature of CHITS is that it was developed by university experts in conjunction with local people working in health facilities. Since CHITS’s inception, the university’s National Telehealth Center has expanded its implementation nationwide, covering around 50 local health centers as of 2011 [9].

CHITS turned a purely paper-based vertical system into one that is electronic and horizontal. This EMR system contains built-in modules for general patient consultations, consultation scheduling, maternal care services, child care, and family planning. It can also generate the monthly reports required by FHSIS for submission to the city health office.

Furthermore, since CHITS captures data at the point of patient encounter, it improves the quality of FHSIS reports, ensures timely submission of reports to the city level, and enables ease of access of data for health center personnel. These features make CHITS a more reliable method of data recording and reporting than the usual manual procedure.

CHITS’s impact on communities so far

Previous evaluations have listed the different benefits reaped from the establishment of CHITS. These include: faster patient record retrieval; reduced patient waiting time; streamlined work flow of health center transactions; more efficient data entry and storage; installation of an appointment and follow-up scheduling system; monitoring of community health through daily data accrual; and easier and more timely generation of FHSIS reports [10].

In 2012, as part of my health policy and community medicine elective, I performed a rough qualitative evaluation of CHITS in two local health centers [11]. Panel 1 summarizes the results of interviews that I conducted with local health center staff, from physicians to volunteer community health workers.

**Panel 1: General changes observed by local health center staff after 8 years of using CHITS in Pasay City, the Philippines.**

**Improved daily health center operations**
- Organized and systematic collection of patient information
- More efficient recording and storage of data
- Streamlined workflow in the health facility

**Better management of health data**
- Faster and easier generation of reports
- More reliable health information
- Easier reviewing of records for patient care and management

**Better use of other resources**
- Reduced use of paper, folders, and envelopes
- Health center space allotted for other purposes
- Time saved for staff members to work on other tasks

**Capacity building of health center staff**
- Computer literacy
- Enhanced managerial and analytical skills

**Enhanced patient satisfaction for health care**
- Reduced patient waiting time
- Enhanced enthusiasm and trust towards health center

**Promise for UHC and future direction**

Strengthening health information systems is absolutely critical in supporting the establishment of universal health care systems across the world. Given the current national situation in the Philippines, there is still much to be done in this arena.

However, the example demonstrated by CHITS offers some promise. One lesson is the importance of harnessing resources in society, such as the technical capacity of academic institutions, and commitment and enthusiasm among community members. CHITS can also be scaled up by responsible engagement with the private sector, especially those members that promote information and communication technologies. Certainly, if poorer people have access to mobile phones and the internet, then with healthy partnerships among decision-makers, implementers, and innovators, health information can truly be made universally accessible to all people.

The benefits of CHITS also highlight the importance of reducing waste of resources to support UHC systems. Less time is wasted by health workers in collecting and retrieving data, and more time is spent on patient care and health promotion.

Finally, an essential value of a UHC system is building solidarity to achieve greater equity in health. The CHITS experience illustrates the heightened capacity and sense of achievement among health workers who learned how to operate an electronic information system. Learning about, and utilizing, e-health systems has also become a shared community activity. This demonstrates that while improving health information systems enhance the technical management and provision of health care, such a transformation also brings intangible social benefits that are essential in ensuring health and equity for all.

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mHealth: Applications for the Clinical Management of Tuberculosis

Helena Chapman

Within the past two decades, the advancement in mobile communication technology along with the innovative mobile health (mHealth) approach, have provided additional tools in healthcare delivery in developed and developing countries [1, 2]. Mobile communications have revolutionized access to healthcare services and health information; diagnosis, treatment and management of acute and chronic diseases; and continuing medical education to providers (Figure 1) [1].

With increased utilization of mobile telephones and smartphones, health professionals are adapting to mHealth and modifying their health communication strategies for patients who are traditionally familiarized with fixed-line telephones or computers [1]. In developing countries however, of the limited research studies conducted, few are conclusive of strong links to benefits and cost-effectiveness of mobile communication technology in healthcare [2]. Barriers may include widened gaps between socio-economic levels, costs, reduced literacy, or lack of familiarity with this technology [2].

Mobile telephone and smartphone technology have been added as a new physician tool in both health education; and in management of non-communicable diseases (including diabetes and cardiovascular disease), as well as infectious diseases (including the human immunodeficiency virus / acquired immunodeficiency syndrome (HIV/AIDS) and tuberculosis (TB)) [2]. With HIV/AIDS and TB as leading causes of mortality across the world, the long-term management of these chronic, communicable diseases is critical for disease control and reduced mortality rates [4].

With approximately 8.7 million new TB cases and 1.4 million TB fatalities worldwide in 2011, Mycobacterium tuberculosis transmission, as well as the rate of progression of TB, present global treatment challenges [4]. The World Health Organization (WHO) recommends the directly observed treatment, short course (DOTS) method for TB management and control. This incorporates: diagnostics - by sputum smear microscopy; treatment - through a sustainable pharmaceutical supply, and supervised medication intake by specifically trained individuals; and control - using a surveillance system and federal support [5].

This essential control measure has been shown to increase adherence to the multi-pharmaceutical TB regimen by six to nine months, while improving health outcomes and reducing the number of patients who do not complete the recommended treatment plan [4, 5]. Non-compliance with the treatment regimen increases the risk of multi-drug resistance, which complicates recovery and increases the time for treatment to up to 18 months [4, 5]. With all of this in mind, it is helpful to know that there are a few published studies that highlight the value added by the mHealth approach in TB management, including one-way or interactive two-way text message communications and smartphone technology [6, 7].

Considering the physical and mental health challenges (such as medication side effects and stigma-related social isolation), that TB patients experience during the lengthy TB treatment regimen, it is critical that there are available community or family support resources to help obtain optimal health outcomes. The question remains: How can mHealth strategies be utilized as part of the treatment program in motivating patients to adhere to the long-term management of TB?

Novel insights have recently been presented with regards to the utilization of mobile communication technology in developing countries, where the telecommunications market and products have increased tremendously within the past decade [3, 7, 8]. Short Message Service (SMS) and telephone calls have offered assistance to TB patients in the form of medication and appointment reminders, and medical advice, during their lengthy treatment plans [5, 6, 7, 8]. Surveillance strategies can track patients’ adherence to TB treatment, identifying side effects and monitoring pharmacologic supplies [6]. Furthermore these mHealth technologies may link and update electronic

mHealth Applications: TB-ACT

Trends in disease monitoring to prevent epidemics
Basic remote data collection and monitoring
Awareness and education
Communication and training for health workers
Treatment and diagnostic support

The acronym, “TB-ACT”, represents the five mHealth applications that may be beneficial in developing countries (adapted from: UN Foundation-Vodafone Foundation Partnership, 2009).
health records as well as facilitate data analysis and provide reports for stakeholders, researchers or policymakers [6]. Most importantly, this novel tool has the potential to improve the quality and delivery of health care services in developing countries [5, 8].

Although mobile technology has increased and continues to grow in developing countries, disparities still remain among those individuals who do not own cellular telephones [6, 7]. Low literacy levels and unfamiliarity with mobile telephone technology may increase their stress, anxiety and frustration in attempting to use this new technology [6, 7, 8].

Although mHealth may appear as a simple solution to improve adherence to TB management, challenges regarding its implementation in developing countries should be recognized. These can be largely attributed to gaps in education and socio-economic levels. Future studies should identify alternative mHealth strategies and develop strong methodological designs for their implementation and evaluation in developing countries. The cost-effectiveness of mobile communication technology in TB management should be considered and compared to that of self-administered treatment, DOTS programs, and medical consults providing written instructions [5]. After all, as future health professionals, our knowledge of the benefits as well as barriers of novel health communication strategies are vital for establishing strong rapport with TB patients, motivating their adherence to complex treatment regimens, and improving their health outcomes.

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The doctor in your pocket: How smartphones are changing medical practice

Eleonora Leopardi

If someone asked me what two items I could not live without at the moment, the first one would most probably be the Pharmacology textbook I am studying right now, and the second would be my smartphone.

Over the last decade, a smartphone revolution has taken place, reaching a peak in early 2013 when they outsold traditional phones for the first time [1]. We freely whip them out of our pockets, carry them everywhere and can’t help feeling a little lost without them. It’s undeniable: they are calculators, libraries containing our most useful textbooks, search engines, pagers and much more.

Due to a number of useful characteristics such as their ability to be carried around in close proximity to the user; their sophisticated computing powers; and their potential to employ mobile applications (or apps), smartphones have become extremely useful and versatile medical tools. Academics and clinicians have seen this potential, and have created a vast array of health-related apps that deal with various aspects of people’s healthcare needs.

Nowadays there are excessive numbers of apps: from calorie counters to asthma management tools; and from workout and running logs to HIV prevention manuals. There are apps for health data collection; symptoms “checkers” in which you type in your symptoms and receive a full differential diagnosis; some apps are even designed to provide specific drug and treatment information for a given condition.

It is impossible to provide an exhaustive review of all the available smartphone apps and accessories, so I will focus on some of the more pertinent ones from a medical perspective.

ECG and heart monitoring

In 2010, US-based physician, Dr Dave Albert, developed and released the first smartphone cover that could be used to perform electrocardiograms at clinical quality, and that featured a unique web storage system [2]. The accuracy of this device has been validated in several studies leading to the US Food and Drug Administration (FDA) recently approving its use [4, 5].

At the time of development, many felt that this was just the beginning of heart monitoring using mobile devices – indeed, it was not long after that a blood pressure analyser application was produced [3].

Together, these two technologies can provide an update on the status of the patient’s cardiovascular health without him leaving his home. What’s more, the data retrieved can be stored online and sent to physicians anywhere in the world.

Ultrasound imaging

In 2011, the MobiSante company released MobiUS SP1, the first smartphone-based ultrasound imaging system, composed of a portable ultrasound probe that can be connected via USB to a smartphone equipped with a dedicated app. This device can generate an accurate bi-dimensional ultrasound image of most internal organs, and allows for internet connectivity in order to store and share images. The FDA has reserved this product for use by qualified medical personnel only. Due to its affordability, portability and long battery life, it is particularly useful for resource poor settings [6].

Dermatoscopy

The cameras built into smartphones have become increasingly sophisticated, comparable to some of the latest digital compact cameras available on the market. It is no surprise therefore, that such a non-invasive and inexpensive tool as the dermatoscope has rapidly become incorporated into a mobile device and application package.

The handyscope is an optical tool that can be attached to a smartphone, providing 20x magnification and LED lighting. It is intended for dermatologists to examine quickly and accurately any kind of skin pigmentation, in order to discriminate between benign moles and malignant skin cancers. The accompanying app can then store the pictures taken and email them to other dermatologists in order to attain a second opinion if need be [7].

Diabetes monitoring

The life of a person suffering from diabetes revolves around her blood glucose level, measured multiple times a day. Glucometers have revolutionised the process of measuring blood glucose through making it possible to perform at home, requiring only a small drop of blood and with minimal pain produced.

Now, blood glucose monitoring has been developed a step further with the Glucodock by Medisana, a glucometer-like device that is attached to a patient’s smartphone and that operates in conjunction with a dedicated application. The Glucodock keeps track of daily
Pros and cons - a conclusion

The introduction and widespread use of smartphones has truly changed how we relate to others and carry out our everyday lives. It is undoubtedly transforming the way we learn and practise medicine, as well as the way in which our patients think about medicine. As a recent article in the New York Times stated, we may soon be prescribing apps to our patients! [9] Are all these changes for the best? At this stage, it is hard to tell.

Among the advantages of health apps and accessories for smartphones is the undeniable fact that most of them are inexpensive, making them available to disadvantaged communities in developing countries, where the cost of traditional medical equipment can be unaffordable. Moreover they are portable, and are able to be connected to the internet - making it possible to share personal data with physicians even at distance, and to store information for easy access and comparison over time.

Nevertheless, there are a few issues that cannot be ignored. Despite the fact that many apps are relatively harmless, aiming at only storing data and generating statistics; some may provide false information which may be taken seriously by potential users. It is therefore important to note that only a small number of health-related apps have been formally approved by government agencies or health authorities.

The second problem to address is that of privacy. As users devolve their personal data upon a web-based archival system, it is necessary to ensure that such information will not be used for unintended purposes or shared appropriately with third parties. An important question to ask is: Are passwords enough to protect this need for privacy?

My final consideration is about the efficacy of these tools. Indeed, several studies have exhibited the usefulness of mobile apps in association with other interventions in dealing with chronic conditions such as diabetes or obesity. [10] However, there is little evidence comparing this approach to that of a traditional medical one involving actual medical personnel. I wonder as well if the significance of a human person, trained in medicine, will fade behind the enormous availability of electronic devices, tools and apps created for every possible disease and malady.

We must not forget that the intuition and experience of physicians, relying on a combination of their five senses, cannot be replaced by technology, no matter how advanced. The patient’s expectations, desires and hopes can only be understood and responded to by a similar being.

It is hard to tell what the future might bring with respect to new advances in mobile health technology. The field is growing faster than anyone could have anticipated. Despite this, I am determined to stay up-to-date with the most recent innovations whilst keeping in mind my patients’ best interests.

References

Telemedicine and Mobile Health: lessons from the U.S. army

James Cook

Much has been learnt from the military in the management of trauma cases [1]. Likewise, lessons can be learnt from their use of technology to improve healthcare in remote locations. It is well known that those living in rural locations of developing countries receive poorer healthcare than those in cities [2]. Telemedicine and mobile health could improve this situation by improving the link between the doctor in the city and the patient living miles away in a remote location. A recent paper by Poropatich showed that the U.S. army’s telemedicine and mobile health programme is successfully providing healthcare services for military personnel in remote locations across the world [3]. Hopefully governments, nongovernmental organisations and private businesses can learn from their example and integrate telemedicine into global healthcare provision.

Telemedicine is defined by the World Health Organisation (WHO) as: “The delivery of healthcare services, where distance is a critical factor, by all healthcare professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries; research and evaluation; and for the continuing education of health care providers” [4].

Mobile health, or m-health, is the use of mobile phones and other wireless communication devices for healthcare services [5].

The U.S army have been using telemedicine since 1992 and have recently introduced m-health services [3]. In doing so they have shown it is possible to provide good healthcare in remote areas. For example, radiological images are sent from Afghanistan, Iraq, Kuwait and Qatar to Germany for rapid and accurate interpretation. The “Email Teleconsultation Programme” enables a soldier worried about a rash to email a photo of it to a dermatologist who provides advice, on average, 5 hours later. Webcams are used to allow a soldier in a war zone to discuss a problem with a doctor in real time. Meanwhile, wounded soldiers recovering in their garrisons are using their mobile phones for prescriptions, health advice and for storing information on their health [3].

The advantages of telemedicine and m-health are numerous. The technology has made it possible for U.S. army personnel to consult with doctors when distance, weather or operational duties may have made it impossible. These teleconsultations ensure that medical problems, such as malignant melanomas, are reviewed and treated earlier than if a soldier had to wait until the end of his or her military operation. They also save the soldiers time - many medical complaints can be dealt with remotely through advice and reassurance. The equipment used to enable these consultations is relatively inexpensive - the camera, laptop and software used costs approximately $355 [3]. Furthermore, doctors in the war zone value the opportunity to access an expert second opinion and discuss radiological images and management of patients through weekly conferences [3].

Soldiers in the U.S. army have embraced this healthcare delivery model. In just under 8 years, over 10,000 teleconsultations have taken place [3]. Soldiers, commanders and doctors have all been highly satisfied with the service. Crucially, 70% of soldiers surveyed said they may not have sought advice for their problem if the webcam service had not been available [3]. The U.S. army have demonstrated that telemedicine and mobile phones make it easier for military personnel in remote locations to access healthcare services. The challenge now is to prove that this technology can be adopted by doctors and those civilians living in rural locations in developing countries. Although doctors are in short supply in remote areas, the internet and mobile telephones are not [6]. History has shown that governments do not have the money to spend building hospitals in remote locations and, even if they did, doctors would not want to work there [2-7]. Therefore it is now up to healthcare providers to utilise the technological infrastructure already present in rural locations and give those living there better access to healthcare.

This model is feasible. In India, the Apollo health group has so far conducted 57,000 teleconsultations in 25 different disciplines [8]. These consultations are cheaper than others so more people are likely to
A video conference to provide expert second opinion

Telemedicine and m-health have been criticised for removing the personal contact between the patient and doctor [7]. Some say that illiterate and elderly patients could not use the service and that even though mobile networks are present in rural locations, they are not reliable [8]. There are worries that patient confidentiality may be threatened [8], and that funding for the new technology is not sustainable [10]. These are important concerns but they are not reasons to give up on using technological advances in communication to improve patient care. Telemedicine and m-health are not replacements for traditional healthcare services - they are complementary to them. This new technology makes it easier for patients to receive assessment and advice in the first instance. Even if medical complaints can’t be dealt with by a teleconsultation, the subsequent meeting in person will be more efficient because a history will have been taken and tests ordered. Where users are illiterate, local health workers can assist in relaying the transfer of information. Further investment in mobile networks in rural areas will improve signal strength and reliability - this is work which Google has already begun [6]. The banking industry has persuaded millions of people that it is safe to manage their personal banking online, so the healthcare industry should also be able to persuade patients to manage their health online [12].

Governments have failed to provide good health services for those in rural locations [2, 5, 7, 8]. New technology is available to revolutionise the way patients and doctors can communicate with each other. The WHO has found that only 25% of countries that responded to their survey had a telemedicine strategy. This percentage needs to grow. One way of helping it do so would be if doctors embrace the new technology rather than shun it.

References

Is Internet Affecting Patient Behavior?

Ismail El-Kharbotly

“I really don’t want to read what’s on the internet, but I can’t help myself … It’s hard to make out what all of this means for my case,” she said. “Half the time, I just end up scaring myself[1].

The internet is hardly new. It has been around, permeating our lives, influencing our choices and life decisions for a couple of decades now. Indeed, with time, more households are being connected to the World Wide Web and its wealth of easily-accessible information; and this has opened a gate of speculation on the influence this phenomenon might have on our thinking and behavior, good or bad. For many, the internet has stopped being a tool and has become the ultimate reference. With this steady growth, the healthcare sector has been influenced by the touch of the internet, and now it is customary for medical professionals to access the latest in guidelines, disease surveillance and research with a few clicks on their computer or taps on their smartphone. Experts have painstakingly toiled over healthcare systems, from prevention to management, and have managed to reproduce and restructure these systems to allow quick, convenient, and reliable access to information over the internet. Information is a double-edged sword, however, and the eagerness in spreading and disseminating access to quality healthcare knowledge to medical practitioners and students has allowed access to previously-unobtainable information by another faction: patients and their families.

A few decades ago, for the average individual to obtain thorough information on their health status and medical procedures, they could either consult a doctor, or become one. Medical terminology (often in Latin or Greek) and the time and effort a person needed to go through the tomes of medical knowledge to obtain a simple fact or two were well-beyond the ability of the average individual who lacked the years a professional had dedicated to learning and mastering medicine. As a result, a conscientious and knowledgeable doctor had the ability to make sure that his patients received the information they needed to make a proper medical decision. With time, the doctor-patient relationship matured from the typical paternalistic model (where the doctor decides what is best for the patient) to one that is more mutual and based on greater patient control and autonomy over their treatments [2]. Naturally, when patients feel more comfortable, when they feel that they are presented with all the knowledge they need to make their own decisions and control the aspects of their treatment, their compliance and adherence are greatly heightened and as a result, treatment efficiency rises [2, 3, 4, 5]. The information related to disease diagnosis and management has become more widely available with the spread of the internet, oftentimes simplified for the benefit of medical students or even patients themselves. Patients can easily access the internet from their home computers and, using keyword-based searches of their symptoms or complaints, match to virtually all conditions matching the keyword, including information on diagnosis, management guidelines both for the patient’s country and international ones, and even videos of surgeries or procedures. A number of websites offer diagnostic services or “symptom checkers”, in which the patient types in his complaint and an electronic algorithm displays a differential diagnosis. Several hospitals have even allowed patients access to their personal profile and health files using remote networking systems, and as a result the patient can comfortably review the results of his tests and scheduled treatments [1]. With a new world of medical information being wide open to the public, are patients faring better with the unlimited access to information on the internet than without?

It is undeniable that the easy and rapid access of globalized information across borders, catalyzed by the internet, has greatly benefited patients. Patients are now free to email professionals from the comfort of their homes and get their questions answered and concerns reassured, not just from their own doctors, but from other medical practitioners from across the world. The multitude of opinions a patient obtains from different-minded physicians and support groups may help form a collective background of the patient’s general condition, allowing him to inspect the disease with much more insight and come to a much better-informed decision. Some physicians are nowadays approached by patients who request a certain modality of treatment of which the physician is unaware [1]. The idea of having greater control is undoubtedly reassuring to patients, and their adherence will overall be improved. Some doctors feel optimistic about this new trend, whether on its accuracy or on the effect it has on the doctor-patient relationship. Some physicians have started to look favorably on the entire concept after a 2006 study showed that Google searches were able to correctly diagnose a condition in 58%
of cases (95% confidence interval is 38% to 77%) [9]. Others are comforted by the results of another paper, which showed that 70% of the participants planned on approaching their physician with knowledge they found online [7], which suggests that most patients view the internet as a supplementary source of knowledge, rather than a replacement.

On the other hand, a substantial voice expresses concern over this phenomenon. Doctors fear that the advice patients receive from websites or online support groups may not be trustworthy, or it may be issued by people who are not authorized to give that sort of advice. Fraudulent doctors are a concern, as well as misplaced advice provided by para-medical personnel, such as physiotherapists or pharmacists, concerning matters not within the jurisdiction of their field, such as disease diagnosis or surgical techniques. Regulating online opinions is difficult, and patients are often tempted to listen to the advice that agrees with their pre-formed ideas and notions they find comfortable, rather than what really is best for their conditions. With the staggering flow of contradictory advice and information online, especially for the more chronic and difficult conditions, patients may be tempted to justify their non-adherence by searching the internet for a diagnosis, the author warns too often find themselves coming across gruesome diseases and debilitating conditions, which may cause them severe distress and non-adherence to typical treatments [9]. Even more, the research results supporting internet-diagnosis are often fraught with warnings; in the paper on Googling for a diagnosis, the author warns that patients may find Google searches less efficient and less likely to produce a correct diagnosis than an expert physician [4]. The internet is still a double-edged sword, it seems, with both edges equally sharp, and equally significant.

The world is a big chatterbox of opinions, and freely-flowing information can be unsettling. Despite that, both the internet and concerned patients are unlikely to disappear, and so perhaps doctors should be aware of the effect of the internet on their patients, and henceforth advise them on a regular basis on the good and bad sides of the internet and self-diagnosis. With that in mind, the patient is more likely to critically appraise online information and to consult the physician when in doubt instead of viewing the two sources as contradictory or conflicting. Perhaps when we as physicians learn to respect the patient’s need for the internet and what the internet has to offer, the patient can in turn respect and trust the human element, and the resulting improved adherence to treatment will be for everyone’s benefit.

References

Overview: Technology in Global Surgery

Hampus Holmer

Surgery is technology

There have been exceptional developments in the field of surgery in the last 100 years. The introduction of anesthesia has given surgeons room to develop surgical techniques previously unimagined [1]. In the last few decades, development in all fields of surgery has gone hand in hand with technological advances, so bringing “the future into the present”.

Global Surgery

Technological developments in surgery are largely limited to high-income countries. As a result, modern advances that lower morbidity and mortality rates, and that reduce total costs for surgical interventions, are often absent in low- and middle-income countries. This is one pressing issue for the developing field of Global Surgery, which takes into account surgery as a global health measure. With global health traditionally restricted to issues such as infectious disease and maternal health; the introduction of surgery has been met with some skepticism, but several studies have shown that the demand for up-to-date and relevant surgical interventions, especially in developing countries, is great [1]. Importantly, such interventions have also been proven to be comparably cost effective. Hence, the introduction of technological advances into the field of Global Surgery is a logical development if it can contribute to more cost-effective and safer surgeries where resources are limited but demand is great [1].

Technology in the developing world

Today, roughly 95% of surgical technology in developing countries is imported despite the fact that these “first-world” technologies may not suit the specific needs or capacities of those countries [1]. It is important to note that many donor organizations are doing a commendable job in supplying resource-poor hospitals and health centers with modern technologies at no cost, however around half of the surgical equipment donated is not used due to factors such as low quality, lack of spare parts or insufficient knowledge about how to use it [1].

Technology and quality of life

Cost effectiveness of medical interventions is often measured in Disability Adjusted Life Years (DALYs) averted - a measure of how many years of life are saved for each unit of money spent, adjusted for disability [1]. This unit is used in the well-known Global Burden of Disease calculations [3], but many of the most high-tech surgical techniques (such as minimally-invasive laparoscopic and robotic procedures) are yet to be analyzed in terms of DALYs averted [5].

Despite the lack of information on DALYs, it can be argued that such high-tech approaches potentially have an important role to play in Global Surgery in the future. The lower post-operative infection rates, faster recovery times and reduced risk of complications associated with these techniques would be beneficial in any setting. Some even argue that such technologies are a potential way of controlling brain drain. According to this theory, ambitious surgeons in rural clinics tend to stay if they are able to develop professionally there through using high-tech equipment amongst other things [1]. This is certainly an interesting factor to take into consideration with regards to improving people’s health, and thus, their quality of life.

Technological prerequisites

When considering introducing medical equipment into resource poor settings there are a few aspects to consider before anything else. A reliable supply of electricity is perhaps the most crucial one. Most technologies rely on it, from the autoclave for sterilizing equipment to suction devices, anesthesia machines and operating room lights. In many places around the world, frequent power failures are a part of daily life, and generators may be equally unreliable if there is an inconsistent fuel supply.

Technological advances are one of the answers to this problem [1]. One example of such an advance is the universal anesthesia machine manufactured by Gradian Health Systems. This is designed for resource poor settings and is a simple, low-energy device with a backup energy supply and a built-in oxygen concentrator which makes supplies of compressed oxygen unnecessary [2]. More innovations like this are needed if we are to address the problem of surgery as a global health issue.

Technology outside the operating room

Perhaps the most important technological advances that benefit surgery in resource poor settings are those that are primarily used outside the operating room. Worldwide, surgical education is supported by online resources (not least in the form of the World Health Organization’s Checklist for Safer Surgeries) which promote the rapid spread of evidence-based practice [6]. Furthermore, the global movement towards open source databases for research and educational material will
change the future of Global Surgery [1, 6]. With respect to practical surgical training, technology in the form of simulators has been shown to greatly benefit learning [1].

Online forums, e-mails and Skype have made communication possible between surgeons across the globe; and extensive mobile phone coverage has facilitated patient-doctor contact. Text messages can be sent to patients from clinics alerting them to an upcoming appointment or advising them on pre- and post-operative medication regimens, for example [1].

Concluding remarks
As has been discussed previously, technological developments are required to improve surgical care in underdeveloped settings. Some of the main issues impeding such developments are related to adaptability and affordability. To combat these problems, up-to-date medical equipment must be designed specifically for the environment where it is to be used and must be able to be produced cheaply. New design collaborations and equitable surgical technology patenting could allow “generic” products to be produced locally, enhancing the capacity for safer and more cost-effective technologies to be employed [1]. This is a concept that should be developed further as it has the potential to improve Global Surgery standards worldwide.

[For inspiring online lectures in the field of Global Surgery, please visit the webpage of the University of Utah’s School of Medicine Extreme Affordability Conference, at http://medicine.utah.edu/globalsurgeryconference/videos.htm]

References
The Projects “powerhouse” is responsible for overseeing the implementation of hundreds of projects every year. This section will take you through the various projects available for you to utilise and get involved in at the local, national and transnational levels. Read all about the contenders for the Rex Crossley Awards, and what efforts are currently underway in our NMOs! Enjoy!
Message from the Projects Support Division Director

“Projects are the beating pulses of IFMSA”

As a federation extending from the Asia-Pacific Region to the Pan-American Region to the European, Eastern Mediterranean and African Regions, the IFMSA has one particularly important and vital role in the global community. This role is a unique one, expressed through the co-operation of medical students worldwide who share the same vision of changing the world for the better through projects.

Within the IFMSA the term “projects” refers to activities in many fields of interest to medical students, which are in concordance with the IFMSA aims, principles and policy statements. These may include events, workshops, surveys, networks and campaigns, amongst others.

The IFMSA has three categories of projects: endorsed projects; transnational projects; and initiative projects. And in this 13th edition of the Projects Bulletin you will be provided with an overview of just some of these projects being carried out under the patronage of IFMSA on the international level.

With my wishes that you enjoy reading this edition,

Karim M. Abu Zied
Projects Support Division Director 2012-2013
Effective training of future physicians is a goal shared by all countries. Even though medical education systems are different in every country, there are common challenges facing medical students regardless of where they study.

One challenge is that students must learn an immense amount of information within a limited period of time. To accomplish this, medicine has traditionally been taught via lists: lists of signs, symptoms, complications, and differential diagnoses. While these lists are straightforward to learn from, for new medical learners they are often not adequately explained. Facing time pressure, students may be pushed, by these lists, towards rote memorization, and away from true understanding of material.

To help students adequately – and easily – understand such lists, medical students at the University of Calgary developed “The Calgary Guide to Understanding Disease” (www.thecalgaryguide.com). Since the launch of our website in August 2012, our freely available online content has been downloaded over 30,000 times in 60 countries (at the time of writing this article). We now have learning material for over 170 topics, covering most disciplines in medicine, with content for hundreds of additional topics on its way.

There are several things we do well that we think has helped make this resource so useful to students around the world:

1. First, medical students author all content, ensuring that our material is worded at a level that’s easy for medical students to understand, and understand quickly. We do, of course, ensure factual correctness via thorough faculty review.

2. Second, we fully explain “why” diseases present the way they do. Our flow-charts explicitly lay out all the mechanisms essential for understanding the manifestation of the disease in question. We make explicit the thought-processes intuitive to practicing physicians, so that new medical learners can understand the disease without feeling like they’re missing chunks of information essential to their learning.

3. Third, we “divide and conquer”. Complex topics such as Myocardial Infarctions and COPD are divided into various aspects (history, physical exam, investigations, etc.) so as to not overwhelm medical students.

4. Fourth, The Calgary Guide is freely accessible worldwide, to anyone with an internet connection. We strongly believe there should be no financial barriers to superior medical education!

Taken together, by introducing a resource that connects pathophysiology with disease manifestation in a thorough yet easy-to-understand manner, we strive to foster durable learning and a greater mastery of the subject matter for fellow medical students. This, we hope, will help students excel in their academic and clinical endeavors.

We feel privileged to be helping fellow students learn about medicine. Many of the students and physicians who read our slides have emailed us with comments and suggestions, making our content even better for our users around the world. Please feel free to do the same via the “Contact Us” section of our website! We can be found on facebook, or directly online at www.thecalgaryguide.com. We are continually expanding our database of learning materials – stay tuned for more content!
First Aid for Schools

Jesper Mølgaard

When you ask medical students about why they chose to study medicine - with the long study hours, hard work and probably a significant student debt afterwards - many will tell you that they do it “to make a difference”. In Denmark, the IMCC has launched a project to help medical students do just that.

The project is called Førstehjælp For Folkeskoler (FFF), translated as First Aid for Schools. We provide free first aid training to children between the ages of 13 to 16 years by sending volunteer medical students out to Danish schools. We have chosen this target group as it represents a wide cross-section of society and also because we want people to learn first aid at an early stage of their lives.

Our medical student volunteers have to participate in a training weekend, with both days lasting from 10am to 6pm, and with a curriculum that includes: first aid training and practical experience; presentation skills; and an introduction to the IFMSA. This ensures the quality of our product and that we all teach the same skills no matter our background.

Internal structure of the project

Our vision is a world where all people recognize the need for skills in first aid; and a world where all people have a basic first aid skillset so that the injured are seen to in a timely and effective fashion.

Our core values and main focus points are: member ownership, testing creative solutions, and carrying out informative first-aid training sessions.

Why the need for a first aid project?

In Denmark, first-aid is a mandatory part of the secondary education curriculum, but only about 50% of schools live up to this requirement. Furthermore, there are no recognised guidelines as to the quality or quantity of the first aid training provided.

The reasons for this discrepancy between law and reality may include factors such as:

• Expense – as an example, many trainers charge up to US$1000 for a 6-hour session.
• The value of first aid not being fully understood by politicians and school leaders.
• A low perceived benefit of teaching first aid to children.

How did it all start and where to from here?

The concept for this project was presented during the project presentations at the August Meeting 2010 in Canada. Today this initiative has grown rapidly throughout Denmark, and more than 300 medical student members are now involved in teaching more than 800 high school students. We thus feel that the project has reached a viable and healthy stage and we are excited to present it to other IFMSA NMOs. Keep a look out for the First Aid for Schools Project!

Jesper Mølgaard is a medical student of IMCC-Denmark. He may be contacted at: fff@imcc.dk
This year, the Canadian Federation of Medical Students has been undertaking various projects in order to promote LGBTQI (lesbian, gay, bisexual, transgender, intersex and related populations) health and equality. The first project involved the creation of a position paper on gender and sexuality in order to show that our organization is supportive of, and respectful to, all individuals regardless of their sexual orientation or gender, and that we expect medical students in Canada to do the same. The policy statement also supports more comprehensive education on sex and sexuality in medical school curricula (ranging from public health to specific sexual health concerns and clinical skills).

The next project we are carrying out is a long-term project to standardize what is being taught in terms of reproductive and sexual health, including LGBTQI health. Currently, some schools in Canada cover this topic quite well, while others do not include it at all. As such, we initially distributed a comprehensive survey to first assess what is being taught (and to which level) in Canadian medical schools. The next step involves using the information collected to develop an effective strategy to standardize reproductive and sexual health medical education.

In Canada, each first year medical student is given a clipboard from the Canadian Federation of Medical Students. Since most students use it in clinical encounters, it has been suggested that we place a “Positive Space” message on it in order to promote LGBTQI equality. By doing so, we will be showing that our organization is LGBTQI-positive and additionally, when used in clinical encounters, it will also show patients that the student will not discriminate on the basis of sexuality and gender. This will help promote a more inclusive environment in medicine.

The CFMS advocates for LGBTQI rights and equality through political initiatives. Last year, during a provincial election, we sent candidates four reproductive and sexual health questions including two relating to LGBTQI issues. We look forward to continuing this activity with upcoming leadership campaigns and elections in 2013 and 2014.

Lastly, the CFMS promotes diversity through various initiatives and projects on a local level, at each of the individual medical schools across the country. In addition to organizing events for the International Day against Homophobia and Transphobia, we also promote a uniquely Canadian event called the Day of Pink. This day was created after a Canadian high school student was bullied for his sexual orientation and for wearing pink. Two of his straight peers intervened to support the student. They purchased pink t-shirts and encouraged everyone at their school to arrive wearing pink, showing solidarity in stopping homophobic and transphobic bullying. Since then, it has become a national campaign and we at the Canadian Federation of Medical Students now host our own Day of Pink events annually at each of our medical schools.

Through these initiatives, we hope to close the gap of health inequality and promote more tolerance and acceptance when it comes to gender and sexual orientation.
The annual Red Party is a popular event at Australian medical schools. This year the old favourites were back in full swing in their respective states; and a few new university members in Sydney and Tasmania were able to join in the fun as well. There were a number of success stories and I would like to look at a few of these in depth.

Firstly, James Cook University (JCU) in northern Queensland raised over AUD$5000 for the En Gadi Charity which is based in Zambia and supports over 600 children who are orphaned due to HIV/AIDS. En Gadi was set up by one of the mothers of a current JCU medical student, and goes by the motto “It takes a village to bring up a child”. It aims to strengthen the community by providing food, medical care and other resources that are necessary for children’s growth and development. Recently, a school was built by the charity for children who cannot afford to go to government schools.

The University of Notre Dame in Sydney also raised over AUD$5000 but to support a small grants program run by the Australian Federation of AIDS Organisations. The particular grant that was chosen aims to assist day care centres dedicated to people living with HIV as well as their families in Papua New Guinea (PNG). These centres are run by the PNG National Catholic AIDS Office under the supervision of Sister Tarcisia Hunhoff; and the funds raised will be dedicated to one of their 80 centres.

And, during their “Red Week”, the University of Western Australia organized free STI health screens thanks to a Department of Health grant and arranged for almost every hospital building in Perth to be covered in red.

Being national coordinator of the Red Party project is a rewarding but challenging experience. This position has only been in place for two years and so it came with a few challenges. The main one was to try and unite each individual Red Party across Australia. But, as each university has its own unique spin on the event (as well as goals to achieve), it is quite difficult to try and bring them together under one banner.

On the flip side, we do not want universities to lose their own identities or their own fundraising campaigns. Some have been raising money for HIV and AIDS for numerous years now, and have well established fundraising methods. For the year ahead however, it will be necessary to try and further unite each individual Red Party across Australia as this will provide a stronger front for the charity and will also allow greater opportunities for raising awareness and funds in Australia.
Firstly, what is the Teddy Bear Hospital (TBH) Project? TBH is a public health initiative that aims to take away the fear children have of physicians and hospitals by pretending that the “teddy bear patient” is unwell and thereby involving the children in role-plays. Medical instruments such as stethoscopes and tendon hammers are also given to children to play with in order to help familiarise them to the healthcare environment.

For many medical students, the TBH represents more than just fun and games - it is a passion of theirs and a philosophical way of seeing medicine. It is deemed important both for the children not to be afraid of doctors, as well as for medical students to reveal their inner child and remember why they wanted to be doctors in the first place.

You may ask if TBH is as much fun, and as amazing as it sounds - and the answer is yes, definitely! To illustrate, here is a short story of a personal experience that I had one day after finishing a TBH session: a child came up to me and started pulling at my white coat while saying “Thank you very much for helping our teddy bears, now we know that doctors are not bad people! Thank you!”. After this happened I knew that what I was doing was the right thing and that the effort I had invested was well worth it.

Even if you aren’t part of the TBH program, you can still take part in a bit of fun with your paediatric patients. Just ask a child if he can hear his own heart beating (the answer is normally a no). Next, place your stethoscope’s ear pieces into his ears, adjust to the mitral focus and place on the patient’s chest over his heart. The resulting facial expression is most rewarding; you will never forget this experience - just give it a try!

Currently, the TBH project is aiming to extend its outreach and efforts are underway to help NMOs in organising their own activities. If you need any help in planning and implementing your TBH project, you can always contact me at the e-mail address provided above. Teddy bear hugs!
CALWHA (Children and Adolescents Living with HIV/AIDS)

Rainer Tan

Since 2005, anti-retroviral therapy (ART) and the medical care associated with it, have been distributed across Tanzania for free to all people living with HIV. This access to ART has been an incredible breakthrough in the fight against HIV. In theory this should allow all HIV positive people to live a relatively healthy life but in practice, we have found that this is not the case, particularly for children and adolescents.

For the children and adolescents enrolled at the Care and Treatment Centre (CTC) of the Nansio District Hospital (NDH), ART is their lifeline. Without strict adherence to these medications and proper surveillance of their health, the consequences can be fatal.

Jennifer, an 8-year-old orphan, is among those who are unfortunately not fully benefitting from the care available to them. Jennifer regularly misses her hospital appointments and is not fully compliant with her ART; therefore she is often sick from opportunistic infections. A combination of factors leads Jennifer and many other children like her, to be non-compliant with medical care recommendations; these include:

- Low self-esteem due to HIV stigma and to their orphan status;
- Poverty barriers such as insufficient nutrition to support ART and a lack of funds for transportation costs;
- Lack of knowledge about the importance of ART; and
- Anxiety of the hospital environment and care.

Such issues have led METIS (the Student Movement Working Against Health Access Inequalities) and the NDH to develop the Children and Adolescents Living with HIV/AIDS (CALWHA) project in Tanzania.

The idea of the project is to transform the hospital experiences of children and adolescents living with HIV into something positive, enjoyable and beneficial. For one day each month, the children and adolescents make a visit to the Nansio District Hospital which allows them to meet peers in similar situations, and teaches them about the importance of adhering to treatment guidelines through interactive discussions and tutorials. The children also undergo medical check-ups and are provided with wholesome meals, as well as nutritious food and antiretroviral medications to take home. The ultimate goal of the program is to increase hospital attendance, improve physical and psychosocial health, and reduce the spread of HIV. The direct care is provided by NDH, while METIS provides the funding, and monitoring and evaluation services.

To date, results from the project have been positive. Within a year and a half since its introduction, attendance has doubled. As a result, ART adherence, knowledge of HIV, and psychosocial and physical health has improved for the children enrolled in the CTC.

Many challenges remain however, including the tracking of children lost to follow-up, communication issues, and sustainability. Despite this, the potential opportunities are encouraging; these include the creation of a similar project in another part of Tanzania, and possible future collaborations with the Tanzanian Medical Students’ Association.
Some didn’t even know where Ethiopia is; others didn’t even care to know. They found out after seeing posters or hearing peers advertise the Ethiopia Project. Many were afraid to travel so far from home but their flights and visas were already booked. The trip was an adventure for them – a way to explore their limits – and all were thrilled to be able to travel to Ethiopia and be part of the Ethiopia Project.

The Ethiopia Project is an initiative that aims to promote voluntary work on HIV and AIDS amongst Greek medical students. The main idea is for them to raise awareness about HIV/AIDS amongst Ethiopians at the grass-root level. Each year, 25 students in the 3rd, 4th, 5th and 6th years of medical study travel to Ethiopia to volunteer with NGOs for 6 weeks. Their main tasks are to: educate people living with HIV/AIDS (PLWHA) and their families; organize secondary school interventions and seminars for people with high-risk behaviors; and promote free HIV testing. The project is the realization of an idea that resulted from the collaboration of HelMSIC and AIESEC-Greece.

How do the medical students obtain the skillset to carry out all their tasks? A preparatory training is the answer! A few weeks before the big trip, HelMSIC conducts a seven-hour training session in order to make sure that all participants are able to cope with the demands of the project. Using peer education, the training is divided into two parts: the first consists of workshops on communication, presentation and leadership skills, as well as crisis management techniques; while the second is made up of educational sessions on HIV/AIDS and its associated issues. To further prepare the students, each receives a survival kit which contains all the necessary information to know about life in Ethiopia, including cultural practices and customs.

How are the participants selected? This is done by judging both the quality of their applications as well as their performance in a short interview conducted by the two Ethiopia Project National Coordinators. Some of the specific selection criteria include one’s motivation, comprehension of the project goals, willingness to adapt to the local environment, and fluency in English.

Where do participants stay? All volunteers are housed in dormitories which are shared with Ethiopian students.

So, you’ve booked your flight, arranged your visa, and have learnt just about all there is to know about the project, Ethiopia and your stay there. Now, you are getting ready to go and your six-week journey can finally start! The Ethiopia Project is just for you!
In recent times, statistics on sexually transmitted infections (STIs) have become more and more alarming. According to the National Centre on AIDS, there were 16,417 HIV-positive people in Poland in February 2013[1]. New STI cases are being discovered on a daily basis, especially among young people who engage in high-risk behaviours and do not protect themselves adequately[1].

Because of information such as this, the “Streetcar Called Desire” project was born. This is a preventative-health and educational campaign, organized by the International Federation of Medical Students’ Associations-Poland in cooperation with the MTV Staying Alive Foundation and the National Centre on AIDS.

The organisers of the campaign have stated that its aim is to “increase public awareness of preventative-health and health-promoting behaviours, in the field of reproductive health” in order to “share with young people how important it is for them to be aware that they are responsible for their own health, as well as that of others”.

Another important goal of the campaign is to promote an attitude of acceptance towards people living with HIV. The organisers have said, “It is worth reminding everyone that these people are among us – that all of us enjoy human interaction. We need to show everybody that we are all the same!”.

This year, the student council of the Medical University of Silesia in Katowice organised the “Streetcar Called Desire” campaign in conjunction with the “Medykalia” celebrations. The campaign was planned to coincide with the “Medykalia” festival to take advantage of the fact that there are many parties planned during this time.

At 9pm on the night of the campaign, a special “party bus” (complete with music and fun games) collected students from their dormitories, taking them on an extraordinary journey. Whilst aboard the bus, on the way to various party venues, students were able to seek advice on sexual and reproductive health matters from trained educators, also known as the “Safe Patrol”. In the city centre, nightclubs were also prepared for the campaign with educational flyers and safe-sex packs.

During the campaign many young people were educated on human sexuality, reproductive health, HIV and other sexually transmitted diseases, and HIV stigma and discrimination. The event was a huge success and would not have been possible without the help and support of the organising team. Many thanks to all who were involved!

For more detailed information on this project, please visit: http://facebook.com/TramwajZwanyPozadaniemPolska
Global Medicine: take a step outside your hospital doors

Esra Dede

In 2001, a group of medical students in the Netherlands conducted a survey at each of the eight medical universities; they wanted to determine if there was a need for a magazine focussed on global health. The outcome was very positive and so, the new magazine was founded.

The magazine is called Global Medicine. It is made by students for students, and aims to: spread awareness on global health issues; enable medical students to publish at an international level; and encourage them to learn more about publishing. Nowadays, more and more students are interested in global health, and “Global Medicine” is one way to allow these students to contribute to their field of interest.

All students and graduates are welcome to submit articles about any global health-related subject. The magazine covers a diverse range of topics, from neglected diseases to which city is among the best to study medicine in. We want medical students to think outside the box and start learning more about international health topics which are not always covered by their medical curricula. It is our task as medical students to change this.

It was exactly two years ago that I took this magazine in my hands and promoted it amongst the students attending IFMSA’s August Meeting in Denmark. Little did I know that I would soon be in the Global Medicine team in just under two years. All in all, the team is very diverse, with members ranging from first-year medical students to graduated doctors.

By promoting Global Medicine during international events such as IFMSA general assemblies, regional meetings and other conferences, we hope to make our magazine well known amongst students from all over the world. This networking also has the potential to create a lot of diversity with respect to the magazine’s contributors - something that the Global Medicine team strives for.

Medical students can subscribe to the Global Medicine magazine for 10 Euros per year (15 Euros for non-students). By subscribing, you will be helping medical students in both spreading their knowledge and experience, and voicing their concerns about global health issues. More information about Global Medicine can be found on our website: www.globalmedicine.nl

Esra is a second-year medical student at the University of Amsterdam (UvA) and a layout design member of the Global Medicine team. She may be contacted at: esradedesp@gmail.com
Every day is World Earth Day

Hsiao Yu Hsin (Nish), Lu Chien-Chi (Lucy), Cheng Kai-Yuan (Kyle)

In recent times climate change has been gaining more and more public attention. This does not however mean that the issue is better addressed than before. Many people are aware of climate change, but few understand how to be part of the solution. Medical students, as future health workers, are obliged to understand the impact of climate change on health, and work towards making a difference.

This is the reason why the “Every day is World Earth Day” project was created. We aim to raise awareness amongst both medical students and the general public, equipping them with knowledge on how to be eco-friendly in their daily lives; and providing them with opportunities to carry out green activities right from the get-go.

Our project is a combination of many smaller projects or initiatives. One such initiative involves teaching young children who attend the Teddy Bear Hospital how to “be green”. Since last October, more than 500 children have learned about the links between the environment and health through activities such as the “recycling game”. This initiative is a simple yet effective way for interested NMOs to start addressing climate change issues.

Another major initiative is the “Mr Ice” climate change workshop which is organized in conjunction with the Pharmaceutical Students’ Association in Taiwan (PSATW). Approximately 110 medical and pharmaceutical students attend the workshop which is composed of a variety of activities, including: seminars based on climate change research; the “health promotion hospital” (a WHO initiative); and a model climate change conference. Participants generally agree that the most exciting part of the workshop involves brainstorming for, and creating, a simple advocacy project. At the end of the workshop a flashmob is carried out in order to put newly-formed ideas into practice in a fun and entertaining way.

World Earth Day is an event in which multiple “green” initiatives are implemented by local officers (LOs) in their local committees. An example of one initiative is the “Green Message Fedex”, which allows students to send gifts such as bonsais and other potted plants to friends at medical schools around Taiwan. All profits made are donated to NGOs that focus on environmental sustainability. Our other initiatives for this day include the sale of notebooks made from recycled paper, and competitions involving the construction of art from recyclable materials.

Through all of our project’s activities, the more than 400 students that participate are able to grasp green concepts.

The fact that climate change is (and will keep on) affecting our health is indisputable. As medical students, we have the responsibility to equip people with the knowledge and the skills to combat it. Climate change is not a new story, but we ask for more than just story-telling! We want our audience to be moved; we want to inspire them to honor the moral of the story by their own actions. Let us make every day World Earth Day, and start living a new life that will benefit the lives of future generations!
Welcome to the world of the SCORAngels! “SCORAlicious” will provide you with much insight into the life of the delightful Standing Committee on Reproductive Health including HIV/AIDS. Open the following pages to find out about concerted efforts to stop violence against women, adolescent health, and much more!
Introduction from the SCORA Director

Désirée Lichtenstein

Medical students of IFMSA formed the Standing Committee on Reproductive Health including AIDS (SCORA) in 1992. Through SCORA, medical students across the globe work locally, nationally and internationally to increase awareness concerning reproductive health and related issues. SCORA focuses on topics related to comprehensive sexuality education, maternal health, gender equality, HIV stigma and discrimination, sexual orientation, safe abortions and sexual violence, amongst others. It also aims to raise awareness on a variety of reproductive health issues amongst the public.

SCORA’s vision is a world free of HIV/AIDS and other STI’s with complete respect for every person’s reproductive rights and choice of sexuality, and with universal gender equality.

SCORA has a variety of projects that differ from country to country, however they all share a common basis: interactive methods which involve young people and stimulate them to think creatively. Our major focus is on discussion, open communication and interaction rather than long didactic lectures. The World AIDS Day and Peer Education Programs are two of our main projects.

Another of the projects that SCORA is proudly responsible for is the SCORA student exchange program, which has several countries participating. The topics vary according to the country involved, including, for example, maternal health, gynecological cancers, and HIV treatment/testing and prevention strategies.

There are countless other activities that our marvelous standing committee carries out. In this edition of SCORAlicious, you will be able to experience some of these. We hope that you will be inspired to take part in our initiatives and join our growing SCORA Family!

Hugs,
Désirée Lichtenstein
SCORA Director, 2012-2013
Exclusive breastfeeding: A mother’s gift to her child

Franchesca Mirre González

Breastfeeding is vital for both mother and child. Benefits include the provision of nutrients needed for child growth and development, the formation of a bond of love between mother and child, and economic relief for the family [1].

According to the Dominican Republic’s Demographic and Health Survey, only 7.8% of infants are breastfed exclusively and the infant mortality rate is approximately 31 per 1,000 live births [2]. Studies have shown that an increase in the rate of exclusive breastfeeding may reduce child mortality by decreasing the incidence of infectious diseases and child malnutrition [3].

In efforts to educate the community about the benefits of exclusive breastfeeding, ODEM members organized a SCORA project to celebrate World Breastfeeding Week. Utilizing the theme, "Breast milk, the best brand", ODEM members implemented the project in five cities and four rural communities, educating more than 1,500 citizens of all ages. Members developed educational posters and pamphlets to be distributed to the target population, organized educational seminars within communities and health centers, and utilized social media to disseminate both the health message as well as photographs of the event. On our ODEM blog, two members shared their reflections – “Breast milk, the best brand” and “Exclusive breastfeeding: Take it to heart” – which included data from the evidence-based literature about the benefits of exclusive breastfeeding.

Three key points to remember are:
1) A woman who breastfeeds is providing the best nutrition for normal growth and development of her child.
2) Breastfeeding immediately after delivery provides a thick and nutritious milk, called colostrum, which protects the newborn against infection.
3) During the period from birth to six months of life, food other than breast milk may increase the risk of diarrhea and other diseases. [1]

Since there are multiple benefits to both mother and child of exclusive breastfeeding, we, as medical students, should educate women and their families about this important activity. After all, breastfeeding is not only beneficial for child growth and development, but it also helps to establish the essential mother-child bond of love.

References

Female Genital Mutilation

Dalia Abd el Nasser Awad Mohamed

Female Genital Mutilation (FGM) is a term that may sound strange to much of the world, but to some girls in the Middle East, it is a term that means “death”.

According to the World Health Organization (WHO), FGM stands for “all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs”, whether for cultural or for any non-therapeutic reasons [1].

Although the practice of FGM is endemic in the Middle East, the highest prevalence lies in Egypt, Sudan, Syria and Oman [1]. Based on false cultural and religious beliefs, FGM has been associated with the perception of an improved marital life. Since the procedure reduces the female’s libido the belief is that virginity is more or less guaranteed, as pre-marital sex would be inhibited.

In Egypt, FGM is usually performed on girls between the ages of 9 and 12 years, often without anesthetic or precautions against infection. In the past, the procedure was generally carried out by traditional birth attendants or midwives, however it has become increasingly common in the medical arena – nowadays, more than 60% of circumcisions are performed by physicians and nurses in medical centres [1]. Efforts are underway through FGM health awareness campaigns to change this trend.

Amongst the critical complications that may result from FGM (which include pain, bleeding, acute urinary tract infections, wound infections, and vaginal or pelvic infections), death is the most worrisome. Consequently, it is even more important to attract the world’s attention to this horrible act. While some girls have full rights in certain parts of the world, others are deprived of this basic human right to protect their bodies.

For these reasons, IFMSA-Egypt’s SCORA team has started work on its “Anti-FGM” health campaign in 19 medical schools across Egypt. We aim to raise awareness about the religious, legal and clinical aspects of FGM to ensure that medical students adopt negative attitudes towards it. It is hoped that this will ultimately lead to a reduction in the medicalization of the FGM practice.

Some of the initiatives that we have been carrying out include: a national Training of Old Trainers (TOT) event on “FGM Awareness” for 60 participants; “step-down trainings” in 19 local committees for 600 medical students; and small working group (SWG) sessions to develop a manual on peer education in the fight against FGM.

On February the 6th each year, the WHO celebrates the International Day of Zero Tolerance to FGM. IFMSA-Egypt takes this opportunity to lead in the field, and to act in order to create real change in our country. We should remind ourselves that when a health problem arises in our society, no matter how large, critical or endemic, we can always work together to make a difference.

References

“Give it with Love” is a SCORA project that aims to promote responsible sexual relations amongst teenagers through workshops about condom use, unwanted pregnancy and sexually transmitted infections (STIs).

Introduction
In Mexico, the high incidence of unwanted adolescent pregnancies is indicative of the fact that there are many sexually active adolescents who are uninformed about the risks of unsafe sex, and about how to prevent pregnancy.

Here are some statistics:
- One in two sexually active young men surveyed in Mexico stated they had used condoms at their first sexual encounter, compared to only one in five young women [1].
- Regarding adolescents’ knowledge about protection methods against STIs, approximately one in four men and one in two women surveyed claimed they were not aware of any such method [1].
- In general, the majority of adolescents considered the condom to be the best preventative method [1].

Having knowledge about safe sex does not guarantee that the individual will practice it. However, it can be assumed that it does promote the use of condoms and other precautionary techniques.

Promoting responsible sexual health
Although “Give it with Love” is aimed at the entire population, adolescents are a special target group because of their lack of knowledge and experience which predisposes them to contracting STIs and having unplanned pregnancies.

Our initiatives include workshops that cover the risks of unsafe sex; as well as the correct use of condoms and oral contraceptives. The workshops provide a relaxing atmosphere where rapport is established between adolescents and speakers in order to facilitate meaningful discussions. By the end of the workshop, it is hoped that adolescents will have acquired new knowledge for future decision-making related to sexual health. Since the best way to make a decision is through being well-informed, adolescents will be better placed to avoid mistakes that may lead to irreparable life consequences.

References
SCORA-Japangels and their fight against taboo

Tsukasa Watanabe

Did the schools you once attended provide sex education and information regarding the lesbian, gay, bisexual, transgender, intersex and related populations (LGBTQI)? When I was a middle school student, I had a very shocking experience when my health teacher initiated a discussion on sexual health and stated, “Can you imagine two men having sex? It is so disgusting. Gays are against nature.” This was the first time I had experienced homophobia.

In Japan, even though youths can easily access adult and pornographic content through the internet, few schools provide classes about sexual health and LGBTQI issues. These topics are considered taboo in Japanese academic institutions. Some schools even take the view that sex education may encourage students to have sex or “become gay”. Also, even in cases where such classes are held, teachers may provide incorrect information to students, based on their poor knowledge of sex education and LGBTQI themes. How can we improve this situation? My answer is “SCORA!”

SCORA Peer Education Project

Our SCORA-Japan Peer Education Project provides lectures to more than 1,600 middle school, high school, and college students every year. We target the younger generation to promote an early understanding of sex, contraception, abortion, sexually transmitted infections (STIs), and sexual minorities. At the same time, we hope that our health initiatives can help students deal with their concerns and allow them to be more confident about themselves and their identity.

SCORA Rainbow Flag Project

Rainbow Flag Project members have participated in a number of gay pride parades and have held workshops for medical students. On May 17th, we created a poster for the International Day Against Homophobia and Transphobia (IDAHO) and shared it with members of the public as well as our collaborators around Japan.

We not only hope that more Japanese citizens will develop and maintain a healthy sexual life, but also that they will accept and understand the different ways that sexuality is experienced. We also encourage that medical students have sufficient knowledge to avoid discriminating against LGBTQI patients in order to provide them with the proper treatment and counseling services that they deserve.

National General Assembly

In May 2013, IFMSA-Japan held its National General Assembly in the Shizuoka prefecture. During this large event, many SCORAngels shared their views and experiences through discussion and participation in SCORA workshops. A joint SCORA-SCORP session was held, in which two lesbian couples were invited as guest speakers to discuss their experiences and facilitate a group discussion on the various socially-constructed stigmas surrounding them.

It is my belief that SCORA-Japan should grow and extend its reach to give even more people access to correct information regarding sexual and reproductive health. We Japangels are happy to be part of the SCORA committee, and always extend a warm welcome to SCORAngels from other countries. Let’s work on SCORA activities together and promote sexual and reproductive health around the world!
My Body is Mine

Delta Jeazul Ponce Hernández and Eric Francisco Guerrero Delgado

Summary
“My Body is Mine” is a noble project that focuses on children between 6 and 8 years of age. Its objective is to prevent child abuse through education and dynamic activities, including puppet theatre and other games.

Introduction
Child abuse is a daily reality in Latin America that threatens the most basic rights of children and adolescents. It includes physical and psychological aggression, rape and sexual abuse [1, 2, 3].

There are more than 190 million children in Latin America and the Caribbean [3]. According to statistics, these are the regions which have the highest rates of child abuse in the Americas. In 2004, from a total sample of 4,000,000 Mexican children aged between 6 and 17 years, one third stated they had suffered from some form of abuse either at home or at school [3]. This is concerning as family homes and schools are meant to be places of protection and affection, and in which rights are safeguarded.

The perfect mix of fun and education
Founded in Mexico, El Salvador, and a few other countries, this project has had a positive impact on society. It aims to educate children about their bodies and how they can protect themselves, while emphasizing how valuable and special they are.

Talking with children about topics such as their private parts is a difficult thing. How should this be done in a sensitive and respectful way? Our project uses a variety of methods to help children learn.

One of these involves the children putting together a puzzle of the human body. Once it is complete, brief explanations are given for each body part. For example, the children are taught that the hands are used to embrace, to hold and to touch; the mouth is used to eat; and the eyes to see. How do we confirm that the children have learned what was taught? Children are asked to place clothes and accessories on drawings of the body, while naming each body part and explaining what they learned.

Through the project children also use dance-forms to learn more about respect for their bodies. Balloons and toys are given out and games played in order to motivate the children to attend and take part.

The two most important things that the project gives children are education and the opportunity to speak openly with trained facilitators. It is hoped that the project will decrease rates of child abuse through educating young children about what is right and wrong.

References
Rainbow Project: For the acceptance of sexual and gender diversity

Joka Reichel

How do you work toward the acceptance of sexual and gender diversity all around the world? Everyone knows that education and knowledge reduce social stigma and discrimination. With that in mind, you could take every homophobic and transphobic person to an all-day-long lecture about sexual orientation and gender, and then get them to spend the evening with a group of transsexuals and homosexual couples. But, seeing as you cannot force education on people, the following are some alternative methods we are trying.

International Day Against Homophobia and Transphobia (IDAHO): 17th May 2013

Every year we hold an international campaign on IDAHO day; this year’s involved the collaboration of various countries in designing posters which depicted homosexual couples in everyday situations. Each participating country was encouraged to add messages to their poster, for example “What is more beautiful than love?”. The aim of the posters was to promote the idea that we do not have to fight homophobia and transphobia, rather we can make peace with homosexuals and transsexuals.

The Day of Pink: 10th April 2013

This day was created after a Canadian high school student was bullied for his sexual orientation and for wearing pink. Two of his straight peers intervened to show support, purchasing pink t-shirts and encouraging fellow students to wear pink in solidarity against homophobic and transphobic bullying. This campaign is promoted internationally by the anti-bullying organization, “Jer’s Vision” (www.jersvision.org), and is celebrated by SCORA members worldwide. For more information on the Day of Pink, please visit: www.dayofpink.org

Spirit Day: 17th October 2013

The Suicide Prevention Resource Centre recently published a study showing that 30 to 40% of gay and lesbian youths attempt suicide. They are also four times more likely to die of a suicide attempt than the average young person. On “Spirit Day”, we wear purple to remember those individuals who were killed or attempted suicide because of their sexuality.

Are you interested in learning more about our initiatives? We at SCORA have a newly revised project proposal, a manual full of ideas for future campaigns, and a Dropbox full of materials. There is also a team of awesome people from various countries around the world. If you are part of any projects, campaigns or research in the lesbian, gay, bisexual, transgender, intersex and related populations (LGBTQI) field, or are just interested in participating in the Rainbow Project, please join us and share your experiences. Just write me an email and become part of a great team that aims to promote peace.

Our project members are: IFMSA-Mexico, AMSA-USA, ASCEMCOL-Colombia, HelMSIC-Greece, LeMSIC-Lebanon, IFMSA-Brazil, IFMSA-Quebec, MMSA-Malta, PorMSIC-Portugal, bvmd-Germany, swimsa-Switzerland, TurkMSIC-Turkey, BeMSA-Belgium, SISM-Italy

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“Suddenly you find - at the age of 50 - that a whole new life has opened before you.” - Agatha Christie

Ageing is the biological progression of changes in structure and function that takes place with the passage of time. Even though it affects the entire body, it is often most obvious because of its effect on the reproductive system. In women, this is evidenced by the progressive deficit of estrogen production in the ovaries that culminates in menopause [1, 3]. This change occurs gradually as a process called menopausal transition (strictly defined as the years leading up to a woman’s last period) [2].

Taking into consideration that 50 is the average age for natural menopause, and that the global life expectancy for females is estimated to be around 80 years, it can be stated that on average, more than one-third of a woman’s life will be lived in the post-menopause phase [1, 4]. In sociodemographic terms, the global population of postmenopausal women is expected to increase from 477 million to 1.1 billion in 2025 [1].

This fact is particularly important because estrogen deficiency is associated with specific physical symptoms in up to 85% of women that can lead to a decrease in their quality of life [3]. In addition to this, it is important to note that psychological and social changes will also take place. The menopausal transition is a complex biopsychosocial process, and so medical student involvement is critical, since we can promote lifestyle changes that may help women maximize the quality of their future years [2].

“Recommence” is a project endorsed by IFMSA-Mexico and ASCEMCOL-Colombia that aims to optimize women’s health and well-being during the menopausal transition through implementing a woman-centered approach in providing healthcare to patients. Our project was designed with one main priority in mind: to make healthcare to peri-menopausal women both comprehensive and humanistic.

With training, medical students will be capable of implementing the campaign through three different interventions. The first and second focus on middle-aged women, providing them with individualized screening, counseling and health promotion sessions on topics such as disease prevention [3]. The third intervention targets local communities, aiming to increase awareness about menopause in order to help eradicate social and cultural life stressors for women.

In summary, “Recommence” offers an alternative strategy to fight for the health of an increasingly large population group that requires our attention and commitment. This project ensures that women in menopausal transition have the possibility of a healthy and fulfilling ageing process that leads to the complete enjoyment of life.

References

“With regards to sex, Polish people are the best at joking about it” – these sarcastic words were spoken by a well-known Polish sexologist to illustrate the fact that, although almost everyone engages in sexual intercourse, few Polish people can actually talk about it casually.

Sexology is a neglected medical discipline in Poland; this is reflected in the medical education curriculum. Since only a few schools list sexology as a mandatory class, there is an overall low level of competence in this field.

In 2010, a group of students from the Medical University of Gdansk decided to try promote sexology as a medical discipline to future doctors through the “Seksualia” campaign. Using a series of daring lectures, “Seksualia” hopes to intrigue, as well as evoke a wide range of emotions in, audience members. Its aim is to initiate national discussions on the introduction of sexology as a compulsory component of the national medical curriculum. It is hoped that this will ultimately lead to improved quality of care given to patients seeking medical assistance for sex-related problems.

This year two “Seksualia” campaigns took place: one in Gdansk and the other, for the first time, in Bialystok.

On the 2nd of March 2013, students at the Medical University of Bialystok were the first this year to organize and participate in lectures on areas of sexology such as women’s sexual lives; everyday sexual problems; and sexual abuse. Student attendance and participation was excellent, and organizers are now motivated to ensure that future campaigns take place.

The fourth edition of “Seksualia” took place in Gdansk on the 9th of May 2013. It was a unique event, mostly due to a special guest - one of the most famous sexologists in Poland - Professor Zbigniew Izdebski. He delivered his well-known lecture “Sexuality of people in Poland” which evoked a whole range of responses from the audience members, from joy and laughter filling the whole room to disbelief and total embarrassment.

Other invited speakers included lecturers from the Medical University of Gdansk, who gave an intriguing talk that shed light on the issues surrounding sexuality in the doctor-patient relationship. The giant applause at the end of the lecture spoke for itself.

Every year, we set bigger challenges to try to increase the importance of “Seksualia” in our NMO. Who knows, maybe next year we will manage to organize a national “Seksualia” event?

IFMSA-Poland hopes that “Seksualia” will soon become a project in other NMOs as we all have sex, regardless of origin, religion or sexual orientation.
Without Locks in Your Hands: Raising awareness on incorrect myths in our society

Lesly Joanna García Gómez

Summary

“Without Locks in Your Hands” is a project for all age groups. Its objective is to refute the most popular myths about human sexuality by not only denying them, but also providing accurate and appropriate information in order to educate people.

Introduction

In our society, there are a variety of myths and false beliefs that lead to misinterpretations of many topics related to human sexuality. We should note that such viewpoints can potentially have a negative impact on our sexual experiences as well as our physical and mental health.

Some myths concern a particular aspect of sexuality while disregarding others. One’s sexuality may be portrayed as something that is dirty and shameful while it is really something as natural as breathing. There is nothing harmful about one’s sexuality; all that is needed is respect and understanding for people and their sexual orientations.

An example of a common myth is that women who publically display their sexuality are judged negatively by society. This causes many women to feel oppressed and restricted, as they are unable to express themselves fully.

What have we done?

Since myths and beliefs about sexuality exist across the world, each culture and country have unique perspectives on this topic. For this reason, it is important to know and understand the myths and beliefs in our geographic regions, so that we can slowly start educating other people about them.

We can make a big difference in our world through education, in the hope of changing inaccurate or false perspectives.

How have we initiated this endeavor? Firstly, we have gathered information about common misconceptions on sexuality within our own countries. Secondly, by utilizing health campaigns, conferences, booklets, and other initiatives, we have provided basic yet accurate information about sexuality to our communities.

Working together as a team, we have already accomplished many of our objectives through this SCORA project. Not only is it important for community health, but it also demonstrates teamwork and individual personal development in medicine. A huge thank-you goes to all volunteers of “Without Locks in Your Hands”!
The Role of Family Planning in Achieving the Millennium Development Goals

Khalid Hussein Khalid

Dear medical students worldwide,

Family planning is an effective method to help in the achievement of the 8 Millennium Development Goals (MDGs). I would like to provide evidence from the literature as to why family planning is crucial to achieving these:

MDG 1: Eradicate extreme poverty and hunger

“Family planning has been shown to generate wealth. For example, the per capita Gross National Product is correlated with the prevalence of modern contraceptive methods [1]. Moreover, family planning also reduces the aggregate demand for increasingly scarce food products. In 1997, 775 million people were categorized as undernourished, and the world grain stocks were 108 days. By 2017, an estimated 1.2 billion people will be undernourished, and the world grain stocks are projected to run out” [2].

MDG 2: Achieve universal primary education

“Family planning prolongs education. Unintended pregnancy is a major obstacle to school attendance, since many youth drop out of school once pregnancies occur. Less than half of all African girls complete primary school [3]. And in developing countries such as Malawi and Bangladesh, approximately 50% of female citizens who are 18 years of age or younger have children or are currently pregnant”[3].

MDG 3: Promote gender equality and empower women

“Family planning empowers women. Unplanned pregnancies interfere with work and career plans. In countries such as Egypt, Brazil and Indonesia, women who use contraception are more likely to be employed than nonusers [1]. The book, ‘Half the Sky’ by Nicholas Kristof and Sheryl WuDunn, reveals that the act of empowering women, including their ability to achieve desired family size, is the most important driver of modern developmental efforts” [4].

MDG 4: Reduce child mortality

“Family planning saves infant lives. Spacing planned births and limiting unintended births increases child survival [5]. Globally, 1.2 million infant deaths are averted each year by preventing unintended pregnancies [6]. Another 640,000 newborn deaths would be prevented if we could meet unmet contraceptive needs” [6].

MDG 5: Improve maternal health

“Family planning improves maternal health. Unintended pregnancy affects a woman’s health in several ways: if she seeks to terminate that pregnancy, the risks of unsafe abortion are among the main causes of maternal death in young women. If she wishes to continue the pregnancy, in low-resource settings without safe delivery services, the risks of maternal mortality are high. By preventing unintended pregnancy, wider family planning access reduces the risk of abortion or childbearing”[7].

MDG 6: Combat HIV/AIDS

“Family planning prevents HIV [8]. Contraception is the best kept secret in HIV prevention. Women with HIV who have unintended pregnancies run the

Khalid Hussein Khalid is a fifth-year medical student at the National Ribat University. He has worked as the Projects Director of MedSIN-Sudan.
risk of transmitting the virus to their child. Preventing pregnancies among HIV positive women who do not wish to become pregnant reduces HIV-positive births and the number of children needing HIV treatment, care and support [9, 10]. Three times as many infants are spared HIV infection by current contraceptive use compared to providing antiretroviral treatment to mothers during pregnancy, birth and breastfeeding [11].

MDG 7: Ensure environmental sustainability

“Family planning protects the environment [12]. Environmental degradation is fuelled by 1) per capita consumption, 2) the technology used to produce what is consumed, and 3) population growth. Preventing unintended pregnancy is the factor in population growth most amenable to intervention. Many women want fewer children, and 217 million have unmet needs for contraception [16]. Moreover, family planning is environmentally cost efficient. Family planning is five times cheaper than conventional green technologies for reducing CO2 climate change” [11].

MDG 8: Global partnership for development

“Family planning promotes global partnerships. Four decades of global investment in family planning programs has contributed to strong collaboration among international agencies, governmental ministries and local community groups. The current move towards strengthening health services has been founded on linkages between family planning and HIV services” [12].

References
Mandala means “circle” in Sanskrit. These concentric diagrams have spiritual significance in Buddhism and Hinduism. They can be used for establishing sacred space and as an aid in meditation.

May this non-traditional love mandala by Nikki Parmenter bring you all the love in the world. Thank you for the wonderful work that you do and the amazing person that you are.
In this section you are going to meet SCOPHeroes who save the day through their Orange Activities. Enjoy learning about various public health initiatives such as the Donate Life Campaign on organ donation; health screening programs in Romania; and SCOPH exchanges. Whatever your interests, you are sure to find something that captivates you in "The SCOPHian".

“Standing Committee on Public Health”
Dear SCOPHi ans,

It has already been 10 months since the 2012-2013 IFMSA term started. So many things have happened during this time in SCOPH, and at this stage of the year, it is safe to say that our SCOPH Family has truly spread its Orange Spirit all over the world.

The beginning is always hard, but just a couple of weeks into our term, active participation by SCOPHi ans worldwide was already tangible: mailboxes started to fill up; social media pages came to life; events were planned; and discussions ran rife. Throughout the year, we celebrated more than 15 International Health Days, ran several public health campaigns, managed different kinds of projects and trainings, published interesting articles and, of course, submitted detailed reports.

Our SCOPH capacity building and training sessions began in earnest with a number of international meetings, commencing in December with the African Regional Meeting in Arusha, Tanzania. In March, IFMSA’s 62nd General Assembly took place in the United States - and I am happy to say that more than 150 participants actively participated in the SCOPH sessions there! In April the European Regional Meeting took place in Italy where delegates were once again educated about public health issues worldwide. But things don’t stop there, as we still have our August General Assembly and Asia-Pacific Regional Meeting to go!

This year SCOPH has also been outstanding in terms of its external representation efforts. Members of the Dream Team as well as active SCOPHi ans from all five IFMSA regions have attended numerous prominent conferences such as the World Health Assembly and the World Health Summit. They not only gained new knowledge on global health issues, but also contributed to the collective youth voice in defending public health around the world.

As we embark on the home straight, I wanted to take the chance to wish you an excellent August Meeting filled with joy and lots of Orange Energy for your future work. Health has always been the greatest treasure in the world, and so it will always be. It really is a privilege to have the opportunity to act for such a cause; what we do is truly more meaningful than many of us might think possible.

With Orange Inspiration,

Kitti Horváth

SCOPH Director, 2012-2013
Together for Rural Health

Haider Mohammed Naser

Of a total population of approximately 21.5 million people in Romania, 55% live in urban areas and 45% in rural areas [1]. A problem for many of those living in rural settings is that they do not have access to basic health services. Indeed, a report from the Romanian National Health Insurance Fund indicates that there is around one medical center for every four rural villages [2].

This issue can be attributed to a number of reasons, but amongst the most common of these is the fact that health practitioners perceive there to be a lack of profitability in working in the country. In other words, doctors believe that they cannot earn enough to sustain a living there.

“Together for Rural Health” is a local project that was started in April 2011 by healthcare professionals. It has the active involvement and support of medical institutions as well as medical students, interns and specialists; and aims to lend a helping hand to the Romanian healthcare system by providing rural clinics with locum doctors and medical student volunteers.

The main objectives of “Together for Health” are:
- To provide primary health services in disadvantaged rural areas;
- To contribute to the medical education of students by involving them in practical activities;
- To raise awareness of rural health in the state institutions responsible for health issues;
- To enhance the doctor-patient relationship and to empower health professionals through a volunteering initiative.

In order to expand the outreach of our project, we need to continuously identify geographic areas which are deficient in primary care resources. Such areas are defined as having no or only one medical practitioner, and lacking the facilities to conduct basic medical investigations such as routine bloods and radiological imaging. Once this is done, we can move on to carrying out the objectives of our project.

Each month, we organize for the project to take place over a weekend that is mutually agreed upon between the medical volunteers and the local project partners. Our team consists of final-year medical students, interns and specialists in a variety of medical disciplines including cardiology, dermatology, gastroenterology, gynecology, ophthalmology, pediatrics and general medicine.

Over the course of the weekend our team sees approximately 80 patients on average. Each patient is given a thorough work-up which includes: a full-history; relevant physical examinations (including measurements of basic parameters such as height, weight, BMI, and abdominal circumference); and laboratory testing (for example blood cholesterol, glucose and hemoglobin levels). At the end of the process, each patient receives a letter explaining any pertinent findings and advising him or her on how to maintain good health.

“Together for Rural Health” has been a successful project in Romania and as such, we have tried to promote it through writing scientific papers about it and presenting it at recent national and international congresses such as the International Student Congress of Medical Sciences, and the National Congress for Students and Young Doctors. At the latter event, we were fortunate enough to win second prize for our project in the “civil health society” category, and first prize for the “students and young doctors” category. In spite of these achievements, at the end of the day, the real prize is being able to make a difference in the lives of so many people who battle to access healthcare. This is what makes us truly happy.

References

Alcohol-related harm and our role as young public health leaders

Petar Velikov

Alcohol and public health
The harmful use of alcohol has serious consequences for public health and is considered to be one of the main risk factors for poor health globally. Alcohol abuse is also one of the four most common, modifiable and preventable risk factors for major non-communicable diseases and disability. It is estimated that 2.5 million people worldwide die of alcohol-related causes each year, including approximately 320,000 young people between the ages of 15 and 29 [1].

The hazardous use of alcohol compromises both individual and social development: heavy drinking inversely affects health and has many social consequences for the drinker, the people around the drinker and society as a whole. International research confirms that heavy and frequent drinking at a younger age can lead to a greater chance of alcohol dependence [1].

Alcohol Policy Youth Network
For the past couple of months I have had the chance to work with one of IFMSA’s external partners acting to reduce alcohol-related harm – the Alcohol Policy Youth Network (APYN). The aim of this organization is to train young people to become change makers in health-related attitudes and behaviors among youths. Among its goals are: to exchange best practices on youth work on alcohol; to empower youth organizations to become advocates of effective alcohol policies; and to promote research projects related to alcohol use.

Although APYN is currently only working on a European level, it has full potential to become a leading worldwide network in establishing effective policies on alcohol use amongst youths [2]. After being granted funds from the Youth in Action program, APYN will soon be conducting training programs for medical students, so stay tuned!

IFMSA and actions on alcohol-related harm
It is important to emphasize the fact that two years ago, during IFMSA’s 60th General Assembly in Copenhagen, NMOs adopted the “Policy statement on the hazardous and harmful use of alcohol” whereby IFMSA commits to reducing the abuse of alcohol at both the local and national levels. We, as future health professionals, have a responsibility to promote healthy lifestyles, intervening amongst school and university students with regards to primary prevention for those who have not yet started using alcohol, and to secondary prevention for those who already abuse alcohol [3].

With this article I send a call for action for all medical students to start working actively on reducing harm related to alcohol. We young people are often simply depicted as a social group that abuses alcohol rather than as individuals that are capable of making conscious choices. It is very important to realize that youths, and medical students in particular, have the potential to contribute towards addressing alcohol-related issues and influencing the policy-making process. We, as future public health leaders, need to take an active role and “become the change that we want to see in the world”!

References
Here in sunny Malta, another SCOPH term jam-packed with events has come and gone. Our main focus this past term was to tackle the main health problem in Malta: obesity and its related disorders.

Malta is frequently thrust forward into the spotlight for its notoriously high prevalence of obesity. Despite its tiny population of 410,000 people, Malta has one of the highest proportions of overweight or obese adults aged 18 and over in the world [1]. The latest data from the European Health Interview Survey (EHIS) reveals that Malta has the highest percentage of obese men in the 19 participating EU countries (24.7%) and the second-highest percentage of obese women (21.1%) after the United Kingdom (23.9%) [1]. As can be seen from these statistics, obesity is a huge problem, and one that is estimated to cost the country around €78 million per year [2].

Obesity is known to be a risk factor for several diseases, mainly type 2 diabetes, ischaemic heart disease and cerebrovascular disease. Malta is once again at the forefront of these diseases – to put things in perspective, recent studies show that the general Maltese population is at risk of diabetes just by simply being of Maltese descent [1]. If we add our growing rates of obesity to the equation, we are heading for a catastrophe.

Thus, the MMSA was full steam ahead this year tackling projects relating to obesity and its comorbidities in order to ensure that we deliver our message to the public and target as many age groups as possible. Amongst our events were the annual World Heart Day and World Diabetes Day celebrations. For the latter event alone, over 150 medical students participated in a week-long initiative which included blood pressure checks, blood glucose and BMI monitoring, diabetes education sessions, and a flashmob (which can be viewed at: http://www.youtube.com/watch?v=1DJeihjCoWY).

Furthermore, our newly-launched Healthy Lifestyles campaign included an “Eating Disorders Fashion Show” and the MMSA Sports Day. The fashion show was a step away from our traditional outreach program, and saw medical students walking down specially-laid red carpets carrying motivational messages and snippets of information about the dangers of eating disorders. Our Sports Day, on the other hand, was part of an ongoing initiative to get medical students and the public more active. It was split over three days and included football tournaments, tug-of-war competitions, relay races, hip-hop classes and zumba sessions.

These events, coupled with our usual barrage of peer-education sessions for schoolchildren, are all intended to offer a new way to exercise, eat healthily, and have fun at the same time. We would be glad to share more information with you. Please feel free to contact us at the e-mail address provided above.

Matthew Baldacchino

Putting “healthy” into action

References
The Donate Life Campaign: a multi-disciplinary awareness campaign on organ donation

Skander Essafi

“Because we are aware of the real situation of organ donation in Tunisia, and because we aim to be responsible and useful to our country, we, the medical students of Tunisia, would like to suggest that a social advocacy campaign is carried out in order to promote organ donation. We will try our best to discover new approaches to raising awareness about organ donation.”

This is how Tunisian medical students initiated their project, the “Donate Life Campaign” in November 2012. The campaign has come a long way since then, with many achievements and some great ideas for the future.

Let’s learn about organ donation!
Our project started with a four-day training workshop for 40 SCOPHians from around Tunisia who were all keen to volunteer. The aim was to have a dedicated group of peer-educators to promote the concept of organ donation to members of the public, especially to university students aged between 18 and 30. In order to help achieve this we had lectures clarifying the main aspects of organ donation in Tunisia, specifically from scientific, legal and ethical points of view; and highlighting the progress that has been made recently. Peer trainings were also conducted on communication skills and advocacy for organ donation. Our campaign is currently receiving a lot of support from the National Center for Organ Transplantation, NGOs, medical faculties and professors.

Let’s talk about organ donation!
Since starting, we have reached approximately 150 students at six non-medical universities through both surveys and workshops. During the initial stages, people were undecided, but after filling in the survey and attending the workshop they learnt more about organ donation and most came to view it as a noble action to take.

In the course of events many questions were raised about religious and ethical issues surrounding organ donation. In particular, people wanted to know what the passages of the Quran had to say about the topic; and what the status of organ trafficking was in Tunisia. We didn’t always have the answers to some of these questions so we plan to develop more comprehensive trainings in order to prepare our peer-educators as best as possible.

At the end of February we had the opportunity to carry out a road show that visited all of the medical faculties in Tunisia. We talked about the promotion of organ donation and transplantation around the world, and had a lively discussion assessing the current situation in Tunisia. We were lucky to have support from a number of transplant surgeons as well as Mr André Le Tutour, the president of “TRANSHEPAT” (an association based in France which specializes in liver donations), who gave of their time to talk to the students. All in all more than 200 medical students attended the road show!

What’s next?
We are planning to have more local workshops soon. We are also trying to improve our peer-educators’ skills in order to spread awareness and make our work more relevant. We have exciting things planned, so watch this space for more updates!

Skander is a third-year medical student and the Local Public Health Officer for his local committee in Sousse, Tunisia. He may be contacted at: skander.es@gmail.com

www.ifmsa.org
{ MSI28 }
Tuberculosis (TB) is considered a socioeconomic disease, linked closely to overcrowding and malnutrition. However, being an infectious disease, it does not discriminate and can infect anyone. TB has been around for a long time, as evidenced by remnants of Mycobacterium tuberculosis bacteria isolated from the lungs of ancient Egyptian mummies. Indeed, modern medicine has known about this disease for many years – its treatment has been around for at least half a century. Despite this, the world in the 21st century still bears the burden of TB.

Amongst the European countries, Romania has one of the highest incidences of TB [1]. In 2012, the city of Iasi - one of the largest in Romania - recorded the most pediatric TB cases nationwide [2]. As a result of this, we felt there was a need to raise awareness of TB through a campaign targeting children and adolescents attending middle-schools and high-schools in Iasi and its outskirts.

Visiting classrooms, school libraries and public halls, we used various means to disseminate information to the students, including lectures, PowerPoint presentations and videos. We sometimes even drew pictures on blackboards to ensure the children thoroughly understood what was being presented. At the end of each educational session, we handed out leaflets to the children and stuck up posters throughout their schools and nearby shopping malls.

The topics that we addressed included: the causative agent of TB; the main symptoms of infection; risk factors (including means of contracting TB); the difference between being infected with the bacterium and having the disease (and whether infection guarantees immunity); complications of TB; treatment options; and prevention methods (including the BCG vaccination). We paid particular attention to highlighting the importance of being compliant to the treatment and attending follow-up appointments even after clinical symptoms have dissipated.

The children were extremely receptive of the information we provided and very inquisitive. Some of the great questions posed by the children were: What is the multiplication rate of Koch’s bacillus? Can a pregnant woman suffering from TB pass on the disease to her unborn child? Can a person with tuberculosis still donate his organs after he dies? Is it possible to get TB through a kiss?

Some say tuberculosis is the first disease known to mankind, while others say it existed far before mankind. Regardless, there is certainly no room for complacency when it comes to TB! Through educating the general population from an early age we can diminish both the incidence and prevalence of the disease. Therefore, thinking big and acting smart is our local way of contributing towards a world without tuberculosis!

References
SCOPH members at the University of the Philippines recognize migration as a phenomenon that has recently grown rampant and pervaded nearly all countries of the world. As transport and communication become more efficient, and as technology advances further, migration has become accessible to more people.

Nowadays, many have the freedom to choose where they want to live and work. It is not surprising therefore, that a large proportion takes up residence in countries that are economically stable and that have high standards of living. Doctors are amongst these emigrants and, because medical students are prospective migrants, we have created a small working group (SWG) to help gather their opinions on this pertinent issue.

During the SCOPH sessions at the 2013 March Meeting in Baltimore, USA, members of our SWG presented the situation relating to the migration of the health workforce in our respective countries. Each country was categorised as either receiving immigrants, sending out emigrants, or both. We then discussed possible factors that may lead to the migration of health professionals.

What we realised was that some of the factors at play only apply to certain countries. Due to a lack of representation from other national member organisations, we decided to conduct an online survey using the Google Forms program in order to reach other medical students around the world.

By carrying out the survey, we hope to attest the various hypotheses we synthesised during the March Meeting as well as attain new information and perspectives on the subject. The final product of the SWG will be a report which will contain a compilation and analysis of the data collected, and from which we will draw conclusions on the factors at play behind this global phenomenon.

If you would like to take part in this survey, please e-mail me at: josephpaguio@gmail.com
In the March 2013 edition of the MSI, there was a call for a small working group (SWG) to commence work on issues concerning the SCOPH Exchange Program. Students from all over the globe applied to be part of the SWG which now consists of members from Algeria, Australia, Catalonia, Denmark, Germany, Ghana, Kenya, Lebanon, Portugal and the Philippines.

The purpose of the SCOPH Exchange Program is to provide medical students with the opportunity of gaining experience in the different fields of public health through exchanges in other countries. The idea behind the SCOPH exchange is very noble and the concept offers a lot of opportunities and possibilities. However, many SCOPHians are still not aware of its existence, and this is where the SCOPH Exchange SWG comes in.

The aims of the SWG are: to promote the program to national member organisations (NMOs) so that more of them take part in SCOPH exchanges; to determine how to make the SCOPH Exchange Program more sustainable, both for the host community and for medical students; and to learn ways in which host NMOs can be further supported during the program.

At the 10th European Regional Meeting in April 2013, there was a SCOPH Exchange session and training. Both were very interesting and useful in terms of contributing input to the SWG. The following conclusions were reached: 1) commencing in December 2013, the SCOPE and SCORE database will be employed by the SCOPH Exchange Program; and 2) National Exchange Officers (NEOs) of various countries will be contacted to ask for their assistance in organising SCOPH exchanges.

These changes will help NMOs that host exchange projects to make decisions on various topics such as: how many international participants to receive; what criteria should be used to judge applicants on; and whether to sign several contracts with just one country, or the same contract with multiple countries. With regards to incoming students, NEOs have much experience in organising exchanges (including finding accommodation). Through collaborating with them, our SCOPH exchange students will be able to enjoy the same social programs as their SCOPE or SCORE peers.

So now that we have decided on the ground rules, we have to find more NMOs willing to work with us on the pilot scheme in sending and/or receiving exchange students. Before an NMO can apply to be a host, they have to send in a project proposal that will be reviewed by the SWG.

The project proposal should contain information on the following:
• Amount of SCOPE or SCORE experience in receiving students from abroad
• Willingness to commit to an exchange program duration of 4 weeks
• Accommodation and food costs
• Ability for the SCOPH exchange project to offer significant insight into issues concerning the social determinants of health of that country

NMOs willing to send and/or receive exchange students are encouraged to contact us at the following e-mail address: ra.scoph.europe@gmail.com. Thank you very much for reading and we look forward to receiving your questions, comments, and project proposals! Orange hugs!
Daniela is a fourth-year medical student at the Jessenius Faculty of Medicine at Comenius University in Slovakia. She may be contacted at: daniela.fedakova@mkmedic.eu

In our country there are many initiatives that support other social groups such as children, adolescents and the poor, but there are hardly any for the elderly. This is despite the fact that there is a trend towards an ageing population. About a year ago, a small group of Slovakian medical students thought of devoting some of our precious time to the care of the elderly in order to try and enrich their lives. And so we created a project called “Young at Heart” and began visiting them in local retirement homes.

So far we have paired up medical students with senior citizens in order for them to carry out mutually beneficial visits. During these encounters memory exercises (such as the “pairs” game) are utilised to help improve cognitive function in the elderly; hand-made crafts are made; and stimulating conversations are held, amongst many other things. We have also established a number of small working groups (SWGs) which come together to co-ordinate interactive activities for the elderly. Some of these activities include a “music therapy” session where well-known “oldies” songs are sung and musical instruments played; as well as a dance class where various forms of the art are taught.

There are countless benefits of this project and we are hoping for it to grow by initiating something similar in our local hospitals next year. For us, the medical students, interacting with and assisting the elderly gives us a sense of well-being and prepares us for our future interactions with patients as we learn how to relate to people from outside our generation. For the elderly (who suffer not just from illnesses associated with old age but also from loneliness), this project gives them companionship and brightens up their days. Needless to say, this is an act of kindness that benefits all parties involved. So let’s do it together all over the world!
“Nothing you do for children is ever wasted” - Garrison Keiller

He was right. Whenever you want to change a particular behavior or attitude in society, start with children.

With this in mind, the SCOPH team of the University of Tanta, together with Nestlé and the Ministry of Health, was enthusiastic to reach as many primary and secondary students as possible through a project which aimed to improve their daily nutrition habits and lifestyles.

In order to implement the project, a training event was organized by Nestlé to equip medical students with skills and knowledge on good nutrition as well as practical tips on how to manage a class of young children.

After undergoing training, each SCOPHian was allocated a school to visit. He or she was required to make seven half-hour visits to the school, with each visit focusing on teaching a different topic to the children. Topics included (but were not limited to): what constitutes a balanced diet; what to look out for in food labels; the calorific intake of various types of food; adequate hydration; and what specific types of food are beneficial for certain ailments.

Towards the end of the sessions, children carried out fun activities to consolidate the information learnt; were provided with the opportunity to ask questions; and were given lovely colorful books on the different types of healthy foods. These books were a surprise hit - they really managed to capture the children’s attention.

Altogether, we were able to conduct outreach visits to 24 schools; and approximately 9600 students were educated. By the end of the project many of the students’ attitudes towards healthy foods had changed for the better. In some cases so much so that children reported talking with their parents about changing the family diet.

This project was a success thanks mainly to the mutual co-operation between the whole SCOPH team and Nestlé. There is a saying that “children are the living messages we send to a time we will not see” - we certainly hope that we will send good messages through this campaign.
Manon Pigeolet and Petar Velikov

From the 17th to the 21st of April this year, European medical students gathered in the small coastal town of Montesilvano in Italy. As you can probably guess, we were there for the 10th European Regional Meeting (EuRegMe).

The meeting kicked off with an open mic evening which was enceed by IFMSA Publications Director, Bronwyn Jones. The first speaker of the night was SCOPHian, Frederik Martiny, who informed us about IMCC-Denmark’s project, First Aid For All. After a great start to the meeting with this awesome session, we had a marvellous, three-course opening dinner.

The first day of the SCOPH sessions started with a fun-filled energiser incorporating knowledge of antibiotics and antivirals, and which was invented by the ingenious Manon and Petar. After the energiser, our focus was centered around delivering basic information about IFMSA and SCOPH to participants as many of them were brand new members. We also covered topics that were included in our SCOPH session “expected outcome document”, such as mental health, advocacy for medical students, and peer education.

In our opinions, the SCOPH sessions on the second day were the most useful and interesting of the EuRegMe. We planned four advanced trainings on advocacy, project management, peer education, and the SCOPH Exchange project, to take place concurrently. They were delivered by amazing trainers with much experience in different areas of public health. Later on that day there was a short session on SCOPH management on the beach, followed by small working group (SWG) sessions on a variety of public health issues.

By the last day, we had accumulated a severe sleep debt and so things started rather slowly. Some of our sub-sessions did not go as planned but nonetheless, we were able to finish in typical SCOPH style with interactive presentations on local and national SCOPH activities in different national member organisations (NMOs), as well as lively discussions on outcomes of the SWGs from the previous afternoon. Since a large part of the SCOPH sessions focussed on the issue of mental health we had Matthew Valentino from SCORP deliver a closing session on this very important topic.

In concluding we would like to say that we were very happy to facilitate these three amazing days. Even though some of the events did not go as planned, we still believe that new public health leaders have been born as a result of the sessions. We look forward to seeing you all in Chile where we shall be SCOPHin’ once again!
“The SCORPion” will take you into the world of Human Rights and Peace where you will find out about the numerous activities that everyday SCORPions conduct on a daily basis. Read about the Write for Rights campaign, disaster relief efforts in Japan, patients’ rights, and more; it’s all here in this green edition from SCORP!
Fares K. Al-Fares

Dear Readers,

It is with great pleasure I present to you the SCORP publication of the MSI. This was created thanks to the creative writers within SCORP, our amazing SCORP editorial team, and of course the Publications division of the IFMSA.

The Standing Committee on Human Rights and Peace (SCORP) is a very diverse committee within the IFMSA. Focusing on a wide scope of issues, including education, healthcare, refugees, violence, mental well-being, and countless other topics; SCORP is where IFMSA members carry out activities that are humanitarian, and that often go beyond the “limits” of medicine. Originally designed with refugees in mind, SCORP has transformed to be able to tackle almost any humanitarian issue in the world, based upon the desires of its members. Whether traveling around schools to speak about education and give books to those who are unable to afford them; or fundraising for refugees and victims of conflict, the projects that have arisen as a result of SCORP are simply astonishing.

It fills me with great pride to see the fantastic efforts of our members, who all work towards a common goal: the protection of rights and the upholding of peace. Their efforts can be seen in the ideas that are shared, and the projects discussed, in this publication. The articles that follow represent work that is merely the tip of the massive iceberg that is SCORP. Truly, it is the noble hearts of our members, and their compassion towards their fellow men, that make SCORP great.

Thus dear readers, I hope you are touched in the same way I am by these stories and articles, and appreciate the great work of this committee’s inspired members. As the great philosopher RJ Muste once said “There is no way to peace, peace is the way”.

Best Wishes,
Fares K. Al-Fares
Imagine you’re a lawyer protecting human rights. For your actions (called “sedition” by the government), you’re sentenced to 3 years of imprisonment and 5 years of probation. Fortunately, the government agrees to change your prison sentence to a house arrest.

After your court hearing you are tortured. Your family has to leave the country because of constant threats and persecution. You too manage to escape, disappearing for a year and then coming back to tell the media about your near-death experiences at the hands of the government. Your return -of course- wasn’t missed by those in power. You disappear again, and after 20 months the government manages to re-capture and imprison you for breaking the rules of probation. You don’t know what is next and you’re not even allowed to see your family.

Then, thousands of people from all around the world who don’t even know you, write letters to your president, to your government, calling to release you, claiming your imprisonment is unlawful. This doesn’t make any big changes - but it’s the small steps that count. You’re now allowed to see your family, maybe there’s hope for more?

This is the true story of one of countless numbers of people profiled through Amnesty International’s “Write for Rights” campaign.

“Write for Rights” was started a few years ago on Human Rights Day when representatives from the Polish branch of Amnesty International (AI) gathered in a number of cities in Poland to write letters to the governments of 10 people whose human rights had been violated. For 24 hours, the activists wrote letters asking for the basic respect of human rights. They also wrote letters of support to the victims. After the action was taken came the first of many successes: people were set free, some were trialed fairly, and others were allowed to see their families or doctors. The campaign was so successful that it has continued ever since, with more and more cities, countries and people joining in.

This is also how SCORPions from IFMSA-Poland got involved. We decided to raise awareness of human rights and work towards protecting them by organizing events in our universities and student unions, giving med students the chance to find out about “Write for Rights”. This campaign was actually my first activity with IFMSA-Poland; it is also one of the most well-known campaigns in my city.

In the beginning, I was very skeptical about it. What kind of president would bother reading my letter? How can my few words force the Chinese or American government to rethink their decisions?

But what if it really works? If, together with thousands of people from all over the world, I can show governments that their actions are scrutinized by ordinary people; that they can’t just do whatever they want? What if, with just a few words of support, I can keep someone on the other side of the globe going? What about you? What do you think? Find out about “Write for Rights” in your country and join in the action! http://www.amnesty.org/campaigns/individuals-at-risk

Izabela Jalowiecka

Izabela is a fourth-year medical student at Uniwersytet Jagiellonski Collegium Medicum in Krakow. She is the National Officer of Human Rights and Peace (NORP) at IFMSA-Poland, and can be contacted at: norp@ifmsa.pl
Physicians and patients’ rights

Joan Rodríguez Jiménez

As human beings, we have rights that protect us. They must be upheld and respected in order to maintain a good quality of life. The unfortunate thing is that many people do not know what their rights are. So if we do not know about our rights, how can we defend them?

As a medical student, I am deeply concerned that people are not oriented with respect to their rights, especially those that relate to healthcare. The Universal Declaration of Human Rights, formalized in 1948, recognizes the “inherent dignity” and the “equal and unalienable rights” of humankind[1]. It is on the basis of this concept of the person that the notion of patient rights was developed[1].

Patients should be able to entrust physicians with their lives and well-being. To justify that trust, we have a duty to maintain both a high standard of medical practice and respect for their rights. Patient rights vary in different countries, but there is a general statement created by the General Medical Council, that has been adopted by the large majority of healthcare professionals to use as a guide on how to uphold respect for patients and their rights[2].

The General Medical Council establishes that, as doctors, we should:
1) make patient care our first priority
2) provide a good standard of practice and care
3) take prompt action if patient safety, dignity or comfort has been compromised
4) treat patients as individuals and respect their dignity
5) treat patients politely and considerately
6) respect patients’ right to confidentiality
7) respect patients’ right to make treatment decisions with our recommendations[1].

In addition, we should be honest and open and act with integrity; patients should never be treated unfairly.

Since our passion is improving health and saving lives, we must act with love and respect. It is our responsibility to ensure the welfare of our patients as we respect their rights, and bring dignified treatment. We should not forget that we can truly make a difference in the lives of our patients. After all, being a doctor requires patience, dedication and a love of our neighbors in its purest form.

References

Disasters do not end overnight: A report from the ACTION Project

Mariko Kondo

Apart from the tour, we held a workshop in which the hospital staff gave examples of vulnerable groups that may need special attention during disaster relief. Then, together with the participants, we discussed what kinds of problems are arising now, along with what is being, and what could potentially be, done.

As an example, my theme was the elderly. Japan is an ageing society, and it is said that more than 30% of the survivors in this disaster were aged 65 or older. Many of them were at daycare centers at the time of the tsunamis, and, while they survived, their families and houses were washed away.

Currently, elderly survivors are suffering because they do not have the money or energy to find new places to live. After the Kobe earthquake in 1995, many aged survivors committed suicide because they were either unable to adapt to their new environments, or felt that they were a burden. The incidents in Kobe were nothing but tragedy, and should never be repeated. Because resources are scarce and full aid by the government is difficult, ACTION volunteers and younger survivors are working to create connections with aged neighbors to help them feel comfortable and appreciated. This is a lot of work, but I feel that a warm community is being created within Ishinomaki. The city is far from full recovery, but changes are surely being made.

Disaster relief is never perfect, and every situation is a lesson learned. ACTION will continue to learn, experience, and take action in spreading these lessons throughout the world.

The ACTION (Asia Collaborative Training on Infectious Disease, Outbreak, Natural Disaster, and Refugee Management) Project is the only transnational project in the Asia-Pacific region. We work to promote the importance of proper disaster preparation and response by developing future leaders of such fields. As the transnational, as well as the national, coordinator of the ACTION Project, and before anything, as a Japanese medical student, I would like to emphasize that disaster relief is not a simple, overnight task.

Our project may be famous for its annual international summer camp, but we also put effort into local follow-up activities in various countries around Asia-Pacific. Japan is not an exception. This past February, ACTION-Japan organized a program to visit the city of Ishinomaki in Miyagi Prefecture. Ishinomaki received tremendous damage from the East Japan Earthquake tsunami on the 11th of March 2011, and approximately half the city got washed away. Many of those who lost their homes still live in temporary housing, and many others have yet to find a place to settle.

During one of our two-day programs, 15 students from around the nation were able to capture a glimpse of what was going on in Ishinomaki two years after the disaster. We spoke to a doctor and a nurse working at a temporary housing district. We visited a hospital that supported almost all of the acute response to the tsunami in the city. We visited a site where there used to be an elementary school. We spoke to volunteers and citizens that are striving every day for a bright future.

Mariko is a fourth-year student at Keio University’s School of Medicine in Tokyo. She may be contacted at: mkondo417@gmail.com
The time is now: our SCORP revolution

Christian Huertas Pagán

As a second-year medical student in the Dominican Republic (DR), I realized that my “real” journey began this year, when I became an ODEM member and one of the SCORP Local Co-ordinators.

In SCORP we learn about the accomplishments of people working in the field of human rights and peace who demonstrate a good work ethic, passion and perseverance; and we recognize that we can be just as successful through applying these same principles. We also realize that we can have a positive impact on other people by motivating them to keep trying harder for good causes.

We not only want to reach out to those who have access to the educational system (and thus to a better lifestyle) – we also want to reach out to each and every child, adolescent and adult in the DR. If our citizens hear about and take part in our SCORP activities, little by little, we will be making small, positive changes in our communities.

In 2013 so far, our SCORP teams have organized several activities that have promoted health awareness on various human rights topics using university campaigns and social media. The activities have been focused on topics such as “Defending the right to cancer treatment in pediatrics”, “The right to know your numbers (blood pressure) in marginalized communities”, and “Say no to racial discrimination”.

In the latter initiative, ODEM members from three universities promoted the fight to eliminate racial discrimination by painting participants’ fingernails in yellow, black and white colors. This is an example of how implementing creative health activities can positively impact the dissemination of health messages to community members.

Despite our steps forward in a number of significant areas, we still need to work on another major topic of concern – how to advocate for, and assist, those DR citizens in marginalized communities of extreme poverty. In time, and by working together, we believe that all our goals will be achieved and that we can create a place where peace is truly our number one priority!

I would like to acknowledge the mentorship from Dr Helena Chapman (National Advisor), Hane King (National Officer on Human Rights and Peace) and Joan Rodriguez, whose support and advice have made the journey a wonderful learning experience! Green Hugs!
Poverty and access to antihypertensive medication in the Dominican Republic

Hane King Montes de Oca

According to the 2010 Ministry of Health report from the Department of Epidemiology, hypertension is considered one of the five main causes of disease mortality in the Dominican Republic (DR) [1, 2]. In recent times the DR National Health Service has been restructured, creating assistance plans, including health insurance subsidized by the government (SENASA) for those who can afford it. Those persons with chronic hypertension fortunate to belong to such health insurance schemes have had the costs of their anti-hypertensive medications reimbursed.

However, what about the uninsured individuals or families with limited economic resources? How can they obtain such critical medications for their chronic disease management? In 2012, the SENASA Health Risk Manager estimated that they had 2.3 million members, with a goal to meet a total of 3.4 million members by the end of that year. SENASA also aimed to extend health coverage to all persons who lived in poverty [3] (estimated to be approximately 3.2 million people in 2009 by one United Nations study [3]). So far these objectives have not been achieved.

The Millennium Development Goals Monitoring Report of 2010 has indicated that, “The poverty gap increases quickly in times of crisis and diminishes growth efforts during recovery”. During this time of crisis in the DR, poverty has increased substantially and the reality is that populations living in extreme poverty remain outside the health system, unable to afford basic antihypertensive medications recommended by the World Health Organization [4]. It is unfortunate that there is no current national program for the control of hypertension, including a specific disease budget, because prevention would ultimately cost less than management.

Since we know that a few individuals can really make a difference, as medical students, we should take the lead and organize campaigns that reach the government sectors in order to promote changes in national policy. Through these community efforts, we can raise awareness amongst political and health leaders on health disparities for vulnerable populations that have limited access to essential antihypertensive medications, amongst many others.

Medical students collaborate to educate community citizens about the importance of regular blood pressure measurements and medical consults in the Dominican Republic.

References


65 years of mental, emotional and physical colonization: Palestine’s story

Yamen Jabr

May 2013 marked 65 years since the fateful Nakba Day. During this month we looked back at the ongoing struggles that Palestinians have faced over the years on their homeland. For them, that day is one of annual commemoration of the hundreds of thousands of Palestinians who were ethnically cleansed or were driven from their homes during the fierce fighting that took place in 1948, in an effort to regain their land, and above all else, their rights. The dispute over the fate of those Palestinians and their descendants, now numbering several million people, remains at the core of the Palestinian-Israeli conflict in the Middle East.

Every May 15th, rallies are held to commemorate the anniversary of Nakba Day. Tens of thousands gather to march in the streets and in some parts of the West Bank, chanting for their voices to be heard and their rights returned, all while facing immense opposition from the oppression’s security forces [1].

Some of the problems faced by the Palestinians in and around Israeli settlements include the compulsory evacuation from, or destruction of, their houses. According to the United Nations Office for the Coordination of Humanitarian Affairs, out of the 60,000 Palestinians who live in the Jordan Valley, “some 3,400 reside partially or fully in closed military zones and face a high risk of forced eviction”. During the month of January alone, the oppression’s forces evicted around 500 Palestinians from their homes in the occupied West Bank [2]. And the problems don’t stop there.

Those living in the Gaza Strip have had to face the oppression’s punitive closure of this area, including the near-total blocking of exports from Gaza. The Human Rights Watch report from November 2012 described the situation as “having severe consequences for the civilian population”, and the World Bank reported that the “severity of poverty has increased” amongst impoverished Gazans [3]. More than 70 percent of Gaza’s population currently receives humanitarian assistance [3].

With respect to Palestinian refugees, the current crisis in Syria adds a further burden to their plight. “While all civilians in Syria are bearing the brunt of the violence, the present situation of Palestinians in Syria is exceptional”, said UNRWA (United Nations Relief and Works Agency for Palestine Refugees in the Near East) Commissioner-General, Filippo Grandi, in a statement. “They are becoming two-time refugees”, he went on to say. “ Sadly, some 525,000 Palestine refugees in Syria are now suffering” [4]. According to UN figures, more than 60,000 people have perished in the conflict in Syria that erupted in March 2011 [4].

Although the aforementioned paragraphs briefly provide an idea as to how the situation facing Palestinians has increased in severity over the past few years, people in general have become increasingly aware of this issue and are endeavoring to provide the means necessary to aid the Palestinians and make sure their voices are heard. Every day is lived with the hope of achieving peace in Palestine; what was once a dream is now shaping up to become a reality for those who wish for it and truly believe in the cause of restoring rights.

References
Communities in Peace

Helena Chapman

Making history in the Dominican Republic, medical students from ODEM celebrated the International Day of Peace together for the first time. SCORP members in four different cities, including Santo Domingo, San Pedro de Macorís, La Vega and Neiba, posed in the shape of a heart and a peace sign and took inspirational photos in green shirts to share via social media. They also developed and disseminated a promotional brochure, “Give one word: Peace”, to promote optimism, collaboration and kind words in our daily interactions. Team members compiled a list of peace quotes in English and Spanish to share with the IFMSA community via social media, organizing the quotes under five subheadings: “What is the impact of a smile?”, “Together in peace!”, “The meaning of one act of kindness!”, “One heart, one body”, and “Life is an adventure!”. After all, we must remember that one of the most peace-loving people in the world, Mother Teresa of Calcutta, said that “Peace begins with a smile”.

Helena is a recent graduate of the Iberoamerican University (UNIBE) in Santo Domingo, Dominican Republic. She is the founding member and former President of IFMSA-Dominican Republic (ODEM), and may be contacted at: hjchapman@gmail.com
"Playing to Grow Up" is a joint SCORP and SCOME project that was started by Sebastián Rivadeneira in 2012. Its main objectives are to improve the skills of medical students in paediatrics; to educate children about how to safeguard their rights; and to promote social inclusion by working with children from disadvantaged backgrounds. For the past two years, we have had the chance to work with an orphanage located in Quito, the capital of Ecuador. Here, parents who do not have the means to support their children, leave them under the care of nuns.

In order to work with the children, medical students are required to undergo a training session organised by SCOME, that focusses on paediatric history-taking and physical examination skills for common case presentations such as asthma and eczema. The trainings are supervised by a paediatrician who offers tips and expertise. This year a new SCORP training about the basic rights of children was added to the program.

On selected days of the year, we hold the project’s “main event” where we start by playing with the children from the orphanage, getting to know them, and befriending them. After the ice-breaker is over we divide the participants into two groups: children from one group have their medical check-ups performed, while those from the other group discuss human rights issues facing children with medical student facilitators. The two groups switch over once their respective sessions have ended.

During the medical check-up, medical students also take the opportunity to talk to the children about basic preventative health measures such as hand hygiene, good nutrition and exercise. On the other hand, during the human rights sessions, SCORP trainers give advice to the children on what constitutes human rights and how they can protect their rights. Emphasis is also placed on the importance of primary and secondary education, and the children are encouraged to study hard to achieve their goals. To consolidate what was learnt, the children are asked to draw or act out what the phrase, “rights of the child” means to them.

This project demonstrates how different committees can work together to do something bigger and better, while considering children’s health from both a medical and social standpoint. It is a growing initiative and in the future we hope to have the support of other standing committees such as SCOPH and SCORA.

David is a second-year medical student and the Local Public Health Officer at the Pontifical Catholic University of Ecuador. He may be contacted at: scoph.puce@gmail.com
Have you ever wondered what SCORE exchanges are all about? Which countries you can go to? Or what research projects are on offer? Find out more here, in “SCOREview”, the publication that has got everyone talking about research exchange! Flip through the pages to transport yourself from a biochemistry laboratory in Taipei, to working on an epidemiology project under the Eiffel Tower. Research exchange is awaiting you!
Introduction from the SCORE Publications Assistant

Akmal Akbar

With great pleasure, I present to you our most recent SCORE publication, the 7th edition SCOREview.

In this section, you will find extraordinary stories from our SCORE members about their exchange experiences around the world, and learn about some great new NMOs to be added to your expanding list of research exchange destinations! And, as you will soon discover, there are plenty of exciting things associated with our exchange program: ground-breaking research projects, the latest technologies, and world-class researchers are awaiting you within the laboratory; and diverse cultures, magnificent sights, fun-filled activities and your soon-to-be best friends are waiting for you outside of the research environment. With SCOREview we can bring all of these experiences closer to you!

Due thanks go to all contributors of articles as well as the International Publications Team for all the time and effort invested, and for the amazing work they have done. Last but not least, thanks to the SCORE International Team as well as NOREs, LOREs, and all SCOREans worldwide for being actively involved in supporting our standing committee and making our exchanges worthwhile for everyone involved.

I hope every one of you enjoys reading this latest publication!
Taiwan, a faraway country where expectations are exceeded

Judit Kókai

Research project
Taipei was my home away from home during my month-long exchange. I was there to participate in a project entitled “The mechanisms of p21 (Waf1/Cip1) induction by histone deacetylase inhibitors in human cervical carcinoma cell lines”. Waf1 or p21 is a cyclin-dependent kinase inhibitor which promotes cell-cycle arrest; hence it has many implications for cancer development and control.

During my time in Taiwan I learned how to culture cells, extract their DNA and RNA, carry out the polymerase chain reaction (PCR) and western blot techniques, and use flow cytometry. All of this was done under the expert guidance of my tutor, Professor Shih-Ming Huang, who was very kind and helpful. The other students in the laboratory also helped me out whenever I had a problem.

City and country
Taiwan is a land full of contrasts – with ancient temples and crumbling houses co-existing with the fourth-highest skyscraper in the world and space-age shopping centres. It is also a place of great beauty – with green parks, tea plantations and black volcanic-ash beaches dotting the landscape.

Taiwanese people are friendly and warm in welcoming you to their country. As an example of how nice the people are, one of the waiters at a restaurant I dined at gave me an umbrella to take home during a heavy monsoon. It is thoughts like this that impressed me most about the people.

I enjoyed the Taiwanese cuisine, which is varied and always delicious. One of the biggest challenges I faced early on was learning how to use chopsticks, but once I overcame this hurdle I was able to eat all sorts of food with them. My favourite dish while in Taiwan was dumplings but the winner of my “strangest food prize” goes to a dish of baked frog legs and snake blood.

To describe the weather, in short, all I can say is that it is changeable. Some days are hot and sunny while others are stormy – but don’t let the unpredictable weather get to you, as a million things are waiting for you to explore both indoors and out!

Lodging
My accommodation was at a student hostel where I had my own room with an ensuite bathroom, air-conditioning and a fast internet connection. For those who like to stay fit there is a gym and swimming pool right next door.

We did not have the opportunity or facilities to cook for ourselves at the hostel, however this was not a problem as we were given meals three times a day, and there were restaurants in close proximity.

Social program
In the first few days our host students organised a welcome party for us where we took part in music and dance performances, and were taught how to make dumplings and prepare bubble tea. After this initial “ice-breaker”, all the exchange students were regularly invited out to dinners and to the night markets by the local students. A weekend trip out of town was also organised.

Our hosts and contact persons were there whenever we needed help with anything – from internet access to telephone cards to public transport tickets. Even when I got sunburnt my contact person magically appeared with a soothing cream! Taiwanese medical students are friendly, caring and perfect in organising programs. At the end of our stay each of us received a photo album filled with photographs - memories to keep for a lifetime!

Judit is a third-year medical student at the Semmelweis University in Budapest. She completed her exchange at the Taiwan National Defence Medical Centre’s Department of Biochemistry. She may be contacted at: kokaijudit1@gmail.com
Pathology research in Campobasso

Kwabena Fosu Lartey

Research project
I have always wanted to go to Italy so was very happy when I received my acceptance letter to carry out a research exchange at the University of Molise in Campobasso. The aim of my project was to determine the level of bacterial contamination of pathology samples meant for culture. We prepared agar gels, and did western blots and polymerase chain reactions in order to identify any contaminated samples.

Each day I had to be at the laboratorio by 9:30am. We were usually allowed to leave by 1pm but sometimes we had to wait until 2pm in order to finish our experiments. My supervisor, Dr Erika di Zazzo, and all of the staff were very friendly. Although we sometimes found it hard to communicate, my newly acquired Italian – English dictionary always came in handy!

Preparations, travel and arrival
I faced some problems getting all of my documents together for the visa application process but thankfully got everything done in the nick of time! And, since my accommodation was not able to provide them, I had to take along bed sheets and an internet cable.

When I arrived at the train station in Campobasso, my contact person was there to pick me up. Throughout the duration of my stay he was very friendly and nice.

Lodging
I stayed at a hostel for medical students, the Collegio Medico, which had very good facilities including a gym, kitchen, laundry room and a reliable internet connection. I had to share my room with one other exchange student which did not turn out to be an inconvenience as there was so much space. My stay at the Collegio was indeed an enjoyable one.

I was given pocket money which I mostly used to buy food from the grocery; I cooked and ate in the hostel.

Social program
There was a nice social program provided by the local officers (LOs). I always went out with a group of both exchange students and students from the local university. In sunny Campobasso there were many things to do: we would go for walks in the city centre; eat ice cream and pizza in its many bars and cafes; and visit the seaside. The city itself was very calm and peaceful.

We also got the chance to visit the Italian capital, Rome, where I experienced the Vatican City, Colosseum, Spanish steps and Trevi Fountain. Now I know why they say Rome wasn’t built in a day!

One particularly memorable event that I participated in was the annual wheat festival (La Sagra) in Jelsi, a village close to Campobasso. The event is a pilgrimage in honor of St Anne, who, it is believed, saved the village from an earthquake in the 1800s. At this wonderful festival there was a parade of carts adorned with ears of wheat, as well as other fantastic exhibitions and fireworks.

Spending time in Campobasso was wonderful. My project helped me to appreciate many things I had only seen or read in textbooks and I met some good people who became great friends that I still chat with on Facebook. I don’t have any regrets going on exchange; it’s really been a great experience and I’m glad I took part. Ciao!
I managed to catch my friend in mid-conversation, “It was an amazing time, I met wonderful people, I enjoyed my work, the country - just everything was perfect. I have to apply again next year”. “What are you talking about?” I asked. “SCORE, of course”, she replied. This is how my adventure with SCORE started. I am a public health student and so I had previously thought that SCORE exchanges are limited to medical students; I couldn’t have been more wrong!

Research project
My project took place in the Department of Hygiene and Environmental Protection at the Democritus University of Thrace in Alexandroupolis, Greece. I was required to analyze the chemical composition of drinking water collected from different public places such as restaurants and pubs, in order to determine whether it was suitable for human consumption.

From 9am until 2pm every day, I was in the laboratory researching and having a lot of fun in the process. By the end of my stay my skills in biochemistry lab techniques were greatly improved. During my time in Alexandroupolis I also got to learn much about the Greek higher education system compared to that of my home country.

The people that I worked with were very open, and created a friendly atmosphere in the lab for me. They were also very helpful and explained everything that I wasn’t clear about. My supervisor gave me a warm welcome and made me feel as though I had been a member of her team for ages.

Social program
Most of my free time was spent with other exchange students. Each one of them was from a different country and culture but we found our common language and created a tight team. Even though the Greek students were busy with exams during our stay, they found the time to hang out and show us their way of life.

I have totally fallen in love with the Greek way of spending evenings – generally this is in the company of good friends and family at a seaside restaurant where everyone knows the owner! There is much laughing, talking, and people having a great time.

Preparations, travel and arrival
As Poland is within the European Union I didn’t have any problems with arranging my travel. My contact person was great; although I was late to arrive in Alexandroupolis she was still able to pick me up from the station.

Stay
The place where I stayed – a campsite – wasn’t the best option. We didn’t have a toilet or a bathroom in our little sheet-metal house; my bed was too small for me; and there wasn’t any heating system or even extra blankets.

It was really uncomfortable but worth it for all the good memories we now have. I will never forget our “excursions” to the toilet where we would make our way through the dark to the ablution facility while scaring each other and laughing about it afterwards. Our complaints about being uncomfortable at night always ended with explosions of laughter and yet more discussions late into the night. We all took care of each other and that is what makes us great friends!

I am truly lucky to count myself amongst those who have had this fantastic SCORE opportunity.
Research project

I completed a research project entitled “Epidemiological research on informal caregivers’ health and quality of life” at the Laboratoire Santé Environnement Vieillissement of the Université Versailles Saint Quentin in Paris. Each day I started lab work at around 9am, breaking for lunch at 12pm for an hour, and finishing the day at around 5pm.

The aim of my work was to study the major determinants of health and the quality of life of informal caregivers (such as spouses, other family members and neighbours) of elderly dependent people in France. I carried out my research by reviewing the scientific literature as well as databases available in the department.

The project was really interesting because we focused on things we actually hardly ever think about in Medicine. The psychological aspects of illnesses are a very important part of the treatment process; and once these are uncovered, we can take into account the root of the problem and how it influences the treatment plan.

Most of the time I worked alone but I had a tutor who was available for me to consult with whenever I needed assistance. I regularly presented my results to my supervisor, Professor Joel Ankri, after which we would discuss pertinent points as well as the direction in which we should proceed with the project.

There was no language barrier although I do regret not being able to speak French because it was not easy for my tutors to speak in English. They tried hard, however, and in the end it worked out.

Lodging

I lived with three French girls in a cozy apartment located 15 minutes from my workplace, in one of Paris’ arrondissements. My room had such a comfortable and huge bed, the like of which I have never encountered before! My room-mates Anne, Chloe and Olivia were great fun and we still keep in touch.

Social program

And now let me talk about France and Paris! Paris is such a great city - full of life, music, delicious cheese and aromatic wine. I was lucky to be there during the 14th of July (Bastille Day) celebrations as the atmosphere was great and there was a stunning fireworks display near the Champs de Mars.

Since it was summer time the weather was ideal for sightseeing - sunny but not too hot. I had the great opportunity to visit such marvellous sites as the Arc de Triomphe, the Louvre Museum, the Cathedral of Notre Dame, and of course, the Eiffel Tower.

Towards the end of my stay I was invited to a graduation party in the Orange Garden at the Palace of Versailles - one of the largest and most opulent palaces in the world. This capped off an altogether fantastic stay in the City of Lights. Thanks to SCORE for yet another successful exchange!
Research project

I worked in the Department of Child and Adolescent Psychiatry at the Belgrade Institute of Mental Health on a follow-up study aimed to evaluate the trends of psychotropic medication prescription for children and adolescents in the inpatient setting. Data was obtained from patient histories and discharge lists and inserted into a database. From this it was possible to find out the most common diagnoses as well as the types and doses of medication used to treat those specific illnesses.

Besides the research project, I was highly involved in the clinical work of the department. I observed several types of therapeutic and diagnostic methods, and got to interact with a number of doctors, psychologists, therapists and nurses. The most exciting part of my journey was having the opportunity to engage in therapy sessions with children suspected to have Autism Spectrum Disorder. I worked hand-in-hand with the therapists as we tried to understand each child’s strengths and needs in order to provide the most effective treatment. We would then guide the mothers to a better understanding of how to deal with their children. It was very rewarding to see the progress made during the 2-week period of therapy. This experience definitely encouraged me to pursue my passion for helping children with autism through my future career.

Preparations, travel and arrival

I faced some problems obtaining a visa because there isn't a Serbian embassy in Bahrain. It took me a while to find the correct contact details of the nearest embassy and this resulted in some delays.

My contact person was brilliant; she picked me up from the airport, took me to my accommodation and introduced me to the other students. Every now and then she would check on me to make sure I was comfortable. I am forever grateful to have had her.

Stay

I stayed at a student dormitory which was average in terms of facilities, but the great thing about it was its proximity to everything as well as the fact that all the exchange students were in one place. With regards to meals, we were provided coupons for breakfast and dinner at the dormitory, but most of the time I ate outside.

Since the other exchange students I met were from at least 4 different countries, the multicultural environment I was immersed in was amazing. As we got to know each other we learned to embrace our differences and celebrate them. I am still in touch with many of these friends and hope to meet them again soon.

As for the locals, the Serbians are a very hospitable and helpful people. They enjoy casual chats, and most of them - especially the younger generation - speak English fluently.

City and country

Although our contact persons were busy with exams, they still helped in organizing several trips for us. We had the opportunity to learn about the rich Serbian history through visiting such notable places as Ada Lake, the Kalemegdan Fortress and the beautiful city of Novi Sad.

Belgrade is famous for its crazy nightlife which we experienced through numerous festivals and parties. The livelihood of the city gives no chance for boredom to set in; there is always something to do or somewhere to go. And if one wants some peaceful quality time, there is always a beautiful park nearby.

This SCORE exchange experience gave me many unforgettable memories and good friends; it also helped to develop my interest in paediatric mental health. For these I am thankful.
Exchange Experience: Wonderful research opportunity at Charles University, Prague

Ayaka Ishihata

Research project
The aim of my project was to determine the diffusion parameters underlying non-synaptic transmission of nerve signals in both pathological human or animal tissue (such as tumors), and in injured nervous tissue during regeneration induced by the implantation of mesenchymal stem cells.

My supervisor, Professor Sykova, is one of the most famous and authoritative scientists in the world with respect to neurological research. I was really impressed by her attitude towards research and her way of living life.

On weekdays I observed experiments and assisted in lab work; sometimes I even helped to make new instruments for use in various experiments. Whenever there were lectures that related to my research topic, my supervisor would give me one-on-one tutorials afterwards to further explain this complicated field.

On weekends, I took journal articles back to my dormitory and finished theoretical assignments in preparation for the following week. Work was quite tough, but I was able to gain a broader view of neurological research.

Preparations, travel and arrival
I didn’t need a visa because the duration of my exchange was only 1 month. My contact person was a student who had once visited my university in Japan. He was very helpful in assisting me to plan my trip so there were no difficulties at all. At the airport he and his father picked me up and took me to my dormitory. I did not have any problems during my stay and really enjoyed it thanks to him. If I had a sentence of advice for those contemplating a SCORE exchange, it would be: remember to take souvenirs from home with you as these are appreciated by your lab colleagues and friends!

Stay
I stayed at one of the student dormitories affiliated with the Charles University. My accommodation was not very comfortable but its plus side was that it is located centrally, close to the university and town.

I usually ate meals away from the dormitory as my contact person and his friends often took me out for dinner.

City and country
Together with my contact person, his friends, and SCORE exchange students from Indonesia and Mexico, I was able to tour around Prague, visiting Prague castle, Staré Mesto (the Old Town), and the Jewish Quarter amongst many other tourist attractions. My trips extended beyond Prague to the spa city of Karlovy Vary, the quaint town of Kutná Hora, and the castle of Český Krumlov. I also got the chance to visit Germany and Austria during my exchange.

A favorite pastime of mine was going to see the opera and other concerts at the grand and ornately-decorated opera house. Thanks to my supervisor, I was also able to attend the Charles University Memorial Concert in celebration of the founding of the university’s Faculty of Medicine. I was lucky to meet many honorable scientists there.

All in all my time in the Czech Republic was thoroughly enjoyed. I would recommend the SCORE exchange to anyone who is interested in research combined with travel!
Immunogold Quantification in Oslo!

Claudia Marotta

Research project

MCT2 is the name for a particular transporter with many substrates which is found on cell membranes. The purpose of my work was to obtain information about the density of the MCT2 transporter in the synaptic membranes of Purkinje cells, compared to the surrounding tissue, from sections taken from rat cerebellum.

Research on MCT transporters has important clinical implications as it could potentially indicate the role that certain MCT mutations play in genetic diseases such as amyotrophic lateral sclerosis (Lou Gehrig’s disease).

Through this SCORE exchange, I was able to learn how to use an electron microscope (EM). Under the supervision of my kind co-workers, I was also taught the technique of preparing immunogold EM sections and given the responsibility to carry out various other tasks in the lab as well.

My project gave me an insight into neuroscience research and trained my mind to think scientifically. This experience will be very useful for my future studies in the neuroscience field, which I am really starting to love!

City

I spent my time in Oslo in the fantastic company of people from Ghana, Portugal, Taiwan, Egypt, Israel, Italy, and last but by no means least, Norway. Engaging with this multinational bunch taught me about other perspectives on life and on medicine, providing me with a unique experience in my personal development. We all befriended one another and, since day one, would share our dinners and lunches, trying out everyone’s home-made national foods.

We also went around the city visiting museums, parks, beaches and other beautiful sites that Oslo has to offer. Outside of the city I was impressed by the beauty of the varied countryside, in particular the breathtaking view from the Holmenkollen ski jump.

Oslo surprised me as everything is so organised – from the university to the city services. The myth that I believed of Norwegians being unfriendly was soon dispelled as I discovered their hospitality and sense of goodwill.

Stay

I stayed in a brand-new apartment that was located on an artificial island and surrounded by luxury boutique stores and classy bars and restaurants. It was right in the center of Oslo so there were always scores of people around at night.

My flatmates were the Oslo local officer for research exchange (LORE) and my contact person - a sweet couple who were so kind to me. They often made traditional Norwegian food for me; I couldn’t have asked for more!

Social program

The local students organized a fantastic social program which was kicked off with a welcome barbecue. There was also an array of themed parties at the dorm and an “International Night” dinner.

But what I’ll never forget is the amazing boat trip we went on: it was a perfect summer’s day when some Norwegian friends took us for a ride in the Oslo fjord on two motorboats. We swam, played watersports and had a shrimp lunch on a picturesque island. This was definitely one of the most wonderful days of my life!

The night before my departure we went to the “Semester start” party at the university disco, where we danced all night long and had a lot of fun together; needless to say that I was very sad to leave the next morning!

Norway is an amazing country with unparallelled hospitality and kindness. I love Oslo and really hope to go back as soon as possible!
Andrea Calciati

Research project
The aim of my project was to study the polymorphisms of HSV-qD (Herpes simplex virus). I spent a month in the laboratory working each day from 9am to 4pm under the supervision of Associate Professor Parvapan Bhattarakosol. The research required me to have a basic understanding of both the polymerase chain reaction (PCR) and DNA sequencing techniques.

My work colleagues spoke good english and were very friendly. They explained every step of my project in detail and took time to answer my questions. I had the opportunity to observe many procedures, and was even able to carry out certain experiments by myself. My exchange taught me a lot about biomedical research and how life really is in the laboratory.

Preparations, travel and arrival
Some vaccinations (such as Hepatitis A and typhoid) were mandatory for me before travelling to Thailand. It was not necessary to obtain a visa since my stay was shorter than 30 days. When I arrived at Bangkok Suvarnabhumi airport I was picked up by my contact person, taken to a welcome dinner and then brought to my dormitory.

Stay
My accommodation was in a very convenient part of town and within walking distance to the laboratory. The building was quite old but a modern air-conditioning system and free wifi were available. I had a four-person room all to myself for most of my stay.

For the duration of my exchange I was given 3000 baht (approximately 75 euros) as pocket money, most of which I used to purchase food. I always ate meals outside the dorm as street food in Bangkok is relatively inexpensive yet delicious. Lunch was generally spent with my friends from the laboratory.

Social program
Bangkok is amazing! Thai people are extremely friendly and everyone was very kind to me, both inside and outside the laboratory. On days off I would walk around the city visiting temples and pagodas; riding on elephants; shopping at the floating market; and sampling many tasty Thai treats. My colleagues from the lab also took me sightseeing.

On a number of occasions I was fortunate enough to go with a friend to the islands in the south of Thailand. The beauty there is astounding; little wonder that two James Bond movies have been filmed in this region of the world!

With so much to offer Thailand has truly been an amazing experience. I am still in contact with many friends I made there and definitely have plans to go back if given even the smallest opportunity!
Country Profile: Jordan

Aisha Gharaibeh

Introduction
A well-travelled bridge between sea and desert, and east and west, the Hashemite Kingdom of Jordan is a land of mesmerizing beauty and contrasts - from the Jordan Valley, fertile and ever-changing, to the remote desert canyons, immense and still. You can explore splendid desert castles, gaze in awe at the haunting wilderness of Wadi Rum, or bathe in the restful waters of the biblical Red Sea.
This is our land, Jordan, and we look forward to welcoming you to our home.

General information
Arabic is the official language in Jordan and is used in daily communications. English (and to a lesser degree, French and German) is commonly used in Jordanian university classes.
The most distinctive Jordanian dish is Mansaf which consists of Arabic rice, a rich broth made from dried sour milk (jameed), and either lamb or chicken. The appetizers (also known as mezze or muqabalat), such as hummus and falafels, are so satisfying that they could be considered a feast in themselves. Authentic Jordanian cuisine promises to satisfy anybody’s taste buds!

As for the weather in Jordan, it is humid from November to March while semi-dry for the rest of the year.

Research projects
IFMSA-Jordan’s SCORE exchange program was born in July 2012. Thus, the 2013 to 2014 exchange season is our first.
Jordan is considered one of the leading countries in the Middle East in the fields of health and education.

Research is held in high-esteem and regarded as one of the best ways to long-term development and progress.
The research projects available for this first exchange season are varied between basic science and clinical projects. Two examples of the projects we have to offer are: “Screening of genetic illnesses in newborns and children using modern technologies in biochemistry”, and “Oncology research focusing on molecular diagnostic assays”.
There are many more projects on offer, and we encourage you to view the IFMSA-Jordan section of the SCORE database (http://www.ifmsa.net/public/ecscoreselect.php) for more information.

Social program
Whether you like cycling, hiking, trekking, abseiling, scuba diving, sightseeing, shopping, or just wandering around, Jordan will meet your interests. Here are a few places that you can visit while on exchange:
• Amman: the capital and largest city in Jordan, Amman is set to satisfy all your cultural needs;
• Aqaba: a modern metropolis that sits on the Red Sea coastline. Aqaba is well-known for its beaches, shopping and luxury resorts;
• Bethany beyond the Jordan: the place where John the Baptist is said to have baptized Jesus Christ;
• Hammamat Ma’in: a beautiful, naturally-heated, freshwater spring and waterfall near Wadi Mujib;
• Petra: a rose-red city carved from stone that is a UNESCO World Heritage site and Jordan’s most popular tourist attraction;
• Umm Ar-Rasas: an archaeological site that contains ruins and artefacts from the Roman, Byzantine and Muslim civilizations;
• Wadi Rum: a spectacular desert valley that has been home to many people’s since pre-historic times.

Lodging
Students can expect to stay in a flat or apartment with other medical students. Meals are generally provided by the university cafeteria. If you are given a “Jordanian invitation” for a meal by a local family, please note that you are not expected to bring anything, and that you are expected to eat everything!

We welcome you to the wonderful kingdom of Jordan and hope you will enjoy your stay!
Country Profile: Germany

Christine Gebhardt

Introduction
Germany is situated in the heart of Europe and offers the keen student many opportunities for high-quality scientific research. In Germany we pride ourselves on our top-class researchers who come from all over the world with vast amounts of knowledge and experience, and with an eye for precision. We are sure you will have a great research experience here.

In Germany you will also find a cosmopolitan society; huge cultural diversity between regions; beautiful scenery; and delicious traditional fare. Our climate changes quite dramatically during the course of the year - from snow in the winter to a mild spring to a hot summer where the daytime temperatures may exceed 30°C. Whatever time of year you decide to come, you are guaranteed to have an enjoyable time.

Research projects
We offer a large variety of exciting projects in the basic biomedical science fields of Anatomy, Biochemistry, Physiology and Molecular Biology. In addition to these you can choose from an array of clinical medicine research projects in areas such as Neurology, Internal Medicine, Otorhinolaryngology and Anesthesiology. Research on hot topics like stem cell therapy, carcinogenesis, genetic testing and much more is also possible!

Where to go on exchange?
Germany has much more to it than just Berlin or Munich. There are many cities that each play an important role with respect to scientific research, culture and economic activity. At the moment there are 13 local committees offering IFMSA research exchange opportunities and there are more to come!

If you want to enjoy the charm of Germany’s typical student towns you should consider going to Freiburg, Heidelberg or Ulm. If you are instead hoping to party it up whilst on exchange, the cities of Berlin, Halle, Cologne or Leipzig may be best suited for you. For an immersion in the culture and history of Germany consider places like Dresden, Aachen or Bonn; while for delicious and wholesome food combined with stunning scenery, complete your exchange in Jena or Magdeburg in the east of Germany. So you see, every city in Germany has its own unique attractions!

Travel
For travel within Germany, we have a well-established and efficient train system which can get you around easily and quickly. Since there are 9 countries bordering Germany, it is the perfect starting point for excursions to other European countries. As part of the SCORE exchange experience we also offer national social programs whereby exchange students can meet up with their peers during a fun weekend in a different German city.

General information
As soon as we receive your application, we will check if the project you applied for is available. Once this is confirmed, our local officers (LOs) will get in contact with you and commence organizing your stay. Usually, exchange students stay with either German students in a flat or apartment, or with a host family. If you are able to speak some German it will be appreciated; but if not, don’t worry, as almost everyone you will meet speaks English. Our LOs offer a great social program including a national dinner night, where the local students cook typical German dishes while the exchange students prepare cuisine from their homelands.

We hope that you will consider applying for a SCORE exchange in Germany and look forward to welcoming you to our country with open arms!
In this section, you are going to meet SCOPEople, read about their professional exchange experiences and meet their friends from every corner of the earth. Prepare yourself as you embark on a SCOPE journey that will take you around the world - from a Tropical Diseases ward in Khartoum to Trujillo, the Peruvian city of hidden treasures. So buckle up, sit back and enjoy the ride!
Dear SCOPEans and medical students worldwide,

I am extremely happy to present to you the latest edition of our official SCOPE publication. Everyone who contributed to this edition has placed a great amount of time, energy and creativity to give you a closer look at the amazing world of SCOPE.

This year has seen the finalization of the transfer to the New Database, moving from www.ifmsa.net to www.ifmsa.org. The New Database provides flexibility, in so that it can be tailored to meet the needs of every SCOPEan, from the student, to the Local Exchange Officer, National Exchange Officer and the SCOPE International Team. All the data from the previous years of use of the old database has been copied and will be stored to be accessed whenever needed.

This term the SCOPE International Team has focused on the Strategic Plan (the main priorities being evidence-based SCOPE, the New Database and support to new countries) and as the end of our term draws near we are proud to say that we have achieved all the goals we set out to achieve. All relevant documents to SCOPE have been centralized on the New Database to ensure continuity and easy access. The New Database is near completion with only a few minor bugs left to fix and has been efficiently managing the exchanges of over 8000 medical students worldwide.

Between the March Meeting and now, the August Meeting, two more NMOs have joined the SCOPE family; Uganda, from the African Region, and Malaysia, from Asia-Pacific. These two regions have been the focus of our term and it’s such a pleasure to see them grow even more. They will join the other new NMOs that have joined SCOPE in our term to sign contracts for the very first time at the contracts fair of the August Meeting in Chile.

We are committed to continue to work to meet any other needs that SCOPE has in order to make the best standing committee in IFMSA even better. If there’s ever anything you think SCOPE needs just let us know so we can work on it.

I would like to thank my amazing International Team: Maria, Erica, Farhan, Carl-Joe, Nienke, Nikos, Pablo, Valter, Susi, Omar and Safa for their amazing work so far. I would also like to thank the amazing SCOPEans who together are selflessly contributing to make the biggest worldwide exchange program what it is today.

Last, but definitely not least, I want to thank the authors of the articles; Nadine and Steffi, the co-Editors in Chief; and also Safa, the Support Division Coordinator on Marketing, who have all done an amazing job to make this periSCOPE possible.

I wish all a very pleasant reading experience.

Welcome letter from the SCOPE Director

David Ekow Arku

David Ekow Arku
Director of the Standing Committee on Professional Exchange, 2012-2013.
It was early December when I applied for an IFMSA exchange clerkship. A few days later I heard that I had been accepted and that I needed to choose my city and country of preference. I was fortunate to have the choice of many wonderful locations, but Bratislava, the capital of Slovakia, was without a doubt the city I was looking for. This was the opportunity to experience a place that is off the beaten track - something different.

To get there, I took a direct flight from Rome to Bratislava. I had already established communication with my contact person, Veronika, through Facebook, and when I arrived she was waiting for me, together with (little did I know it at the time) one of the greatest experiences of my life!

After meeting Veronika, a bus took us to my accommodation, where I got to check into my room in a very nice flat which I was sharing with people from Turkey, Serbia, Romania, Malaysia and Portugal. At the dorm I also met many other people who were to soon become my close friends.

The next day some kind girls took the time to explain where the hospital was and how to reach it; they also described the layout of the city and major landmarks to look out for. At the hospital I was supervised by knowledgeable and helpful doctors who were willing to teach. I really appreciated the learning experience as it helped consolidate much of my clinical knowledge and skills.

The social program, in a nutshell, was perfect. We took part in many activities such as paintballing and swimming in the lake. Additionally, we went on sightseeing tours of the historical part of Bratislava which were really fascinating. One of the social program’s highlights was the shopping and coffee-drinking in Eurovea, a huge mall on the edge of the Danube River.

Bratislava city is wonderful; I still cannot believe how many opportunities it offered me. To get to the middle of the city, all it took was one bus. It was a joy to travel so easily to and from the dorm to the centre (where all the clubs were located) and to the river (where all the best restaurants were). Even when we couldn’t commute around, the dorm was right next to restaurants, pubs, pizzerias, nightclubs; and basketball and tennis courts. We were surrounded by other students so there was never a dull moment.

The magical experience of meeting 30 strangers, and subsequently becoming part of a great group of people in so few days will always stay with me. I still smile when I think about all the fun times, the laughter, and all the languages that I heard. At the end of my stay, I could say “thankyou” in more than 20 different languages.

This SCOPE exchange was one of the best experiences in my life; I recommend it to everyone with all my heart. Thankyou SCOPE, thankyou Bratislava; grazie.
Clinical experience

I made the decision to go to Peru because my friends went there on exchange last year and they told me their experience was excellent. I completed my clerkship at the Regional Institute of Neoplastic Disease (IREN) in the city of Trujillo, under the supervision of doctors specializing in abdominal surgery. Fortunately, I was able to play an active role in many surgeries (including emergency procedures) as well as clinical case discussions. I subsequently learnt a lot about abdominal pathologies (particularly cancers) as well as imaging and surgical techniques.

The health system in Peru differs in some ways from that in my country, but in general Peruvian healthcare is good. A problem for a large proportion of the population however, is the issue of finances, so oftentimes people are not able to pay for their medical care. This is a great pity as people are forced to work very hard in order to afford basic healthcare needs.

Overall, I was impressed by the hospital staff who were very nice to me, giving me the support I needed. They have all provided me with great experiences that I will cherish for the rest of my life.

Trujillo

I would never have imagined that my month-long trip could ever have been as amazing as it was. Peru is a country famous for the historic Inca sanctuary of Machu Picchu, however there is a lot more to it than that.

Other beautiful places worth visiting include the cities of Lima, Ica, Cuzco, Arequipa, and of course, Trujillo.

Trujillo is a large city with beautiful beaches and friendly people. In between clinical work I got the chance to visit many tourist attractions within the city walls thanks to the SCOPEans of IFMSA-UPAO. Together, we visited the Chan Chan archaeological site, the coastal resort of Las Delicias, the Pacasmayo and Huanchaco beaches; as well as museums, theaters, nightclubs, restaurants and much more. All the trips and social activities that we did together were just awesome - there are no words to describe everything they gave me.

Every single day of my stay was lived with great enjoyment and wonderful experiences. The local SCOPEans took good care of us, becoming something akin to family. “Love”, “friendship”, “affection”, “family”, and “home” are a few words that aptly describe what comes to mind when I think of Peru and its people. I hope that God allows me to go back as Peru is not just another country in Latin America; rather, it is my second home, my second family.

I would like to thank the SCOPE group of IFMSA-UPAO in Trujillo for allowing me to experience great things in my personal and professional life. I’m going to keep them all in my heart forever. Thankyou so much for everything!
Introduction
Last summer I went to Sudan to complete one of my clerkships. Why did I choose Sudan and what did I expect before going there?

To be honest, my decision was made on the spur of the moment but I have always thought about going somewhere different to gain new experiences, meet new people and get to know their culture. When I found out about the opportunity to go to Sudan on exchange, I knew that I had to take the chance! After getting my ticket, visa, and all necessary vaccinations, I was finally ready to go to Khartoum to fulfill my dreams.

During my 12-hour flight to Khartoum I tried to imagine what it would be like there. After touchdown, as soon as I got out of the airport, I felt a stream of hot air and was inundated by the sound of countless taxi drivers shouting, “Taxi!? Taxi!? Taxi!?”. I was overwhelmed but luckily I was soon picked up by a friendly medical student from MedSIN-Sudan.

Clinical experience
In front of my dormitory was the Faculty of Medicine, on the other side of which was the Khartoum Teaching Hospital, where I was to work in the Internal Medicine and Tropical Diseases wards. It took just 3 minutes of walking time to get there.

During morning ward rounds I learnt a lot, because the doctors took time to explain in English. I always felt welcome to ask questions as the doctors seemed happy to answer them! I joined other students in taking case histories, examining patients and referring cases to our professor. They were nice to me and helpful in translating patients’ histories to English; likewise, when I wanted to ask patients questions, they assisted in translating my words into Arabic.

In the Tropical Diseases ward I saw many cases, of which schistosomiasis and leishmaniasis, were the most common. After spending time in this ward, an area that was quite concerning for me is that there are still many people (especially those that live in tribes) seeking medical assistance from shamans. I will never forget a patient with huge burns to his upper abdomen caused by a traditional healer trying to cure his splenomegaly (which was due to leishmaniasis). It is needless to say this treatment was not helpful at all.

Conclusion
I was constantly surprised by how nice the people were - not only the doctors and the students at the university and hospital, but even people on the street! They always asked me where I was from and what I was doing in Sudan. Even when I was standing on the street waiting for a lift or for a friend (it took me a while to get used to the Sudanese concept of time!), people would always come up to ask if I was lost or if I needed help with anything.

After spending almost one month there, I think that the Sudanese are the nicest people in the world. I will never forget this experience and all of the people I met. I can’t wait to go there again!
Clinical experience

I completed my clerkship in the Department of Anesthesia at the largest hospital in Göttingen. Although most of my experiences were in the operating theatre, I also spent time in the pre-anesthesia area and the pain clinic.

The daily clerkship schedule started at 7:30am and ended at 4pm, except on Mondays, when we started at 7am with academic lectures on anesthesia. Although I could not understand German, I still attended these academic sessions.

I assisted in pre-operative preparations, including the placement of intravenous lines, catheters and ECG electrodes, and taking blood pressure readings, before observing various surgical procedures such as aortic valve replacement, coronary artery bypass, and tumor extractions. Post-operatively, I was able to help in the patient’s recovery from anesthesia.

I feel that learning is largely dependent on how much study preparation you invest into your clerkship as well as the mentorship from your supervisor. Since I rotated through different surgical disciplines in order to observe a range of procedures, I had several supervisors. While some were very cautious, only permitting students to observe, others wanted students to assist in minor procedures for learning purposes. On my last day, I was lucky enough to be able to intubate a patient for the first time.

Since I am not proficient in German (and since many physicians had a limited grasp of English) there were some communication barriers. However, we were still able to understand each other even if it did take a bit of time.

City and Country

During my time in Göttingen, I met four other exchange students from Italy, Holland, Slovenia, and Brazil. We became close friends and socialized by going on walking tours through the city or in the park.

Although Göttingen is a small place with only a few historical sites and cultural activities, there were numerous parks in which to observe nature. One weekend we took the chance to leave Göttingen for a larger city, Hannover, which is only a short train ride away.

Preparations, Travel and Arrival

My trip did not require much preparation since this was my second exchange and I understood what was needed. I booked my flights and packed essential travel items, while looking forward to the month of clerkship and meeting new people. Once I had finally arrived in Germany my contact person picked me up at the train station and drove me to my apartment. During my exchange I was provided with a German mobile phone and a rental bike.

Stay

Located in an area with lots of trees, my apartment was spacious and came with a balcony on which I could read during the evenings. It was located only 10 minutes by bike from the hospital but was far from the city center. Göttingen has excellent bike paths so there was never any problem cycling home at night.

Each week 50 euros were provided for food, but this was only sufficient for eating at home because hospital and restaurant meals are expensive. On the last evening of our stay, we had an “international” dinner party, where everyone prepared food from their country to share with the group.

In summary, I had a wonderful time in Göttingen. However, I would like to recommend that students consider choosing a larger city, where there are more doctors who speak English, cultural events and social activities. Thanks to SCOPE for making this possible!
From the 16th to the 19th of May 2013, my NMO, HelMSIC, organized its first Sub-Regional Training (SRT) in Chalkidiki. This kind of training event is dedicated to both exchange students as well as any other medical students who might be interested. The SRT was an unforgettable experience for me, as I got the chance to be involved from the very beginning until the very end.

When the call for the SRT organizing committee (OC) members went out, I was immediately interested so I sent my application in. Thankfully, I was chosen to be part of the promotions team. The day I received this confirmation an amazing journey started.

The newly-formed OC held numerous online meetings in order to plan every little detail for the participants of the training. Each sub-team within the OC had a plan of action it had to follow. Co-operation both within the promotions team and between teams was excellent; and, as time passed, our work became more efficient.

As soon as we started receiving applications for the SRT I became anxious to have as many people as possible apply because we had worked hard on promoting the event and really wanted it to have a good turnout.

When the SRT started, it was better than I had thought possible. The camping ground we selected for the location turned out to be an amazing place, providing us with high-quality accommodation and training rooms as well as a wonderful beach for the participants to have fun.

The participants that took part in the SRT came from all over the world and brought with them their different cultures and ways of thinking. They were all eager to make full use of the program and learn as much as possible. Despite the differences between the participants, we all managed to befriend each other and were sad when we had to part ways and return home.

The talented SRT trainers did their best to provide us with useful skills and knowledge for life. In the mornings, we had training sessions on topics such as intercultural learning, project planning, organizing exchange programs, and effective leadership; while after lunch, we had small working groups and workshops on, for example, problem solving and promoting our exchanges.

During the social program the participants were given ample free time which they used to: enjoy beach activities such as swimming and dancing at the beach bar; listen to music; and hold a flashmob, amongst many other things. On the last day, the participants had the chance to enjoy breathtaking scenery during a tour to Thessaloniki (the second biggest city in Greece), while later on that night the National Food and Drinking Party took place (which I totally loved!).

This experience was truly awesome and, so far, the highlight of my involvement in HelMSIC and IFMSA. I have been to other international meetings and trainings but this SRT was something entirely different. I am lucky to have had the chance to live every part of it.
After a successful first Sub-Regional Training (SRT) which generated positive feedback from participants, IFMSA-Egypt’s exchange team was enthusiastic to organize another – but this time, aiming to make the event the experience of a lifetime.

Under the glistening Egyptian sun, in the city of Ras Sudr near the beautiful Red Sea coast, IFMSA-Egypt gathered 70 medical students from all over the world for its second Sub-Regional Training. This event consisted of a series of workshops, trainings and small working groups over a period of 3 unforgettable days from the 9th to the 12th of May 2013.

15 trainings took place in order to develop and nurture various skills that members are able to utilize during, and after, their IFMSA journey. Topics included communication and presentation skills, effective leadership, conflict resolution, fundraising, and external representation. The trainings were carried out by 9 great IFMSA trainers including a number of IFMSA Team of Officials’ members as well as members of the international training team.

Alongside the trainings, small working groups (SWGs) and workshops were conducted, covering such topics as projects management and research opportunities. Overall, the attendees were greatly impressed by what the academic program had to offer.

With regards to the social program, the organizing committee held an Oriental Night, a Beach Party and a National Food and Drinks Party. These wonderful events, spread over 3 nights, provided the participants with a lot of fun and made the event even more memorable.

The journey concluded on the 12th of May with a group trip to one of the 7 wonders of the ancient world, the fantastic Giza Pyramids; as well as a cultural night out to the famous Khan El Khalili bazaar.

To sum up, the experience was a truly unforgettable one and the skills, knowledge and friendships everyone gained are those to keep forever. We, at IFMSA-Egypt, greatly look forward to organising yet more marvellous training events.
SCOMEdians are the guardians of our medical educations; their mission is to improve the quality of medical education curricula throughout the world. In the following pages you will meet some courageous and inspiring members of the SCOME crew, who will discuss with you such essential topics as the use of statistical packages in medical school, communication with deaf patients through sign language, and the role of simulation laboratories in medical education. Be enlightened!
It has been almost a year now and the term is rapidly coming to an end. Throughout many long months, SCOME members have been wholeheartedly dedicated to improving medical education worldwide.

Much hard work, through brainstorming sessions, think tanks, meetings, trainings, projects, small working groups and debates, has taken place at the local, national and international levels, all for the sake of our very important cause. The regular reports sent on the SCOME server are testament to this.

However, much remains to be done. We are nowhere near to achieving the worldwide medical education standards we crave, but we persevere and continuously push forward to advocate for medical education and for medical students’ involvement in its decision-making processes.

In the next few pages, the SCOMEdy will take you through a variety of medical education efforts from different geographical areas, showing you a glimpse of what has been going on in SCOME committees all over the world. It is our hope that you will be motivated to help achieve some of our SCOME goals, while taking into consideration our IFMSA motto of “Think Global, Act Local”.

Enjoy reading!

Ahmad Badr Mesbah, SCOME Publications Assistant, 2012-2013
Introduction

Statistics and its use cannot be over-emphasized in medicine. Good medical practice has begun to involve statistics and the use of statistical packages like Chronux, the Statistical Package for Social Sciences (SPSS) and EPI INFO, as it has become more and more evidence-based. Training in statistics has been a component part of medical education in the UK since 1967 and yet, some African medical schools have still not incorporated this important subject into their curricula [1].

Trends toward evidence-based medicine can only flourish in a culture of statistical literacy. Such a culture requires physicians who are equipped with the knowledge and skills to critically and accurately interpret statistics. This has implications for health as, for example, a doctor with knowledge of statistics is more likely to prescribe medications based on evidence rather than mere advertisements [2].

Although the curriculum in many medical schools now contains medical statistics, some students experience “numophobia” – a perceived and disproportionate fear of numbers and simple mathematical manipulations. As a result, there is a need to find various means of making statistics more interesting and student-friendly [3].

A study on statistics in medical schools was carried out during the African regional meeting in Arusha, Tanzania in December 2012. Its aim was to determine the students’ level of awareness of statistics in their medical curricula, and their use of any statistical packages.

Results of the study

102 respondents answered the questionnaire completely. Of these, 77.8% were between the ages of 21 and 25; 55.8% were male and 44.2% female. Altogether 20 medical schools were represented from the east, west and south African regions.

95% of the respondents stated statistics was an included component in their medical school curriculum, and 68.7% claimed to enjoy statistics as a course. However 24.2% did not know of any statistical packages and 67% had not had any training on any of the packages. 99% believe they need statistics to practice as a good doctor and 94.6% think it should be part of the medical curriculum. 68.8% think statistics is not difficult and as many as 62.5% were ready to take statistics or biostatistics classes even if they were offered as an elective course.

Discussion

Despite the fact that many universities have adopted medical statistics or biostatistics into their curricula, as many as one in twenty universities still do not have it. Studies have proven the effectiveness of medical statistics courses by the superior quality of doctors produced [4].

Bart K. Holland, a noted biostatistician based in the US, believes that only a small minority of physicians will ever be responsible for using statistical packages to perform data analyses during their careers; and that those who become part of a research team are generally able to rely on statistics specialists instead of having to learn how to use the packages for themselves [5]. This is unfortunately not the case in many African countries and other developing nations as such specialists are not readily available - even when they are, they are often too expensive to employ.

Conclusion

Statistics, and the use of statistical packages, is an integral part of any medical curriculum. This is especially true for the African medical education system as such knowledge would greatly assist doctors and other medical professionals (who cannot afford specialists in statistics) with practicing evidence-based medicine.

References:

SCOME Role in Medical Education Across Asia-Pacific

Fatia N Masriati

The Asia-Pacific region has two regional organizations for medical education that are recognized by the World Federation for Medical Education (WFME) [1]. The organizations are: the Association for Medical Education in the Western Pacific Region (AMEWPR), and the South-East Asian Regional Association for Medical Education (SEARAME). Their mutual aim is to advance medical education across the region [1, 2].

Despite the work of these organizations, our region is facing a huge gap: on the one hand there are countries with model examples of medical education systems, while on the other there are some with no medical schools whatsoever (an example of such a country is Bhutan). This gap is, of course, mostly dependent on the social sector of each country [3].

By the year 2015, there will be a free trade area within the South-East Asian region that will also include the health sector. This will act similarly to the European Union and will be a step forward with regards to health workforce migration and protection [4]. After this has taken place, it is likely that many countries will be better placed to work for the advancement of medical education in the region [3, 4]. SCOME in Asia-Pacific should take the lead and play an active role in helping to bridge connections amongst national member organizations (NMOs) of IFMSA within the region [5].

At the 2010 IFMSA March Meeting in Jakarta, an executive board representative from SEARAME was present as an external speaker for the SCOME sessions. That same year, the SEARAME executive board invited medical students to participate in their first conference. Unfortunately this partnership has since been discontinued. Re-connection with SEARAME and continued communication with AMEWPR is something that should be on the region’s to-do list. These partnerships are very beneficial for the good of medical education in Asia-Pacific.

In September 2013, the Asia-Pacific Regional Meeting (APRM) 2013 will be taking place in Yogyakarta, Indonesia. More than 8 NMOs active in SCOME will be present during the medical education sessions which will cover topics from projects to collaborations with government bodies. There are great expectations that this meeting will be the place for major decision-making on how to strengthen medical education within the region; and for informing medical students about important issues pertaining to their medical curricula.

References:

Update on the SCOME sessions at the European Regional Meeting 2013!

Stijntje Dijk

From the 17th to the 21st of April, the tenth European Regional Meeting (EuRegMe) took place in Chi-eti, Italy. Each year this meeting gathers around 200 medical students from all over Europe to participate in standing committee sessions, trainings and project presentations. At the end of it all, the participants take home new friendships and great ideas.

I am honored to have had the opportunity to host the SCOME sessions during this year’s EuRegMe. The sessions were well turned out and enjoyed by all. Here is a brief run-down of what happened:

On day one, after getting to know each other, we started by learning about how SCOME operates in various countries. A map was created to indicate whether the structure of SCOME in different national member organizations (NMOs) is more student representation-based, projects-based, or a mixture. We then split up into two groups: one for newcomers, where SCOME’s international structure, goals and way of operating were explained; and the other for “oldies” where ideas on medical education policy statements and the August Meeting 2013 SCOME sessions were discussed. At the end of this first session, a “fishbowl” was held whereby each member was able to share any difficulties they were facing with respect to medical education at home.

During day two, we split up again. The first group was trained on student representation and advocacy in medical education, that is, students were taught how they could personally influence decision-making regarding their medical curricula. And the second group learned about project leadership, covering such topics as “Project management”, and “How can you help your project excel?”.

Day three focused on topics of interest: some of the more experienced SCOMEdians organized small working group (SWGs) discussions on a variety of pertinent medical education topics; and one member held a talk on the upcoming SCOME event, “Workshop on Access to Medical Training in Europe” (WAMTE). As a bit of background, WAMTE is an important meeting that focuses on debating the structure of the medical residency program, as well as the mobility of resident doctors, in the European Union.

After an amazing week of activities, we shared a “conclusion kit” on the SCOME server. This kit contains details of what we did during EuRegMe 2013, as well as information on SCOME projects in Europe and conclusions that were reached after SWG discussions. Whether you missed out on this amazing meeting and want to catch up with what happened, or whether you were there and want to refresh your memory, I hope you will enjoy reading it. If you have any remaining questions afterwards, please do not hesitate to contact me at the e-mail address provided. Once again, many thanks to the participants who made this week as incredible as it was!

Stijntje is a third-year medical student at the Erasmus Medical Centre in the Netherlands. She currently serves as SCOME’s Regional Assistant for Europe.

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Medical students are the first target of the medical education system. Therefore, they should rightfully have the opportunity to be involved in the process of designing their own medical curricula.

To date, the key role of medical students in medical education decision-making has unfortunately largely been neglected. This shortcoming may be due to an existing general apathy amongst medical students. Another explanation could be that they underestimate how much they can potentially contribute, especially with respect to curriculum design and development.

To help combat this problem, SCOME members of IFMSA-Iran-Tabriz organised a medical education festival through the Education and Development Centre (EDC) of the Tabriz University of Medical Sciences. The festival was titled the “Shahid Motahhari Medical Education Festival” and was very warmly received by the student body.

One of the programs in the festival involved holding a contest to hear medical students’ thoughts on various issues existing in different areas of medical education. The contest aimed to inspire students into being more active in medical education-related issues. Possible solutions, as well as strategies by which to carry out the solutions, were put forward. Due to the great number of interested participants the deadline for submitting applications to the contest was twice postponed.

In the end, forty main concepts were collected from the contestants. They were categorized into several themes (creativity in medical education; curricula design and development; medical assessment tools; medical students’ role in medical education; and educational products) and judged upon by qualified referees. At the end of the judging process, fourteen ideas were selected as focal points for future efforts in medical education.

Since medical students are the first checkpoint of the medical education system, they should be actively involved in the decision-making process, and should be able to influence curriculum design and development. By carrying out a variety of programs in the Shahid Motahhari Medical Education Festival, we believe we have created an environment conducive to motivating medical students to take part in building their own medical education systems!
Sign Language: a bridge to health care inclusion

Ana Beatriz Carvalho

When a child is born deaf his family is faced with a host of decisions that need to be made in order to maximize the development of his communication skills. The challenge is to understand how to achieve his full potential - the best way for him to interact with the world.

When a hearing child starts socializing she is surrounded by many sounds, amongst which is the human voice. So language is something that happens naturally. When a child’s hearing loss is pre-lingual (occurring before five years of age), his deafness has a profound and lifelong effect on his ability to acquire oral language, compromising his understanding of syntax and vocabulary extension.

For many years, deaf children were obligated to learn oral language and encouraged to avoid using their hands or any form of gestures. However, we now know that gesturing is the natural language of the deaf - the child acquires this skill spontaneously without the need for specific training.

Through IFMSA-Brazil’s national project, “Libras em Saúde” (Brazilian Sign Language in Health), we explore not only the fact that the deaf have many difficulties accessing healthcare information, but also that their involvement in social activities is compromised because of how they may see themselves - that is, as part of a deaf “sociocultural community”, with a disabling condition and an inability to function “normally”.

“Libras em Saúde” aims to stimulate the interest of medical professionals and students alike in helping to better deaf people’s quality of life. The project works in three main ways: it facilitates medical professionals’ understanding of deaf people and their capabilities through trainings and providing more opportunities for them to interact with each other; it teaches medical staff how to use sign language and how it can be employed in sharing health information; and it organizes cultural and social events for the deaf to be able to interact more with their local communities.

Through our project, we believe that we are able to make healthcare more accessible to deaf people and that we can help them integrate better into their communities so that they feel important and loved. We will keep doing our best for this great cause.

Ana is a fifth-year student from the University of Pará (UEPA). She is the current National Officer on Medical Education (NOME) for IFMSA-Brazil.
SCOMEdians from the Al Mergeb University’s Faculty of Medicine recently organized the very first Libyan edition of the iMED (International Medical Education Days) event which took place at the Zliten and Alkhums teaching hospitals. It was a great challenge to organize such a large international project, although organizers and participants alike had great fun being involved.

iMED 2013 was altogether an eight-day event offering medical students lectures, workshops and trainings:

The 1st day saw renowned professors giving talks on radiological imaging in the emergency setting. The lectures were very informative as they taught pre-clinical medical students how to interpret X-ray, CT and MRI scans of patients presenting with life-threatening emergencies.

The 2nd day focused on medical ethics. As medical students and physicians, we face many challenging situations on an almost daily basis with patients and staff members alike. The talks given were really useful as they advised students on how to approach and react to certain situations.

The 3rd day was about communication skills, and was conducted by an IFMSA trainer. The training was beneficial as it explained how thoughts can be clarified to others, in both a verbal and non-verbal fashion.

The 4th day concerned presentation skills and how they can be used in many aspects of life. Two of our IFMSA trainers, Walid Ganod and guest-speaker, Dr Muftah Al-Zaidy, helped the students practise and perfect the art of speaking in public.

The 5th day taught us about basic surgical skills. It was great for pre-clinical students to learn how to suture as well as practise the different suturing techniques with various needles and types of material. This was a useful course for those interested in surgery.

The 6th day consisted of lectures and workshops on Basic Life Support (BLS) and anaesthesia. BLS was deemed an essential topic, as it may be needed anytime, anywhere during the course of our lives.

The 7th day was all about medical research. Lectures were given to explain how to write research articles, how to perform literature searches using such tools as PubMed, and how to critically appraise the literature.

The 8th day covered the essentials of paediatrics, including paediatric history taking, examination and management of a number of common paediatric case presentations. This module was especially useful for fifth-year medical students who are studying paediatrics this year.

Since this was our first iMED event, we wanted to make it particularly special so we added a few creative twists. Members of Libya’s SCOME group got together to write articles for, and produce, the inaugural “iMED-Libya newspaper” which included information on medical education topics, as well as iMED events in other countries such as the Czech Republic, Iran, Dominican Republic and Russia. In addition to this, our marketing team created unique notepads and pins with the iMED and SCOME logos printed on them.

Organizing this big international event gave us the experience of how international projects should be carried out. We are glad we were a part of it and are very excited for next year’s iMED. Keep your eyes peeled for more information from SCOME-Libya!
Simulation in Medical Education at the Faculty of Medicine in Maribor

Eva Senica

Background
Simulation in medical education has been used at the Maribor Faculty of Medicine since 2009 and has significantly developed over the last two years. It now represents an important part of our medical curriculum and an effective learning method for all practitioners of medicine, particularly for medical students [1, 2].

Summary of work
The simulations are currently divided into two major areas. The first is the Clinical Skills Laboratory and the second is the Simulation Laboratory.

The Clinical Skills Laboratory is primarily used for peer teaching purposes, and involves training on basic clinical procedures such as venepuncture, abdominal ultrasound, basic cardiopulmonary resuscitation, rectal examination and many others. It is used in different medical rotations, including emergency medicine, anaesthesiology, first aid and internal medicine. The laboratory also organises an OSCE, for which there are currently more than 10 stations.

The Simulation Laboratory on the other hand, is mainly focused on human patient simulators (HPS), or manikins, which come in adult, adolescent and child sizes. HPS represents a unique technical model of human physiology, allowing for processes such as the exchange of respiratory gases; the induction of anaesthesia; and cardiac, respiratory, neurological and pharmacological monitoring.

A major focus of the Simulation Laboratory is to provide opportunities for students to become familiarised with specific procedures such as endotracheal intubation, laparoscopic surgery, radiological techniques and many others. The manikins provide opportunities for teamwork as well as learning through repetition and through making mistakes without harmful effects on the patient.

At the Faculty of Medicine in Maribor, simulation has been the basis of much research, primarily concerning the quality of medical education and the OSCE system. Our research has shown that OSCE training through the Clinical Skills Laboratory, can be used in the early undergraduate clinical years to effectively train medical students; and that students can successfully transfer these clinical skills to their peers [3, 4].

Conclusions
Simulation in medicine is widely used at my medical faculty and shows great results in the field of medical education. As an undergraduate student I find that practising with the simulators is an excellent learning method. I believe that it enables us to improve our competence and confidence, consequently improving patient safety and reducing the risk of mistakes.

The OSCE system and peer teaching are also a great way for students to be involved in the educational program and I hope that they will be used even more in the future.

References:
In 1981, a new disease appeared in the world, claiming to be fatal and uncontrollable. This was the acquired immune deficiency syndrome (AIDS), which was first discovered in a population of homosexual men in the United States. Not long after, it became clear that the human immunodeficiency virus (HIV), which is responsible for AIDS, had spread largely unnoticed throughout most of the globe.

The HIV/AIDS pandemic consists of many separate epidemics around the world. In Latin America and the Caribbean, HIV/AIDS still stands as one of the region’s top public health priorities [1]. Worldwide, HIV is the fourth leading cause of death in recent times, with 35 million people (most of these, in Africa) having died from AIDS since it became known to the world 32 years ago [1]. Data projections to 2030 indicate that the virus will remain a global disease burden of immense proportion [2].

Objectives such as reaching an AIDS-free generation and achieving zero new cases of HIV are unrealistic in the foreseeable future, but this does not mean we should give up trying. We need to focus not only on protecting healthy people from the virus, but also on taking care of the 34 million people currently living with HIV (PLWH)[3].

In recent times, medical students from IFMSA-México, ODEM-Dominican Republic and DENEM-Brazil have come together to collaborate on the “AIDS: mind, heart and body” project, which serves to work towards improving the quality of life for PLWH.

In order to achieve our goals we carry out a number of trainings in order to provide future healthcare professionals with tools on a broad range of topics, including: HIV/AIDS in general; reducing the stigma and discrimination associated with HIV; understanding the needs and rights of PLWH; how to perform psychological, nutritional, social and medical evaluations of those living with HIV; and how to employ a palliative care approach for PLWH.

Through this project we have realized that, as medical students, we too can make a difference in the lives of those living with this devastating illness. So let’s fight ignorance with quality medical education and do a better job as future doctors!

References:
Since its recent inception, SCOME in Tanzania has taken a lead in trying to enhance medical education for students, healthcare professionals and the general public. It has carried out numerous initiatives in order to achieve the broad goals of SCOME:

To start with, a research project was conducted by SCOME members at the University of Dodoma on general cancer awareness amongst youths. From the results of this study, it was concluded that more effort needs to be made on educating the population about the specific risk factors and symptoms of various types of cancer, as well as the preventative measures that can be taken. Advocacy efforts have since been underway to push for this topic to be included in high school curricula nationwide so that cancer awareness can start from a young age.

Encouraged by the work of their colleagues, students from the International Medical and Technological University have organised an event called “Rise and Tell the World”, which serves to explain and debunk myths about common cancers in Tanzania (for example, cervical and colorectal cancer) to the general population. Furthermore, the event also aims to educate medical students about the burden of female genital mutilation (FGM) in Tanzania, including how it is performed and potential complications of the procedure. Medical students have been urged to be good ambassadors for health by providing their societies with education on FGM and its associated adverse health effects.

At the Muhimbili University of Health and Allied Sciences, SCOMEdians have taken the initiative to prepare a Statistical Package for the Social Sciences (SPSS) course which is designed to help students develop a better understanding of basic statistics concepts for use in medicine. An overview of data analysis and statistical software is provided, and skills offered in performing analyses and interpreting results. The program has proven to be especially beneficial to those students carrying out medical research projects.

In the near future SCOME-Tanzania plans to conduct a number of medical education training sessions, including: interactive tutorials at various medical schools on some of the more difficult topics in medicine; and first aid sessions at the Hubert Kairuki Memorial University. All the trainings will be conducted by medical students.

As can be expected with any project, we have faced many drawbacks in trying to implement our SCOME initiatives. These have included, but are not limited to: a lack of funding, time restrictions, and poor participation. But all in all we have persevered, achieving a few of our goals and moving forward through solid team work!
Ahmed Wagih

The idea started with a simple question: “Should antibiotics, with all their side effects and issues of resistance, be the only way to cure bacterial infections?”

The research that resulted from this idea was not conducted in my years at university; but rather, in high-school, as part of an advanced-level IGCSE biology course.

After constructing my hypothesis I decided to test the bactericidal effect of several natural herbal extracts on a certain strain of Staphylococcus aureus bacterium, versus that of common staph-sensitive antibiotics such as Ampicillin, Erythromycin, Penicillin and Vancomycin. The natural extracts included: Nigella sativa (black cumin), Punica granatum (pomegranate), Allium sativum (garlic) and Zingiber officinale (ginger). I tried to standardize the experiment as much as possible, using the same agar gels and keeping different variables (for example, temperature and time) constant.

The pilot test was not easy, and I met many obstacles - the main one being the creation of disks with which to contain the natural extracts (the antibiotics came in ready-made disks). I solved this problem by using thick filter paper cut into the same diameter and thickness of the antibiotic discs, and applying a standardized dose of 10 µg of natural extract per disc.

By employing the Zone Diameter Interpretive Standards [1], I found that the only antibiotics that the bacterium was susceptible to were Erythromycin and Vancomycin, which gave average inhibition zones of 30.5 mm and 20.5 mm respectively. With regards to the natural extracts, Nigella sativa and Punica granatum were the only ones with favorable results, with inhibition zones of 25.0 mm and 12.0 mm respectively.

An experiment comparing the two most effective antibiotics and the two most effective natural extracts was repeated 25 times. Mean inhibition zone measurements were as follows:
1. Erythromycin – 30.96 mm
2. Nigella sativa – 22.92 mm
3. Vancomycin – 21.04 mm
4. Punica granatum – 11.52 mm

In addition, statistical analyses using the one-way ANOVA and Tukey HSD tests showed that the mean differences of the four samples were statistically significant (all p values were below 0.01). And after comparing these results to those from similar research studies, they were found to be quite similar. These findings gave a degree of validity to my acquired results.

My conclusion is that the Nigella sativa and Punica granatum extracts have a significant antibacterial effect. However, these results are of a tentative nature and should not be used to influence treatment plans unless there is further evidence to support them.

This study is an example of how one can carry out a simple yet exciting research project without needing to have much of a prior research background. This experience was beneficial to me, and I sincerely hope that more evidence is found in support of the bactericidal action of black cumin and pomegranate extracts in future so that this theory can be put into practice. After all, there is nothing better than making use of nature to treat illness.

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