Migration of Healthcare Workers

MSI 32
Medical Students International
The International Federation of Medical Students’ Associations (IFMSA) is a non-profit, non-governmental organization representing associations of medical students worldwide. IFMSA was founded in 1951 and currently maintains 125 National Member Organizations from more than 100 countries across six continents, representing a network of 1.3 million medical students.

IFMSA envisions a world in which medical students unite for global health and are equipped with the knowledge, skills and values to take on health leadership roles locally and globally, so to shape a sustainable and healthy future.

IFMSA is recognized as a nongovernmental organization within the United Nations’ system and the World Health Organization; and works in collaboration with the World Medical Association.
Dear readers,

The term 2014-2015 is in its last couple of months, and it’s time that we present you with yet another issue of MSI. For a couple of months now, the publications team has tirelessly worked - alongside the Standing Committee Directors, Projects Support Division Director and Vice-President for External Affairs - to bring you the best that is being developed on the local, national and international levels.

Working on this publication has been an eye opener for us, going through over 170 article submissions, choosing the most relevant to the theme and the priorities set by the Standing Committees, and actually learning about the activities and projects that members of this Federation lead on a daily basis. We would like to thank everyone that had a part in this work, no matter how big or small.

On behalf of the Mikolaj, Esraa, Sadia, Mohamed, Zineb, Tade, Amine, Haleema, Youssef, Ammar and Joel - the Awesome Publications Team - I invite you, dear readers, to embark on this amazing journey, and I wish you a pleasant read.

Best regards,

Firas R. Yassine

IFMSA Publications Support Division Director 2014 - 2015

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Dear Friends,

An assessment of the impact a man has made at any point in his or her life is based on what difference such person has made to his or her immediate environment. In simple terms, we are only remembered for changing the status quo, usually making it better.

The scale of difference can be seen individually and as a cumulative effect. Individual efforts bring about the cumulative impact.

IFMSA as an organization is positioned to making a difference in health and education matters in the world today, and so, training us to do the same. It is our individual efforts, in our various medical schools, that bring about the cumulative successes that IFMSA records. Those little trainings, awareness campaigns, SWG meetings, research and projects all come together to make your society and the world a better place.

The fact that you are not directly seeing the impact of the flyers you are sharing or the small trainings that you are conducting doesn’t make it a futile effort; you are contributing to that pool of cumulative impact!

Making a difference begins with identifying needs in your immediate environment and thinking of ways to begin to satisfy them, even when you know you cannot solve it all. An average person doesn’t take the time to consider what (s)he can do to develop the community, but is rather thinking of what the community can do to make life better for him or her. We stand at different points on Earth as ambassadors of IFMSA. If we can all make little contributions based on the tutelage we have had, the World would begin to transform to “the World we want!”

As you read through this magazine, you would see how your colleagues have dared to make a difference individually and collectively at various places on the surface of the Earth. I hope to read yours in the next edition.

Nelson Mandela said, “What counts in life is not the mere fact that we have lived. It is what difference we have made to the lives of others that would determine the significance of the life we lead”

And this is what IFMSA is about, making a difference in our environment.
Dear reader,

You may be wondering why we have dedicated this edition of the MSI to the migration of health workers, and why it is relevant for medical students. These are questions, which we will try to provide answers to in the next pages. An easy first answer would be that it’s about our future, our communities, and our families!

As the Declaration of Geneva states, we, medical students – and future physicians – are here to serve the purpose of humanity. The present times are bringing us new challenges: working conditions and future opportunities have to be discussed among health professionals – regardless of the specialty we chose to pursue.

Nowadays, it is common to witness young doctors who struggle to run their lives and careers, while not having decent work conditions, underpaid, or even unemployed. It happens that some of us have to work more than 120 hours per week. In many places of the world, doctors are maltreated physically and mentally: a wave of depression and suicides has become a steady trend within the medical profession.

When we think about all of these issues, it is not surprising to see that future physicians are searching for new possibilities, for places that provide a safe work environment, for places they can build and raise their families, build up their future and fulfill the initial purpose of serving humankind. It is impossible to give our best to the communities we serve if we don’t have the conditions nor the motivation.

This is not an isolated problem: it is faced in countries that see a lot of trained health professionals leave their lands, and in countries that receive many foreign physicians. Years of short term solutions and lack of planning have been continuing the global trend of migration, not only from global south to global north, as one might think, but also regionally, from one country of high income to its neighbour. This problem is vast and cannot be explained by numbers only. Responsibility of the medical profession, government care and regulations, engagement of the civil society are among the topics that must be exposed and debated.

We, medical students, recognize the problems and understand that serious action is needed. Simplification of complex topics is not possible anymore. We must seize the opportunities and change the model of migration that is not optimal for our communities anymore. In our global and interconnected world a holistic perspective is needed more than ever. And that is exactly why this MSI edition and the theme event of our next General Assembly are dedicated to this new reality.

IFMSA will continue to constructively work towards exposure, debate and recognition of the migration of healthcare workers, while being careful not to fall for fallacies and easy solutions. We hope to arrive to concrete solutions, which would allow us to support and coordinate action between our members.

I call you, medical students across the world, to reflect about your role in this discussion. Are you taking action for your future? Are you trying to challenge the current models to create a sustainable change? Think about the powerful voices you have and the untapped potential of your actions.

Once again, I would like to show my gratitude to the publications team, for making this magazine happen and of course, to all those who took time to write and submit articles. This truly shows how the medical student community can take meaningful action in the world of continuous change.

With best regards,
Agostinho.
In this section you will find articles on the theme of the August Meeting 2015: Migration of Healthcare Workers.
The migration of health professionals from one country to another is a phenomenon observed worldwide, and is due to a vast multitude of reasons, such as better opportunities, working conditions, or infrastructure. Amidst the WHO Global Code of Practice on the Recruitment of Foreign Healthcare Professionals and the Global Economic Crisis of last year, it is important to address the situation from our own perspective, here in Guatemala.

In fact, migration of healthcare workers is not only taking place between countries, but also within our own borders, especially when it comes to medical doctors. Guatemala is a Central American country, with a surface area of 108,889 km², and an estimated population of 15,073,375 persons. There are five medical schools in six of the 22 departments of the country. A large proportion of students who leave their hometown to pursue medical education end up either staying in the city where they studied, migrating to the capital, or even leaving to another country, seeking better opportunities.

According to a 2009 study carried out by the Pan-American Health Organization (PAHO), the actual number of registered physicians in Guatemala was 13910, giving a ratio of 9.92 physicians per 10,000 people. What is really interesting in this study the variability of percentages and ratios from one region to another within Guatemala: Guatemala City has 71% of registered physicians (ratio 1:332), whereas departments such as Quiché have only 1% (ratio of 1: 9,064).

As would be expected, urban areas have more medical specialists than do rural areas; this could be due to the development of the urban cities, which have better infrastructure and facilities.

Residencies and post-graduate training programs are difficult to access, as the spots available within each specialty are limited, despite have large numbers of applicants and an ever-increasing demand. This is a problem our health system faces on a yearly basis that has yet to be solved.

Migration of healthcare workers, whether internal or external, takes a heavy toll on the health of the population, especially in Guatemala. All hypotheses as to the specific reasons behind this phenomenon are yet confirmed by formal studies – at least in Guatemala. This problem needs to be addressed in collaboration with our healthcare department and our government to improve our overall development by creating more appropriate medical facilities and opportunities.

“Achieving universal health coverage requires sound health workforce planning, quality transformative education systems for health professionals, innovative strategies of service delivery and regulation.”

References:
For the past 20 years, Portugal has faced a big lack of practicing physicians, mostly due to a cap on the formation of medical doctors to about 500 per year. Over that time, the government steadily increased this number by around 400%, which definitely was the biggest increase in the OECD recently, with over 2000 new medical students yearly. If raising the cap on the number of students formed each year was, at the beginning, the obvious and easy solution, it quickly became the problem:

- **Decrease in the quality of medical education in Portugal**: Over the last 20 years, and despite the exponential increase in the number of medical students, only 3 new medical schools were created; they can accommodate around 400 students, only a quarter of the total number. This has obviously increased the student/tutor ratio to intolerable levels, making clinical rotations in some cases impossible or even useless;

- **The number of new medical doctors exceeds the availability of postgraduate residency spots**: One of the best quality assurance measures of the health system in Portugal was the fact that every medical graduate had to go through postgraduate training before they can practice in Portugal. However, the system accommodates around 1500 residents per year, which is far less than 2000 graduates. This has created an enormous burden on Portuguese hospitals, and has ultimately led to a drop in the postgraduate education. Slowly but surely, the possibility of not being able to provide all graduates with a residency spot is becoming imminent;

- **Migration of health workers**: ultimately, the deterioration of the Portuguese pre- and post-graduate medical systems, will force an ever increasing number of medical graduates to leave Portugal, seeking better education and working conditions.

While this problem persists and becomes more serious, we now know that its origin ceased to exist. Portugal is nowadays the country with the 5th best ratio in the OECD (with 4.1 doctors/1000 inhabitants).

The government partnered with specialists in human resources for health and studied about the planning of human resources for health in Portugal, which indicated that the number of medical students needed per year to meet the needs of the Portuguese health system was 1175.

Keeping all this in mind, PorMSIC has organized a campaign over the last 10 years, calling for the sustainable reduction of the medical students cap in order to achieve the proposed value of 1175 per year. On the short term, this would increase the level of pre- and post-graduate medical education, and guarantee every medical student a residency spot.

However, succeeding governments have ignored our proposal, arguing that it is an impossible measure that would be poorly accepted by the general population who still feels the impact of the lack of medical professionals. There are areas in Portugal, where the population unfortunately still faces a large shortage of medical professionals. However, this is a problem related to the management of health human resources, not a question of quantity of human resources. Basically we are choosing quantity over quality (when quantity is not even needed)!

In order to overcome this difficulty, we have readapted our strategy, not only to target stakeholders directly (as we have been doing over the years unsuccessfully), but also to mold the opinion of the general population, through informative campaigns on social media, TV and magazines. PorMSIC will keep pursuing this goal: fighting for the improvement of medical education, and consequently, the quality of our National Health System, which is intricately connected with the reduction of medical students.
Migration of Healthcare Workers: 
Overview of Effects and Policy Making.

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“Whatever house I may enter, my visit shall be for the convenience and advantage of the patient; and I will willingly refrain from doing any injury or wrong from falsehood, and (in an especial manner) from acts of an amorous nature, whatever may be the rank of those who it may be my duty to cure, whether mistress or servant, bond or free”

-Hippocrates of Kos, ca. 460-370 BC

Approximately twenty-five centuries ago, things were looking really good for the small, yet gloriously sunny and rapidly advancing country that lies on the crossroads of three continents. In ancient Greece, during 5th century BC, all aspects of scientific, social and cultural life are in full rise. It is at this exact time that the father of rational Medicine, Hippocrates, establishes the medical school of Kos and writes the texts that are today cherished as the foundations of modern medicine\[2\]. The above citation comes from what probably is his best known text, the Hippocratic Oath, and serves as a rite of passage for medical practitioners worldwide\[3\]. Throughout the text, Hippocrates clearly states that the medical practitioner’s duty shall remain the same, regardless of the rank of the seeker cure.

Two and a half millennia later, the Greece remains gloriously sunny. And that is pretty much all that has stayed the same. Greece is one of the countries hit especially hard by the European Debt Crisis\[4,5\], with inevitable results in each and every one of the public sectors. When it comes to health, Greece’s crisis is worsening as a result of continued healthcare budget cuts\[6\]. Thus, more and more medical practitioners choose to pursue a career in foreign countries, mostly within the EU, due to (1) EU regulations allowing easy transportation/accommodation within European borders and (2) lack of language barrier in English-speaking countries\[7\]. According to last year’s Athens Medical Society figures, more than 7,340 doctors left Greece during the last six years to pursue a medical career elsewhere\[8\].

Greece, undoubtedly a good example for our case, is not the only country where health workers migrate largely. Other countries suffering from flight of medical personnel or medical ‘brain drain’ include other Mediterranean countries (Portugal, Spain, Italy, and Cyprus), Ireland and many South African countries\[9,10\]. It is worth mentioning that this human capital flight happens in the majority of cases right after graduation from medical school, so that the country of origin has already invested large sums of money into training the young health professionals.

While authors support that this export of human resources has lately become a money machine for the receiving countries such as the US, contributing large sums of money to the country’s own economy, its flaws are inherent in its title, since it involves a loss of human capital for the countries of origin. Emigration of skilled and/or trained health workers may only provide personal benefits for individuals rather than public benefits. This process is more likely to result in an uneven distribution of knowledge and skilled professionals worldwide, with predictable results into the future healthcare systems of the countries involved and further economic imbalances for the countries of origin\[11\]. Those health workers who remain in public health systems with inadequate numbers of health workers experience added stress and greater
workloads. Many of the remaining health workers are ill-motivated, not only because of their workload, but also because they are poorly paid, poorly equipped, inadequately supervised and informed and have limited career opportunities compared to their colleagues who have fled[12]. As for health systems of the countries of origin, they are left with insufficient – in both numbers and skills – health care workers, thus deeply harming local health systems.

Remittances – the portion of international migrant workers’ earnings sent back from the country of employment to the country of origin – are of crucial importance in the economic settings, nowadays becoming a focal point in the ongoing debate concerning the cost and benefit of international migration for employment. Although remittances provide some compensation for the countries of origin, they are most probably not directly reinvested in human capital for the health system. This means that those countries sending more health professionals than they are either receiving or producing will end up with a net loss of human capital in the health system[12].

The health migration situation has been painfully familiar to health policy makers and stakeholders internationally over the last years, resulting in World Health Organization trying to apply global health diplomacy by coming up with the WHO Global Code of Practice on the International Recruitment of Health Personnel. In the context of migration, the Code encourages “receiving” countries to consider the impact of their policies and actions on the countries from which health workers migrate[13][14]. The Code was adopted in 2010 by all 193 Member States of the World Health Organization and has shown new light on the efforts for efficient distribution of health workers globally. Apart from the WHO, the World Medical Association supports the Code and furthermore provides recommendations for countries involved in exchange of medical personnel, in yet another effort for these exchanges to be somewhat facilitated and for their negative effects to be diminished[15].

Crucial to the success of the Code is the willingness of countries to implement it, which in turn depends largely on national and international dialogue and cooperation, including the exchange of information and data. However, in terms of policy setting, the most vital truth remains that managing migration in only viable through international co-operation. This co-operation can take the form official agreements among countries and/or their health institutions in favor of return migration. Moreover, improving numbers and statistics in terms of tracking down the migration tendencies over the last years will help the involved countries to develop evidence-based policies, applicable in the specific cases[16].

Note: The opinions expressed in this article are the author’s own and do not reflect the view of HelMSIC, or any other group.

References:
Migration of Healthcare Workers
In the Americas Region

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The loss of national talent, dubbed by many as “brain drain,” is a global phenomenon requiring a comprehensive approach from all sectors. The Americas’ region isn’t indifferent to this phenomenon. Many are the reasons behind Health Workers migration: the three main ones are: pursuing post-graduate education, looking for job satisfaction with the opportunity to have a decent life, and finally, escaping political oppression and professional stagnation.

It has been stated that the primary reason for medical migration is not financial, but rather the desire to learn and the yearning for professional achievement; though regionally, we still face underpaid Medical Doctors and political persecution in many of our countries, only exacerbating this already troublesome situation.

Health workers migration:
Is estimated that between 25 and 28% of doctors currently practicing in the USA, UK, Canada and Australia, have obtained their degrees elsewhere, mostly (40-75%) in low-income countries. Combined figures show that 1,589 Jamaican physicians are working in the aforementioned 4 countries - that’s approximately 70% of the total number of doctors in Jamaica. Similarly, there are 1,067 Haitian physicians (55% of those working in Haiti), 3,262 Dominicans (21% of those working in the Dominican Republic); that should divert attention from the case of doctors from Bolivia, Panama, Colombia, Peru, among other countries, though their numbers are much less.

The scenario described is plotted as a carousel, in which for example doctors from Uganda move to South Africa, doctors from South Africa and Pakistan move to United Kingdom, doctors from the UK move to Canada, and doctors from Canada end up migrating to the United States.

Among receiving countries, the USA hosts the highest percentage of migrating doctors; their percentage rose 18% in the 70s to about 25% in 2008.

What motivates the migration?
It is observed that factors corresponding to salaries, career development, employment, economic crisis and conflict are present across all countries in the Americas. There are important differences that should be noted, however:

• In the case of Venezuela, the weight attributed to conflict is the highest;
• In the case of Bolivia, the predominant factors are related to employment and professional development;
• In the case of Colombia, all factors contribute equally to migration of health professionals;
• In the case of Peru, the weight factors related to employment remains significantly higher compared to factors related to salaries, professional development and economic crisis;
• Finally, in the case of Chile, the pattern is remarkably unique; most of the weight is attributed to factors related professional development, with no weight to factors related to economic crisis or conflict.

Tackling migration: What is needed?
Exporting countries:
• Protection and fairer treatment of health workers, who still face difficult and often dangerous working conditions and poor pay.
• Training of health workers specifically for rural areas, and development of policies that facilitate the return of health migrants.

Importing countries:
• Reducing dependency on migrant health workers in industrialized countries, by training more health workers at home. The United States, for example, trains 30% fewer physicians than needed to meet its needs.
• Bilateral agreements with exporting countries aimed at softening the financial impact of migration of health
workers.
• Responsible recruitment policies by industrialized countries and fair treatment of migrant health workers.

The Facts:
• Migration of health professionals, particularly physicians, is a right that should not be limited, modulated or prevented, regardless of the consequences for health systems in our countries.
• Migration of doctors is a process that affects the quality of health systems in many countries, depriving them of highly qualified personnel.
• Countries should work on an incentive scheme for medical doctors and health professionals that covers not only financial support but also access to quality education.
• Migration of doctors, mainly by influencing junior and recently graduated physicians, significantly compromises the prospects of the healthcare workforce.

A new generation, a new challenge:
We face a different reality than past generations; globalization has broadened horizons of many medical students and junior doctors. The changing socio-economic reality in the Americas has become a threat to the health systems in the region.

More so, national governments have realized the problematic behind the health professionals’ migration and started to develop better educational programs and more attractive work opportunities.

We live in a time where talent is highly valued and it is up to us to decide where and how we want to develop ourselves; yes, we have a commitment to our home countries but we have a bigger commitment to ourselves.

Migration of Healthcare Workers:
The Mexican Perspective

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One of the major problems any society can face is social inequality. When addressing such a topic, it is essential to mention the disparities of the health sector.

A balanced society requires healthy, productive people with good quality of life. But what happens when one of its fundamental pillars (e.g. the healthcare system) crumbles? And what happens then to the healthcare providers?

Currently, government, military, and private providers hold most of the healthcare system in Mexico. When the government (public) healthcare systems were put into effect in 1943, the future of healthcare in Mexico was promising, with quality services, modern and sufficient infrastructure planned, and decent wages to service providers (doctors, nurses and staff). The medical profession was the most prestigious in the country and the number of medical graduates met the need for Mexicans. It was a sustainable healthcare system.

The great recessions of the 90s and the alleged corruption of politicians and officials in charge of health services, coupled with a stagnant national economy, an exponential increase in extreme poverty and social inequality, have all caused great challenges in the national healthcare system, reflected in a lower budget
allocation by the federal government. This resulted in a shortage of healthcare staff (especially doctors), overcrowding of hospitals, and poorer care of first contact patients.

Mexico also suffered due to violence triggered by the war on drug cartels by former President Felipe Calderon, causing doctors from rural areas to retire to urban areas to avoid risk, thus depriving rural populations of primary care physicians.

The advent of Seguro Popular (People’s Insurance), a program funded by the federal government covering health expenses citizens without health insurance, lead to further crowding of second and third level hospitals. This has directly affected service providers – especially young doctors who feel they are being overexploited.

The perspective of Mexican doctors: Working conditions for medical interns, rural doctors and residents are not adequate. They have 36-hour shifts, adding up to more than 100 hours per week, with their salaries ranging between US$1,000 and US$2,000 per month. They have a huge patient load to attend to in a short period of time, which increases the risk of human error and malpractice.

Vacant healthcare spots in rural communities are often filled by new graduate doctors, who are contracted for a one-year period as part of their continuing training, with salaries around US$200 per month. These physicians sometimes work without proper medical supplies or in situations of physical insecurity.

As in many developing countries, top-ranked medical graduates seek opportunities abroad where better job conditions and better quality of life are offered. They can be the future of an almost broken healthcare system, yet, we are being deprived from their skills by their migration to other countries. The Mexican government is yet to act on behalf of physicians. In fact, over last year the government has reduced the overall budget allocation for health, which will further increase inequalities and deteriorate the healthcare system.

What are possible solutions for all these problems?

One of the biggest challenges facing the Mexican government is making the healthcare system more efficient, and providing doctors optimal working conditions and decent wages. A simple, but not so tangible short-term approach is dealing with corruption and diversion of federal public funds.

A Healthcare reform that benefits everyone is seeking to form as many primary care physicians (family physicians and geriatricians) as possible, with a larger focus on the development of rural areas, as well as a better remuneration of physicians based there. Also of paramount importance are the improvement of the general security, the reform of job conditions, and the provision of adequate and sufficient medical supplies and equipment to hospitals, based on international standards.

Above all, the government needs to support new medical graduates, and encourage and allow them to play their part in the transformation of the healthcare system. The future of health in Mexico depends on the ability of new leaders, entrepreneurs and young doctors to change an entire – failing – health system. Public policies put forth by politicians and organizations such as the WHO, will not do much if the biggest problem (corruption) is not addressed.

Most of the migration of physicians in Mexico is due to the disappointment in national institutions and the apathy towards the government.
Migration of Healthcare Workers: A Major Contributor to Health Disparities

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Looking at Africa, and more specifically at Uganda, through a lens to try and assess the migration of health workers we are confronted with here, we can see that it is dependent on many factors, which we call “push” and “pull” factors. Examples of push factors are poor working conditions, limited educational and career opportunities, low pay, poor government health policies, economic and political instability. Pull factors are the opposite. These contribute to the “brain drain” phenomenon.

In early 2015, the Ugandan government wanted to export 283 highly skilled health workers to Trinidad and Tobago, despite the fact that the ratio of doctors-to-patient in Uganda currently stands at 1:25,000 and the ratio of nurses-to-patients stands at 1:11,000, which way below the WHO recommendation. This move was revoked after being challenged by many individuals and non-governmental organizations. A group of students in a Social Medicine class wrote an anonymous letter to the president of the republic asking for increased government budget allocation for health (up to at least 15% GDP as was previously agreed). The letter argued that, in signing onto the Abuja Declaration in April 2001, the Ugandan government committed itself to continue efforts to designate a full 15% of its budget towards tangible health sector improvement. As of 2013 this spending totaled less than 9%. In order to meet the WHO International Sustainable Development Goals, the group advocated for a strong push towards increased budget allocation, especially in the areas of healthcare worker recruitment and retainment. The lack of support for healthcare providers in areas such as health facility infrastructure, access to medical resources, and remuneration remains a significant problem in Uganda. In 2012, a cross-sectional study of Ugandan health students indicated that 63% of recent graduate left Uganda within five years of their graduation while 84% intended to pursue post-graduate studies abroad. Seventy percent of nursing students surveyed at one Ugandan institution intended to practice outside the country. The Uganda Medical and Dental Practitioners Council found that, of the 4,200 physicians registered in Uganda in 2013, only 1,200 were actively practicing clinical medicine. An estimated 2,000 left the country over the past 10 years.

These numbers are extremely troublesome, especially when the current healthcare worker to patient ratio is only 1:1,298. To meet basic healthcare needs, the WHO recommends a health care worker to patient ratio of 1:439. A 2011 study performed at 18 Ugandan hospitals indicated that 63% of physicians who ultimately choose to stay in Uganda are dissatisfied with their work, while 47% are considering leaving their jobs or the country. Reasons cited include poor compensation, lack of medical resources, poor quality of facility infrastructure, and patient overload.

Ultimately this medical “brain drain” has grave consequences for Uganda. In addition to the estimated $13 million lost annually due to emigrating health professionals, loss of health professionals in Uganda dramatically reduces Ugandans access to healthcare. Unacceptably common are the dramatic and tragic stories reported by exhausted health care where shortage of providers and/or resources directly resulted in preventable patient injury and death.

By examining health sector financing in other countries it becomes clear that increased government spending has huge positive impacts on the health outcomes of its citizens - and this, by extension, positively impacts the country’s economic environment as a whole. Two standout examples are Sri Lanka and Rwanda. In Sri Lanka, the government spends $189 per capita on the health sector, which has resulted in a life expectancy of 75 years and a physician retention rate of 87%. Rwanda
has become a health care model for countries around the world; they currently spend $144 per capita and have an average life expectancy of 69 years\(^\text{10}\). By comparison, the Ugandan government only allocates $108 per capita and continues to lag behind other countries in outcomes, with a life expectancy of only 56 years on top of the previously noted poor retention of health care workers\(^\text{11}\).

These results cannot come as much of a surprise, as less than half of the healthcare workers (3,037 out of 6,839) were able to access their payroll in 2013-2014\(^\text{12}\). Poor government funding of public health sector has resulted in a shift of focus towards privatized institutions, often at the expense of public ones. In addition, over 85% of health care sector spending is obtained from outside funding and international donors\(^\text{13}\). If our goal is to continue to strengthen and improve the health of the Ugandan people in a sustainable fashion, increasing the government’s investment in the public health sector, particularly in the areas of recruitment and retention of Ugandan health workers, is absolutely key. And this can apply not only in Uganda but out in any country especially in Sub-Saharan Africa.

References:

0) http://www.ippr.org.ug/index.php/uganda-under-fire-for-exporting-health-workers


“House, MD,” the American television medical drama, is one of the most popular series among my colleagues in class. For most of my classmates, it offers a perfect break from the enormous workload of medical school. However, although most students would hardly admit it, it also offers a moment to fantasize about the ‘ideal’ medical career, which most Kenyan students dream of having, but are not sure they will ever get a chance to. This is because most of the local health facilities are despicable compared to the ultra-modern hospitals portrayed in medical drama series. This is in fact one of the reasons why Kenyan health professions opt to leave the country at the nearest opportunity.

Migration of health workers continues to be a huge tragedy in Kenya, in spite of the increasing health worker to patient ratio. According to a 2007 survey, there were 16 medical doctors per 100,000 and 88 nurses per 100,000 inhabitants (Mwaniki and Dulo, 2008). At the Wajir District Hospital, one of the local district hospitals, there were only 2 doctors remaining, serving a population of 200,000 people. A study done on the Impact of Out-Migration on the Nursing Workforce in Kenya found out that for every 4.5 nurses trained by the government, 1 applies to and takes a job outside the country (Gross, Jessica et al., 2011). This potentially reduces Kenya’s ability to increase its nursing workforce through training by approximately 22%. However, could this huge exodus be justified?

Several factors fuel the migration of Kenyan health workers to developed countries, mainly the US and UK. Top on the list is poor working conditions. Most of the district hospitals and dispensaries lack even the very basic of utilities like latex gloves, cotton, needles, and syringes. For a health worker who clearly understands the adverse effects of poor hygiene and contamination in a hospital, this practically paralyses his or her services. Moreover, as a consequence of the increased migration, most hospitals remain understaffed. This leads to an increased workload for the remaining health workers, subsequently leading to burnout, stress, and demotivation. With such poor working poor conditions, health workers in Kenya continue to shy away from public hospitals and would rather work in private hospitals or start their own private practice at the slightest opportunity.

The effects of migration of health workers cannot be ignored. Apart from increasing the burden on the already understaffed health centers, the country also continues to lose great minds who have been trained and bred locally to the developed countries. Inarguably, majority of the health practitioners emigrating are the most experienced ones. This further starves the country of quality medical service.

Kenyan health workers generally perceive migration to developed countries as a path to better working conditions, better remuneration and more options for career development and progression. For those who make it to the greener pastures, they continue to excel at the international stage. Sadly, this is at the expense of an entire nation’s health, not to mention the huge loss the government incurs after spending approximately US$ 95 million on university medical training.

Fortunately, the Kenyan government is slowly coming to terms with this calamity and has finally started taking this bull of migration of health workers by its horns. In the past few years, there has been significant development in increasing the remuneration of health workers. The government is also keen on providing career development options and numerous incentives in an attempt to lure health workers back to the public sector. The government has also invested in training health workers by increasing the number of institutions offering medical and health-related courses. While these efforts deserve to be applauded, a lot still remains to be done to fully stop the migration of Kenyan health workers.

As for my classmates who continue to build their fantasies on medical dramas, I can only hope that by the time they graduate, our local hospitals will have reached the caliber of the fictional Princeton-Plainsboro Teaching hospital, complete with an enviable diagnostics team! Then they would have no reason to migrate.
Brazil is a country of continental dimensions, located in South America, with about 202 million inhabitants, and an average territorial extension of 8 million km². In spite of these challenging numbers, the right to health is ensured by the Constitution to every Brazilian citizen, without distinction based on color, gender or social class, as per Law No. 8.080 of September 1990, which also ensures the creation of the Unified Health System (SUS), the Brazilian public health system [3,8].

The Unified Health System resulted from a long campaign by health professionals and the general public, based on the national need of providing a greater commitment to health in its broadest sense. The objective was to change the old model, where big hospitals and healthcare were regarded synonyms of treating diseases. People considered health as a careful and interdisciplinary status of working, with other social issues, such as food, work, income level, education, sanitation, housing, leisure and others [8,9].

The public health system was thus built around policy principles such as universal access, decentralization and social participation [8].

To better understand this phenomenon, which culminates with the creation and operation of SUS and the present perspective of Health in Brazil, it is crucial to understand the installation of medical schools in Brazil. The establishment of medical courses in Brazil dates back to the year 1808, with the creation of the Bahia School of Surgery, in northeastern Brazil, and later with the foundation of the National School of Medicine, in Rio de Janeiro. According to data from the Brazilian Ministry of Education, there were 9,906 spots in medical programs in 2001. By 2011, that number had increased to 16,752. Accompanying this growth was the opening of medical schools, with a strong policy of increasing spots available in the North, Northeast and Midwest areas of the country [1,9].

Brazil’s population growth raised a deeper discussion about the distribution of medical professionals. What would the ideal number of physicians be for our population? To be able to better answer this question, a comparison with other countries is needed: Portugal (2.64 doctors per 1,000 inhabitants), United Kingdom (2.74), United States (2.67), Cuba (6.04) etc... In 2012, the Federal Council of Medicine (CFM) hinted that the number of practicing physicians in Brazil nearly 400,000, resulting in a rate of 2.0 physicians per 1,000 inhabitant. Yet, Brazil still faces huge challenges with the distribution of medical professionals across various cities of the country, exposing the reality of a great disparity between its regions [9]. While the capital state reaches a ratio of 4.09 doctors per 1,000 inhabitants, other states such as Maranhão may have rates as low as 0.71 doctors per 1,000 inhabitants [9].

It is well known that the majority of doctors formed in Brazil end up working in major cities, with the main reasons for that including well-developed health services, good work conditions, employment offers, good pay and good quality of life. These factors also influence directly the migration process of health professions, either national or international level [11]. The internal migration of health professionals is a voluntary unidirectional movement, taking into account the various benefits given to the health professional in major cities. In contrast, the non-retention of physicians in small towns and rural areas is mainly due to bad of working conditions, no career prospects and poor quality of life [1,5,9].

The Brazilian government attempted to amend operating conditions of medical schools by introducing Law No. 12.871 in 2013, aiming at the creation of spots in rural areas and the establishment of the program “Mais Médicos” (More Doctors, in English) [7]. Despite its objectives, the project was not well received by much of the medical society; many critics pointed out several flaws in the platform, including the agreement signed with the Pan American Health Organization (PAHO),...
which established the compulsory migration of Cuban professionals, the neglect of the current residency programs, the difficult access and poor working conditions in the peripheral areas of the country, etc...

Following the example of the Brazilian Judiciary System, whereby the appointment of magistrates follows a certain structured procedure ensuring adequate service distribution, the Federal Council of Medicine and the Brazilian Medical Association proposed the creation of a “state career” in the Unified Health System for Brazilian physicians, as a measure to solve all problems at hands that are due to the internal migration of health professionals (2,5,6). The system would work as such (2,5):

- Physicians would sit to an exam prior to going into public career;
- A minimum wage would be established to ensure adequate remuneration;
- Well-defined mobility would assistance to remote communities that most need it, with the possibility of future change over time;
- Functional ascension, both professional and financial, would be guaranteed for physicians with longer years of service;
- Professional development would be encouraged, taking into account the importance of continuing medical education (CME);
- Funding from the National Treasury would ensure adequate investment in and maintenance of the program;
- Finally, physical infrastructure and adequate facilities would be installed in municipalities, in order to guarantee the quality standards expected to be met through the public health system.

There are currently three proposals for Constitutional Amendment before the National Congress, with similar versions of the State career advocated by medical organizations and public authorities in searching a decent and sustainable solution. The aim is to bring such knowledge to the public, remembering the importance of teaming up with medical organizations and public authorities in searching a decent and sustainable solution. The quality of Public Health should always be our priority, and we must fight for everyone’s (universal) right to Health. The implementation of a state career in the public health system is the most promising of debated solutions.

References:

Exceptionally in this issue, the publications team has decided to give you an overview of the new IFMSA Programs, which were voted into effect during March Meeting 2015. Enjoy!
Take the step. Make the change!

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“You may never know what the result come from your action. But if you do nothing, there will be no result.”

- Mahatma Ghandi

The actions of medical students all around the world come together through activities done by National Member Organizations. Those activities matter because they are actually making the change across communities. They not only improve the environment of people around us, medical students, but they also improve us, make us prosper, evolve and learn from our actions, even when, sometimes, those actions are not be producing visible outcomes.

The beauty is hidden in the road you take from the idea you get while having a coffee with a friend, while travelling in some village in your country or by while reading the newspapers and observing. There are many ideas and dreams out there, but only you, who take that first step, will makes those ideas a reality and create the change you desire.

Many medical students, members of IFMSA, have taken their first steps. Some of their actions are represented with words and pictures in this section MSI. Some will be displayed during the Activities Fair of the August Meeting 2015 in Ohrid, Macedonia. All those, as well as the ones not put in letters, make the change and teach us medical students about medicine, health, and life.

On behalf of the Project Support Division, Lilly.
An Overview of IFMSA Programs

What are IFMSA Programs?
IFMSA Programs are centralized streams of all affiliated activities done by IFMSA National Member Organizations (NMOs) and IFMSA as a Federation internationally. They address a problem within a specific field that we, as medical students and global health advocates, stand up for while connecting local, national and international activities and opportunities that contribute to the final outcome.

All IFMSA Programs fall in line with IFMSA’s vision, mission, priorities, strategic plan and work of NMOs locally and nationally. They are established by NMOs during IFMSA General Assembly with the support of the IFMSA Executive Board, ensuring their quality, consistency and sustainability.

Joining IFMSA Programs
There are two ways to join IFMSA Programs: either by enrolling your activity with relevant IFMSA Program as an Activity Coordinator, or by joining the Program Teams. Any medical student that is a member of any NMO and organizes any type of activity can apply to enroll the activity within IFMSA Programs. Activities include, and are not limited to, projects, campaigns, celebrations, workshops, events, trainings, and theme-based publications relevant to the theme of the program.

IFMSA Programs Teams are informal and flexible groups of medical students from diverse countries worldwide that support the work of Program Coordinators. Any medical student that is a member of the IFMSA can be involved in the international work of the program while some such are members of Program Teams have official tasks in the Program Teams.

Program Teams are led by Program Coordinators, whose task is to facilitate communication while supporting members to organize diverse activities, whether local, national, or international. Additionally, they build capacity on the topic of a program among medical students worldwide, promote and coordinate research on the same topics as well as related IFMSA advocacy efforts.

Medical Education Systems
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Medical Education Systems is an integrated program aimed at creating a platform where medical students will learn about the medical education system and students’ meaningful participation in faculty decision-making. Ultimately, these skills will empower students to take a leading role and actively advocate their inclusion in decision-making.

Projects, trainings and workshops are organized for students to learn about different areas of medical education. The core issues of this program include curriculum development, quality assurance, student mobility, student’s rights, global health education implementation, meaningful participation of medical students in university decision-making, and recognition of non-formal education. In the future, we expect to include educated and empowered students on medical education topics, students’ participation in the quality assessment and evaluation of medical education in the faculties, medical curriculum adapted to globally recognized medical education guidelines, and integration of Global Health in the curriculum.
An Overview of IFMSA Programs

Teaching Medical Skills
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Although medical education should provide each aspiring physician with appropriate knowledge, skills, and attitudes for independent work right after graduation, in reality, there is often a gap. Students do not have enough opportunities for clinical practice or are taught using outdated methods, while some other skills that are necessary for everyday work are assumed to be learnt spontaneously.

Teaching Medical Skills aims to work on the following: (1) analysing of the current situation across medical schools, (2) assessing of the quality and needs of medical students, (3) providing learning opportunities through educational activities, such as competency-based trainings and workshops with academic quality ensured, and (4) advocating with faculties to provide support, recognition of non-formal education, and work towards integration of well-structured competency-based programs in curricula. Contributing to creation of competent and confident doctors, we directly ensure that the best possible care is provided to the ones who most depend on us – our patients.

Healthy Lifestyles & Non-Communicable Diseases (NCDs)
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Healthy Lifestyle and Non-Communicable Diseases (NCDs) is a comprehensive program approaching the issue, both directly and indirectly. Our goals are promoting healthy lifestyles, raising awareness about what NCDs and their burden are, and raising awareness about the modifiable risk factors leading to NCDs. Knowing that physical inactivity, imbalanced diets, and excess alcohol and tobacco consumptions are very adjustable, any intervention towards their control and prevention, builds a better perspective for reducing the burden of NCDs. Needless to say, the program focuses on educating medical students about the issue; as future health professionals, we often lack proper knowledge on non-clinical and public health aspects that contribute to NCDs. On the other side, the program works on empowering medical students worldwide to join multidisciplinary advocacy efforts in local, national and international level.
An Overview of IFMSA Programs

Comprehensive Sexual Education (CSE)
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The subject of sexual health is usually not brought up because teenagers often feel uncomfortable talking about it with their parents and teachers. Many schools also have no teachers sufficiently trained to teach about the subject. Failing to provide CSE in schools has been shown to actually increase the rate of teenage pregnancies and STIs. Providing CSE on the other hand has been shown to raise the age of sexual debut, decrease STI transmission, stigma, and discrimination against LGBT and teenage pregnancy.

The goals of CSE is to help young people gain a positive view of sexuality, and to provide them with developmentally appropriate knowledge and skills to be able to make healthy decisions about their sex lives, now and in the future. It can build a generation of women and men comfortable in their own skin, able to make responsible decisions, form healthy relationships, and take care of their bodies. Another important goal is increasing the number of trained peer educators on sexual and reproductive health issues, who are equipped with the most recent and relevant information.

Maternal Health & Access to Safe Abortion
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The program Maternal Health & Access to Safe Abortion aims to provide medical student with the tools necessary to understand the importance of maternal care, and reduce stigma and discrimination surrounding abortion. There is a great need to get more outreach to the population; youth, women, medical students, providers of healthcare services, non-governmental organizations, could all transcend cultural barriers through collaborations on different activities. IFMSA and Ipas have been working together educating future physicians on the topic, through trainings at General Assemblies and Regional Meetings, and the manual “Youth Act for Safe Abortion.”

One of the our goals is to start implementing trainings, advocacy, and activities relevant to maternal health across National Member Organizations, both locally and nationally.
An Overview of IFMSA Programs

Dignifying & Non-Discriminatory Healthcare
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The right to health, as mentioned in the Universal Declaration of Human Rights, entitles all individuals to the highest attainable standard of healthcare. This program aims to empower medical students to advocate and work towards dignified, non-discriminatory health systems that are inclusive and accessible to everyone. Special attention is given to cultural, religious and ethnic minorities, refugees and undocumented migrants as well as people suffering from physical or mental impairment, facing geographical, economic or linguistic barriers and all other vulnerable groups. The program also aims to improve the living conditions of these populations, as these are strong social determinants of health.

The work of the program entails action by medical students from local to international level, as they work with stakeholders to change the current situation of health and healthcare in their countries. The program will include trainings and peer education on skills such as advocacy as well as on human rights and health. In addition, medical students, will receive training on how to understand and communicate with patients that come from vulnerable backgrounds.

Emergencies, Disaster Risk and Humanitarian Actions
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Health is endangered in emergencies and disasters; even more so in cases of weak public health systems, lack of preparedness, and lack of safety precautions. Medical professionals are often not equipped with the knowledge and skills needed to react. Emergencies tend to disproportionately affect the poor, children, women, the elderly, and other marginalized members of society, hence aggravating existing health inequities.

The aim of the program is to enable medical students to contribute to the creation of resilient and safe health systems, equipped to tackle hazards be it natural, technological and man-made, and prevent them from turning into a disaster, while ensuring humanitarian support to the ones that need it most. It will tackle topics like conflict and peace-building, placement of refugees and migration within countries, disaster management and resilience, border health, disaster ethics, humanitarian response and law, the right to health in disasters, safe health facilities, etc...
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 utilize and to get involved at the local, national and transnational levels. Here, you can read about the contenders for the Rex Crossley Awards.
The mental health and wellbeing of medical students is a subject often swept under the rug, a stigma hidden by white coats.

Medical students consistently have higher rates of mental health issues compared to the general population – including stress, distress, burnout, anxiety, and depression. We enter university with the same levels of psychological wellbeing as the general population, but during the course of medical school our risks go up significantly.

- 1 in 5 Australian medical students in the last 12 months have had thoughts of suicide;
- 1 in 2 Australian medical students suffers from emotional exhaustion;
- Almost 20% of Australian medical students have been diagnosed with depression;
- 40% of Australian medical students perceive stigmatizing attitudes towards mental health conditions.

Our campaign aims to improve and address medical student wellbeing through action at a “grass roots” level, as well as affecting change at a university and external advocacy level.

In order to successfully address these issues, the AMSA Mental Health Campaign aims to:

- Decrease stigma and increase awareness and mental health literacy regarding mental health issues amongst medical students;
- Promote preventative measures to improve coping strategies and resilience;
- Enable and empower students to look out for their peers and colleagues;
- Facilitate improved access to and uptake of mental health services.

It aims to achieve this through a range of activities and projects, such as

- Academy of the Mind online course focusing on mental health of medical students. The course focuses on wellbeing, looking after colleagues, and the broader issue of mental health and wellbeing from a public health perspective;
- Blue Week, a series of events over a weeklong period that aims to engage the medical student body in the area of mental health and wellbeing through increasing mental health literacy and reducing stigma among the medical profession;
- Keep Your Grass Greener, a wellbeing guide for medical students and first released in 2011 in conjunction with the New Zealand Medical Students’ Association (NZMSA);
- National Mentoring Network, a national initiative seeking to bring together all those interested in the establishment of mentorships for medical students;
- Campaign for medical students to get a general practitioner, born out of a growing concern that few medical students and doctors had their own general practitioner, and as a result were not seeking help when required or self-treating;
- Social media & our website which consists of information regarding student mental health, as well as a resources for seeking help across Australia;
- Code Blue, a pre-GA workshop delivered at the 2014 AM.
Anti-Drug Addiction

Omneya Mahmoud  
IFMSA - Egypt

A catastrophe that hit young adults and adolescents of our population has recently been proven to be a social and economic burden over the past few years. Drug addicts and distributors prey on young adults and adolescents by making them believe drugs are their key to excitement, and to escape life’s burdens. They perfect mind games, claiming drugs make a person act like a man and help them gain respect.

IFMSA-Egypt decided to take action, and those are exactly the issues we are tackling: misconceptions should be corrected. They should be faced by knowledge and science.

With such bad habits infesting our productive age group, we work along the side of the Egyptian government to put an end to such an act. We signed an official agreement to decrease scenes with drug addiction and smoking in Egyptian movies and series, with the full support from various government agencies including the ministry of health and ministry of youth.

All in all, we are facing a time bomb, which could explode any time but we are on the right track of diffusing it.
HealthFest is an annual celebration of health, well established in MMSA’s annual calendar. It aims to celebrate our health from a holistic aspect, as well as tackling a wide variety of health issues, and empower people to adopt a healthy lifestyle.

This year, we organized three events in the span of one week. Seating students down and educating them about their health is not enough; we decided to challenge them through interactive fitness competitions. Packs of healthy food were distributed to participants in order to expose them to healthier alternatives. We also have distributed prizes to winners such as free gym memberships to remove any financial obstacle.

On the last day of celebrations, we set up a tent in the heart of Valletta, to offer the general public free blood glucose and blood pressure measurements. We have also collaborated with the Health Ministry’s Health Promotion Department to offer free BMI testing. MMSA Campaign Coordinators set up their stands to educate the public not just on Public Health but also on Human Rights and Sexual Health. We distributed free samples of healthy food and held sports demonstrations in collaboration with various sports organizations, such as a Taekwando group, to encourage people to sign up.

New to the program this year was a 5-day conference targeting students aspiring to work within different disciplines of the healthcare system. It took place parallel to the HealthFest on the University Campus, and was funded by a European Union grant. It consisted of sessions in which students, government representatives and medical professionals sat together and discussed health issues that need to be tackled in our country, such as drunk driving and sex education. Medical professionals gave an overview of the problems at hands while government representatives, including members of parliament and personnel from the Health Ministry, explained what the government is doing to tackle them. The students then debated together all possible solutions, leading up to a draft policy paper, which we distributed to the national media.
Every day in Slovenia, at least one person commits suicide, we rank 6th worldwide. Committing suicide has almost become socially acceptable and part of the culture.

Project In Reflection tackles the problem at several levels. First, we are organizing workshops targeting secondary schools students (ages 14-17), where we destigmatize mental disorders through a debate between 2 students. The workshops start by brainstorming about mental health and mental disorders. Topics such as eating disorders, psychosis, substance abuse and anxieties, self-harm and suicide, as well as stress prevention are covered. Each participant gets a scroll with a motivational quote, a follow up email and help line numbers. Our workshops have been proven to raise the percentage of correctly answered questions on pre- and post-workshop forms from 25% to 85%.

Several other campaigns are organized: (1) Eating disorders Awareness Week; (2) International Self-injury Awareness Day, with a literary contest entitled “When the pain hurts less” held in partnership with the national newspaper; (3) International Day against Drug Abuse, with an art contest; (4) European Depression Day, with a cross-faculty obstacle course; and finally (5) World Mental Health Day, with activities in Ljubljana.

One may say making a change takes a long time. Does it? Our project is relatively new (2013) and we already see results. There is nothing like students sharing their struggles with mental disorders more and more commonly in the workshops. It not only benefits them by relieving stress, but also us, organizers and participants. Unfortunately, nobody is immune to mental disorders. Step up, speak up and make a change!
Let’s Learn About Bullying

Carles Pericas Escalé & Josep Ferrer Arbaizar
AECS - Catalonia

Bullying has been defined as “unwanted, aggressive behavior among people, which involves a real or perceived power imbalance; the behavior is repeated, or has the potential to be repeated, over time.” It is clearly a serious social evil and a health issue: studies have shown bullying to be related to physical injury, social and emotional distress, psychosomatic complaints, poor school adjustment and even death. Although the link between suicide and bullying still remains controversial, several studies have shown bullying to cause mental health issues such as depression and anxiety, which, in themselves, are key risk factors to suicide. Moreover, a study published in 2014 in JAMA Pediatrics, found that victimization is a risk factor for child and adolescent suicidal ideation and attempts.

As statistics show that the number of bullying cases is currently on the rise (presumably due to the emergence of new harassment tools, like cyber-bullying on social networks), taking action has become crucial. In fact, studies carried out in the USA have shown that school bullying prevention programs decrease bullying in schools up to 25 percent, proving that acting against bullying is in fact useful. AECS-Catalonia designed a peer-education-based project in order to assess this issue with students who may someday become actors in bullying. This is how the LLAB (Let’s learn about bullying!) project was born.

Peer education has shown to be an effective tool to fight bullying. Many schools worldwide have already embraced this strategy; however, in Catalonia, no previous peer-education-based method had been established to date. For months, medical students from AECS gathered to devise the best approach to the issue. We had to research the most interesting target groups (statistics show that bullying peaks in middle school, while children are making the transition from children to young adults), as well as peer-education methods. National Peer Education Trainings had to be organized in order to provide students with the skills necessary to correctly communicate with the children. It was hard and time-consuming, but the efforts have definitely been worth it: this project allows both peer educators and children to learn about the issue and act against it.
In Sweden, public health is generally good, but there are substantial problems with social inequalities in health. For example in my town, Gothenburg, the life expectancy is nine years longer in the area with the highest average income than in the area with the lowest. These differences are caused by personal lifestyles and living habits, as well as more complex, economic and social conditions. A more vulnerable group is people who have immigrated to Sweden. Studies show that they have a higher mortality than people born in Sweden and they rate their own health as poorer. Since immigrants come from different cultures and countries, it can be hard for them to integrate the Swedish health care system.

The idea of LIVH (which stands for Medical and Health Care Students Inform about Health Care and Health) is that medical and health care students visit Swedish classes for immigrants (called SFI) to talk about the Swedish health care system, health, common diseases, STIs and contraceptives. SFI schools contact the local contact person who assembles a team of 2-3 students for a certain date; they visit an SFI class where they try to be as interactive as possible, mixing a lecture with group discussions and exercises. Holding a LIVH session is truly a stimulating challenge where everyone in the room learns something new! We have a script and PowerPoint presentation, which is based on a national framework but locally adapted. At the end of the session, participants fill out an evaluation form.

Our project also aims to educate future health care professionals on effective communication with our patients and advocate for their rights. This is crucial in order for us to engage in the struggle for equal access to health care after graduation, a central ambition within SCORP Sweden. Therefore, all volunteers have gone through a workshop about common diseases and STI/HIV, the Swedish health care system and how it is organized, and how to communicate over cultural and language barriers. This year, we will have our third national training for the LIVH-volunteers.

So far we have had a very good response. The majority of SFI students and their teachers have been pleased with the workshop. They feel like they have a better understanding of how the Swedish health care system works, and what rights and obligations they have as patients. They also point out that they have an improved vocabulary after our sessions and therefore know how to better voice their concerns when seeking medical help. We now hope to continue to grow and contribute to a more equal health in Sweden.
NICE Project

Lukasz Scibik
IFMSA - Poland

NICE Project, or National Incomings Care and Excursions Project, operating under the Standing Committee On Professional Exchanges and the Standing Committee on Research Exchanges in IFMSA-Poland, focuses mainly on organizing weekend trips to cities other than those in which our incoming students spend their month of exchange.

This is primarily part of the social program, so the aim is having fun, all while presenting the most picturesque parts of our beautiful Polish cities. Through this program, all incoming students have the opportunity to get to know each other out, share experiences and make new friends.

The program was established in 2004 and all IFMSA-Poland local committees take part in it. Approximately 540 incoming students arrive in Poland per year, and all go back to their countries with millions of unforgettable memories.

The NICE project is supervised by our National Exchange Officers for incomings and outgoings.

You must visit us and take part in our project - we guarantee 100% satisfaction and a smile on his face.
Onda Sinapsis, the radio of IFMSA-Spain, is an online radio program produced by medical students for medical students. It all started with a few people concerned with the huge lack of knowledge regarding topics strongly bound to Medicine.

Slowly, the program grew and today it is a perfect forum to raise concerns, topics, and debates and speak up. Through debates on sexuality (e.g. the role and stigma of transexuality in the society), medical education (e.g. teaching methods), human rights (e.g. the “Mediterranean as a border”) or public health (e.g. the role of pharmaceutical companies in the health system), we aim to create a critical spirit among Medical students and raise concern about World Health problems and society topics strongly related to Medicine.

Every two weeks, discussions with our guests (interlocutor, specialist, witness and medical students) can be followed online. It is also possible to actively participate by expressing opinion and asking questions through chat with other listeners.

After less than a year of work, we are proud to have achieved many of our goals, and it is all thanks to our listeners and those who helped us promote the project by word of mouth.

If you are a student who feels something is missing in your education, if you believe that education and self-awareness are the motor of the change, know invited you to check out our program and take part in it.

Do not hesitate to contact us if you want to suggest topics to be discussed, if you want to take part in one of our debates or even if you feel like starting the project in your country or city. We are always happy to hear from students all over the World who can give different perspectives and points of view!

What are you waiting for? Turn on the radio, turn on Onda Sinapsis.
Consumption of psychoactive substances is a phenomenon that has existed across civilizations and across cultures. In the past, drugs have been used in religious or mystical rituals. More recently, consumption is more for socio-cultural purposes. Drugs – both legal and illicit – occupy a central role in social dynamics, are present in various social settings and in different classes, and are linked to the leading preventable causes of death at world and in scenarios of urban violence, psychosocial conflicts, and absences from work.

Our project is organized by the Federal University of Santa Catarina, with the support of the National Secretariat for Policies on Drugs of the Ministry of Justice, the Ministry of Education and the Federal Government of Brazil. It is a course developed to strengthen community leaders and other professionals directly involved in preventing drug use/abuse, for them to act at the local level and make a change. The course is free, offered in Distance Learning mode to nearly 40000 people, and has a workload of 120 hours over 4 months. The target group is responsible for managing learning process by choosing they go through the course content. In this training model the population has a space to exercise their autonomy and can interact with other course participants, building pathways to individual and collective learning.

The course is fulfilling its main objective of enabling state and local councilors and community leaders to act in the prevention of crack, alcohol and other drugs use by strengthening the Community Network. In addition, we’ve made available updated, quality information about drugs and their interface with the theme of violence, focusing on prevention in a human rights perspective. Intervention projects were delivered by the participants to assist in developing the course in their communities, thus promoting knowledge and strengthening psychosocial care networks and social assistance.

It is important to understand that the various aspects of drug abuse situation require a comprehensive approach for the problem to be solved. The project results are promising, and we aim to continue our efforts and establish a wider base of activities.
The discovery of the Rotavirus was a dramatic breakthrough in biomedical science, shifting experts’ paradigms about one of the main causes of diarrhea worldwide. The information about the Rotavirus casualty is still limited among pediatric and medical experts, because there is no urge from primary healthcare providers to find out more.

Diarrhea cases are often treated as non-urgent in Indonesia, since they are common among infants. This is where danger lurks: the lack of knowledge in management of diarrhea can and does increase the morbidity of the disease, due to severe dehydration not noticeable by parents or healthcare providers. This could be fatal! Diarrhea in Indonesia is the leading communicable disease after influenza, and the first cause of hospitalizations. It is ironic how lightly it is taken as an illness.

Rotarix®, and RotaTeq® are vaccines used to prevent Rotavirus infections. Unfortunately, they are too expensive to be used in Indonesia. However, Indonesia is currently developing a national Rotavirus vaccine program. Until it goes into effect, the Community Development Society, CIMSA UGM, is working on activities aiming to raise awareness and help prevent the disease. We are taking a multi-dimensional approach, involving targets of various backgrounds: primary healthcare providers including doctors, midwives and nurses; teachers; parents; public figures and even children.
STEP 7 is an internship program focusing on tropical diseases in Sudan; it will consist of a scientific part, including a medical mission to a rural area, and a unique social program. A total of 25 students from all over the world will take part in the first edition from August 1, 2015 till the September 1, 2015 in Khartoum, Sudan.

Since tropical diseases are spreading fast due with the growth of tourism internationally, migration and conflict-related issues, it is important for medical students worldwide to get a background education on tropical diseases and clinical syndromes, which they do not usually encounter in their home country. Through the scientific program, students will learn about the pathological and clinical features of Tropical Diseases, and will get to discuss their management.

During the final week of the scientific program, students will go on a Medical Mission in the vicinity of Khartoum, aiming to provide considerable aid and help improve the health status of rural communities. This mission is a truly unique experience and will give students an idea about the possibilities and limitations of working in a tropical area, where there is limited medical supplies and facilities.

Students will experience and learn from a completely different society; the social program offers them the opportunity to get a glimpse of Sudanese culture and visit places of interest in and around Khartoum, including the 7000-year old Sudanese pyramids. It is a magnificent health care and cultural experience. Students from all over the world are welcome to join the project.
In numerous countries, October 31st is known as Halloween night. It is a magical evening where many children stroll down the dark streets wearing their scariest costumes and ask for candy in front of houses. But, would you expect to see medical students wandering the roads, disguised as zombies, and visiting houses to raise awareness on organ donation? You would, if you lived in Quebec, Canada. On October 21, 2012, the initiative Zombies Hungry for Organ Donations (ZHFOD) was created by IFMSA-Quebec and has now spread across all six medical campuses in Quebec. Every year, it positively impacts the public’s awareness and consent about organ donation and attracts attention from several organizations as well as the media.

A single organ donor can save up to eight lives or provide dramatic improvements in the quality of life for these recipients. In Quebec, there is a notable lack of organ donors. In 2014, there were only 154 organ donors (20.2 per million inhabitants) and 442 organ recipients, whilst 1073 patients were on the organ waiting list. Numerous factors contribute to this low organ donor rate. It is noteworthy that Quebec’s consent rate is only 60%. Therefore, it is clear that something needs to be done to address this public health concern.

The most obvious objective would be to sensitize the general population about this shortage and encourage consent, right? That’s what a group of SCOPHians also thought, so, back then, they organized a first conference to discuss organ donation with medical students. But it did not stop there. An original idea emerged and rapidly reached out to their colleagues. Why not dressing up as zombies in white coats and go door-to-door and talk about it to people? It is safe to say the public was pretty and amused by the idea of zombies “demanding” their organs on Halloween.

Recently, a few IFMSA-Quebec SCOPHians recognized the necessity of integrating organ donation teaching within the medical curriculum to make our awareness efforts more sustainable. To accomplish this, a policy statement on Organ and Tissue Donation has been adopted by IFMSA-Quebec and McGill University has recently decided to teach this topic to second-year medical students from now onwards. With the collaboration of CFMS-Canada, deans, professors and interested partners in organ donation, we are looking forward to expand our activities across Canada.

Zombies Hungry for Organ Donations is a collaborative effort aiming at giving life back to patients. Our motto? Act locally, think globally.
Warmth to the Refugees

Bahast Salih
IFMSA - Kurdistan

It is almost impossible to know how a father feels when he is forced to leave his home behind and take his family to a safer place, hide in the mountains fleeing from terrorists who have threatened to decapitate him, kill his sons and wife, and sell his daughters as slaves. This is not just a horror story, but actually the reality of people in northwest Iraq and areas of Kurdistan.

The Standing Committee on human Rights and Peace (SCORP) of IFMSA-Kurdistan has had many projects since the humanitarian crisis. One of the first was started as a charity event for collection of donation in the local committees. Basic goods such as canned food, baby milk, diapers, etc... were collected and distributed to more than 10,000 refugees. Additionally, oral rehydration solutions and first aid kits have been provided for more than 1,000 families.

The highlight of our charity campaigns for refugees was a nationally-coordinated project: “Warm The Refugees.” SCORPions collected winter clothes and blankets alongside other goods, through collection points set up at schools and colleges around Kurdistan. In the period of 45 days, about 20 tons of clothes and more than 800 blankets were collected and distributed. Medical students also helped provide medical care for more than 1,400 families and distributed about 1,600 kilograms of food. This initiative benefited about 20,000 refugees.

Up till now, millions of people have taken refuge in Kurdistan, and they need any and all help they could get. We, at IFMSA-Kurdistan, hope to continue helping refugees. With the support of UNICEF-Iraq and the Iraqi NGO CDO (Civil Development Organization) the campaign was even more recognized.
SCOMEdians are the guardians of our medical education; their mission is to improve the quality of 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 what they have been up to lately.
Introduction
from the SCOME International Team

Ahmad Badr,
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Dear SCOMEadians,

With another term coming to an end, we hope that through this year we could provide a little bit of the vast knowledge of medical education, and give you a little push of motivation to be a part of the change. Medical Education is one of those areas where there is no right or wrong, and many different approaches to curriculum, teaching, and assessment can be greatly praised for their excellence, but also criticized for their drawbacks. However, what matters for decision makers in medical education is to take an open-minded stance, granting the opportunity for students to share in the process of formation of their medical education structure, so that they can craft together a system which they think has the most benefits and least drawbacks.

In SCOME, this is what we try to do, not through lecturing on what may be the best technique for an education system, but through creating a space for medical students worldwide to share their experiences on different medical education approaches, and share how and what they have done to be involved in its creation. By also having in the mix multiple workshops on the general basics of medical education, communication skills, and advocacy, we go back home after our meetings feeling competent and well equipped to be creative, propose changes, and join the decision making process of medical education.

We realize that sometimes it will be hard to create change, fighting against rigid structures, and very conservative minds, but we still continue our work optimistically, realizing that even if we failed to change a present that is not so ideal, we have succeeded in securing a future of open-minded professors-to-be who will do their best to create a utopia of a perfect Medical Education system

We invite you to go through the SCOMEdy section of this issue of MSI, read about the experiences of some medical students in the field of Medical Education; maybe a spark with light up in you and push you to start your own experience in your city or country!

Yours,
Ahmad.

On behalf of the SCOPE International Team:
Stijntje Dijk (Liaison Officer for Medical Education issues); Zamzam Ali (Regional Assistant for Africa); Victor Echeveste (Regional Assistant for the Americas); Ying-Cing (Angel) Chen (Regional Assistant for Asia Pacific); Abdulrahman Nofal (Regional Assistant for EMR); Rachel Bruls (Regional Assistant for Europe)
In 2001, the Brazilian Ministry of Education published the first National Guidelines for Medical Schools Curricula (NGMSCs), which were subsequently reviewed and updated in 2014. Through these guidelines, the government attempted to set the standards of medical education, to which all medical schools should adhere. In the months and years that followed, a movement of curricular reform began in Brazil and each school obtained the autonomy to structure its own curriculum as long as it fulfills the requirements of the national guidelines.

The process of building and applying a curriculum is extremely complex as it depends on material and human resources. Adequate space for theoretical and practical learning are necessary, as well as the constant effort to find professors best qualified to transmit their knowledge to the students. It is extremely important to continuously evaluate the entire process and the outcomes of this evaluation must not be ignored; they must guide changes to improve the quality of teaching and – ultimately – the quality of future health professionals.

Students and professors of the Federal Fluminense University (UFF) debated a curriculum change. The goal was to form a future physician with a more humane focus, who would look at the patient as a person and not just as the illness (s)he is presenting with. The long process started in the seventies and envolved with both the university and the health care structure of the city where the university is located. Finally, in 1992, a new curriculum was published and became effective in 1994. It is noteworthy that this new curriculum later served as a model for the publishing of the first national guidelines in, which it was already compatible with.

However, as it has already been mentioned, the establishment of a new curriculum is not enough; it is necessary to turn what is written there into reality. Sixteen years after UFF’s “new”curriculum became valid, it still isn’t fully applied. Rather, a mix of the old and the new curricula survived. To properly address this problem, the Diretório Acadêmico Barros Terra (DABT), the Local Comitee representing medical students at UFF, organized the medical school’s first Curriculum Conference.

The aim was to get students and professors to discuss how to apply the curriculum in full, and debate the quality of the health professionals formed by the faculty. Participants evaluated the curriculum, thought about the challenges, mistakes, and wise choices made since, and to came up with ways to improve the applicability of the curriculum. The conference was so successful that it became a yearly event on our medical school calendar; with its sixth edition taking place this year.

The subject of the conference is chosen by DABT on a yearly basis. They take into account the students’ needs and challenges. So far, the subjects discussed include models of evaluation for the theoretical and practical disciplines and ideas for the integration of different disciplines. An official final document is produced at the end of each edition, comprising actions that shall be executed by students and teachers.

References:
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The Daily Challenge

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Do you remember the feelings you’ve had on your first day of medical school? This was the place where we would spend the next six years of our lives, working hard to become the future physicians we always aspired to be. Personally, I enjoyed medicine and I was very excited at first. But then days turned into months, months into years, and the routine began to take its toll; we weren’t exactly having the “new experiences” we thought we would. Lectures, laboratory and clinical sessions were more or less satisfactory, but I something was missing, an innovative experience of some sort.

That’s how the Daily Challenge came to be, aiming to:

1. Freshen up and revive the college atmosphere, and get rid of the boring daily routine;
2. Make medical education a more cheerful experience for the students;
3. Increase the new students’ fund of knowledge, and refresh the memory of their seniors;
4. Provide a platform for students to discuss questions with each other, allowing them to interconnect and build new friendships;
5. Raise awareness about issues such as HIV/AIDS, breast cancer, prostate cancer and so on;
6. Familiarize students with IFMSA-Iraq, SCOME, IHAO and their activities.

The concept of the project is simple: we set up a board near the university cafeteria and post whatever we find “medically” amusing. This would rang from random questions (which would be answered by all students, regardless of which year they are in), raising awareness about diseases breast and prostate cancer, to writing jokes, drawings or wishes, etc... Everything is prepared in a way to attract the attention of every passerby.

On Thursdays, we would review all answers posted on the board and, among those who’ve answered correctly, five winners are selected in a random draw. These students would be awarded the text books of their choice.

The Daily Challenge has been running for over a year now. It was first introduced at the Baghdad College of Medicine. Thanks to its success and the amazing feedback we received from students and faculty alike, we’ve expanded to 7 other medical schools, each of which having its own OC and specific overall design.

Students immediately admired the idea and began participating in the challenges. They were discussing the questions, having fun and making new friends; professors also had their share of fun. We’ve obviously reached our initial goals. To date, more than 100 students have taken part in the challenges per university and we have distributed more than 100 textbooks with the support of IHAO (Iraqi Health Aid Organization).

We can only hope that, through The Daily Challenge, we continue to make the Iraqi medical education a very unique experience.
Pediatric Communications Skills
Workshop in Pakistan

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“Raising children uses every bit of your being - your heart, your time, your patience, your foresight, your intuition to protect them, and you have to use all of this while trying to figure out how to discipline them.”

- Nicole Ari Parker

It is hard enough for kids to be hospitalized. It’s even harder when they have problems communicating with their caregivers and/or are bored out of their skulls. Unfortunately, many of the communication barriers that arise in Children’s Hospitals can have serious negative consequences, in term of patient safety, health outcomes, cost of care, length hospital stay, etc...

The psychology of children and the elderly varies a great deal from that of adults. Pediatric care requires emotional strength along with good clinical skills. Effective communication is more crucial, and often more complicated, than it is with adult patients. In Pakistan it is vital for all future physicians to learn the essential skills of dealing with young patients, from the earliest point in their training, as pediatrics problems are quite common in Pakistan. There are valuable techniques, tools, strategies that healthcare providers can rely on to communicate more effectively with even the youngest patients, as well as family members who accompany them.

To mark the International Children’s Day on June 1st, 2015, IFMSA-Pakistan-SKZMDC organized a workshop on Pediatric Communication Skills, in collaboration with the Department of Pediatrics at the Shaikh Zayed Hospital Lahore. The workshop was divided into two parts - an interactive lecture and a practical application. Our day started with guest speaker, Dr. Spenta Kakalia, a specialist in Pediatric Infectious Diseases, and Assistant Professor at the Pediatrics Department CMH Lahore. She gave an animated and interactive lecture on how communication with children is different from adults. She described ‘three way communication’ and taught us ways to gain the trust of patients as their caretakers. Professor Dr. Aslam Khichi then conducted a small test to judge the outcome of the previous lecture.

Participants were also informed about the Communication Matrix. According to “A Handbook of Resources for Parents, Patients, and Practitioners,” the Communication Matrix is an assessment tool suitable for pediatric settings across the continuum of hospital care. It was designed to be used with children with communication disabilities, and builds on the skills that children already have to help them communicate in a given context. The Matrix is available online, in both English and Spanish, allowing parents and professionals to observe and take notes about children’s communication behaviors.

Participants were then divided into groups, went up to the pediatric ward and put their newly learnt skills to the test, guided and supervised by post graduate doctors. Fundraising was done to install a bookshelf at the Pediatric ward. A book drive was also initiated to collect books to fill the shelf.
Teaching methods at Brazilian medical schools largely emphasize the disease rather than the symptoms. This fact certainly makes graduating with a degree in medicine far from a “clinical art.” The Emergency Clinical Course at the University of Taubaté (UNITAU) offers students a comprehensive training in the emergency setting, based on discussion of clinical cases, which can be an important tool in improvement of clinical reasoning.

The exercise of establishing a differential diagnosis allows the examiner to become familiar with the various presentations of the disease. First, one has to identify the clinical syndromes that can affect the patient, considering the anatomical sites related to the pathology presented. An etiological diagnosis that allows the definition of a particular therapeutic approach can only then be established. It is extremely important that the reasoning begins with the most likely diseases, taking into account factors such as gender, age, origin, and profession, among others.

It is very important to learn the steps one must follow to assess a sick patient. In sequence, one should include the chief complaint, the history of present illness, the background and the physical examination, which are details that assist in the analysis and understanding of the disease and to determination of a possible etiology.

The IFMSA Brazil local committee of Taubaté organized the Emergency Course II clinics, which provides scholars each semester with a broad view of protocols, guidelines and several updates in the field of emergency medicine. We are offering the opportunity for interested parties to integrate the various methods and actions to psychological services in emergency care sectors, training their clinical reasoning.

The ultimate goal is to integrate students and faculty providing a network of professionals aware of the most updated guidelines and protocols at any particular time, able to give proper urgent care. What makes this course unique is that the information is transmitted through the discussion of clinical cases, not didactic lectures.

This pediatric module included the following discussions:

- Poisoning exogenous;
- Diagnosis of meningitis;
- Anaphylaxis and urticaria;
- Asthmatic crisis;
- Cardiac emergencies;
- CPR (basic and advanced support);
- Trauma;
- And the main drugs used in PS (first aid).

Considering the high demand we’ve received from students wanting to take part in this course, and trying to include the as many as possible, we organized an event that would offer participants brief updates from specialties, focused on emergency settings. During our meetings we discuss various clinical cases that we may encounter throughout our practice in the future.

References:
Death has always made man afraid and distressed; this is even truer in cases of patients with serious illnesses and those hospitalized for a while. The physician – whose aim is not only to cure disease, but also heal the patient in all aspects – is therefore a point of support for most people. He strives to administer the best treatments and – equally as important – to provide comfort when physical cure is not possible. Can this be truly achieved when there is neither a holistic view of the patient nor a good doctor-patient relationship? The answer is simply, no!

Throughout the learning process, we learn about the basis of disease and prescribe drugs, but seldom do we get to know our patients well enough to make a good diagnosis and help them deal with it the best way possible. It has been shown that increased levels of stress, anxiety and depression that come along some treatments cause patients to stay longer in the hospital and have high mortality rates.

When the physician shows more interest and respects the patient’s spirituality, but making the patient feel comfortable and supported, (s)he helps get the patient on the shortest path of treatment/therapy. It also results in a better doctor-patient relationship. The patient trusts that his physician cares for him as a person, and go ahead more comfortably with the proposed treatment. It has also been shown that, when a patient believes in the medical treatment, its efficacy much greater

Some hospitals in the USA have already contracted chaplains to attend to the patient’s spiritual needs. What is even more important, however, easily and tightly the doctor-patient relationship is formed. Many might think that patients become more spiritual when they are faced with a non-expected, negative health event, or when the possibility of death looms in. This is mostly due to the fact that the patients’ spirituality may indeed be more clearly expressed at such times. However, when patients are approached about this topic on the first visit, not only does it strengthen the doctor-patient relationship, but it also puts at ease most if not all of the patients’ concerns. The idea is to introduce this practice in a daily basis. At my university, for example, some events on the theme have been done and we have a study group that tries to bring it up more during our learning years. It’s important to demystify it so the benefits arise and we can treat better our patients, worldwide and despite any different beliefs.

References:
Medical education widely covers theoretical surgical competences, but practical skills are less represented. Practical teaching of skills is often neglected due to the cost of materials required and lack of available mentorship. As future physicians, medical students need to be provided with both the theoretical knowledge and practical skills, regardless of their ultimate career choices.

The International Federation of Medical Students’ Associations (IFMSA) strongly believes that all future medical doctors should be well trained in basic surgical skills. This is especially the case in the less developed and developing countries, where health systems capacity is under-resourced with limited surgeon availability.

The vision of the Standing Committee on Medical Education (SCOME) affirms our commitment in ensuring that medical students worldwide attain an optimal professional development, in order to reach their full potential as future physicians, for our ultimate goal: better healthcare for everyone.

In line with the above, we believe we can improve undergraduate surgical education by collaborating with our faculties, national and international institutions, providing them with scientific evidence, and advocating for the teaching of surgical.

There has not been a large-scale analysis of the different programs so far. Multiple student-led initiatives have arisen, in numerous countries, with different scopes and objectives, but have often stayed largely unknown to any institution overseeing medical education, mostly due to lack of communication and support from universities.

With the IFMSA transition from Projects to Programs, there is a wonderful opportunity for better coordination and wider impact of students’ activities. However, there is the need to perform a baseline assessment of currently active initiatives. A team has been formed and has been working to evaluate existing IFMSA projects related to practical surgical education. After systematic review of the literature, we have put a lot of effort into further investigation of the topic, aiming to collect data from medical students’ associations. We also want to collect data from institutional implemented programs. For this reason we pursued the mentorship of several surgery professors and Deans.

We decided to explore the exposure of medical students worldwide to practical surgical skills, either compulsory or optional, student- or institution-led, in medical curricula. With this study we hope to gain insight as to the usefulness and satisfaction of such programs for medical students, assess and compare different programs, identify good practices and create suggestions for further steps.

The study consists of a short survey, designed to collect data on training within core medical school curricula, electives, and trainings that are part of an extracurricular activity organized by either the medical faculty or students worldwide. It includes questions about students’ personal experience and perspective regarding practical surgical skills training within their university.

Ultimately, we want to compare the student-led initiatives with institution-led practical courses, to create a standardized guideline for courses to be implemented worldwide, either through medical students’ associations or, whenever possible, in university curricula. Our results will support the work of the IFMSA program “Teaching Medical Skills” in improving the activities related to surgical trainings and in advocating for a better undergraduate education. We hope that, with our study, student-level initiatives and the evidence of their efficacy will receive the recognition they deserve from local institutions.

We believe that the best feature of our research is that it paves the way for future cooperation with institutions in the field, a process that is already established at the local level, in order to improve undergraduate practical surgical education.

How can you help?
We need you to fill in our survey and share with us your experience and opinion. Click on this link and please share it with your friends in your university and other universities!

http://bit.do/surgicalskills
In this section, you are going to meet SCOPEople, read about their professional exchange experiences, their challenges, and meet their friends from every corner of the globe. Prepare yourself as you embark on a SCOPE journey that will take your breath away!
Introduction
from the SCOPE International Team

Omar Cherkaoui,
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Dearest SCOPE Family,
I am extremely proud to present you the new peri-SCOPE section of MSI.

After one term full of hard work, dedication, and accomplishments; after one General Assembly and five Regional Meetings; and after many other incredible international meetings, here we are, gathered once again to discuss the hottest topics in SCOPE and to share some unforgettable moments with you.

Since the beginning of our term, our commitment to SCOPE has never dropped. We have been exploring new horizons. The promotion of our Exchange Program has been one of our top priorities, and undoubtedly, MSI contributes to that.

In this section, you will read the best SCOPE articles we’ve received from our NEOs and members. Reading through them made us realize the just how much voluntary work is done by every single Exchange Officer to provide incoming and outgoing students with the best experience possible. We cannot be more proud of you all!

Thank you very much for keeping SCOPE alive. Thank you very much for making the dream of more than 14000 students around the world come true. Our exchange program would not be possible if it weren’t for you!

I cannot turn this page over - now that this term has come to an end - without expressing my enormous gratitude to the best team ever, the SCOPE International Team 2014 - 2015. Thank you for all your support throughout the term, I have been honored to serve as your SCOPE Director.

Yours,
Omar Cherkaoui

On behalf of the SCOPE International Team:
Ivana di Salvo (Liaison Officer for Research & Medical Associations); Chioma Audrey Amugo (Regional Assistant for Africa); Carlos Morales (Regional Assistant for the Americas); Armalya Pritazahra (Regional Assistant for Asia Pacific); Karim Salah Abd El-Motaleb (Regional Assistant for EMR); Philipp Foessleitner (Regional Assistant for Europe); Amr Diaa Ajlan (Development Assistant on Information & technology)
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A Month in Germany

I guess we, students of the modern age, are really lucky. We are blessed with countless opportunities – the entire world is open for us: no limits, no borders. It comes as no surprise today to see students from, for example, Russia, taking one or more clerkships in Europe or somewhere else around the world. It is not only a great opportunity for students to study medicine, improve their skills and meet new people – it is actually a way IFMSA and other international students organizations participate in building the model of the new world, the world of equal medical standards, with no racial and social prejudice.

This year I was among the lucky people who took part in the IFMSA professional exchange program. My clerkship took place in Marburg, Germany – a small picturesque university town in the very heart of this beautiful country. I can honestly say that this month was my lifetime experience. It was both a month of a great joy and a hard challenge. I was hosted in a student flat. A cozy room and friendly neighbours made my stay even more cheerful. Though I was the only foreign student in the flat, not even once did I feel like a stranger there!

My true challenge was the high German standard in everything – punctuality, devotion to work, strict and perfect organization of treatment. To satisfy these high demands and become a part of the system you should do your best and work hard.

I was placed in the Department of Obstetrics & Gynecology. My working day started at 7 o’clock (German time, as we called it among the exchange students, not a minute later). My duty was to draw blood and change postoperative bandages. Unfortunately my poor knowledge of German did not allow me to participate in taking patient history as much as I’d hoped. However, I did my best and improved my language skills by the end of the month. The main and the most delightful part of my day was assisting in the operating room. That was a great step forward for my surgical skills.

Equally as important for me during the exchange, I travelled and explored Germany. I went to Koln, Frankfurt, Dortmund, Essen, and Munich. I never expected Germany to be so diverse and so charming at the same time.

I would like to thank IFMSA for this opportunity. I believe that this kind of international work and cooperation leads to unification of the medical service around the world. IFMSA plays a far more important “non-medical” role – it helps us, young people from all over the world, to see each other, to know each other in reality and not to be blinded by the mass media, phobias and prejudice of the society. Study medicine, explore the world, widen scope and learn to be tolerant – this is what we achieve by taking part in IFMSA work.
During January 2015, I had the opportunity to complete a medical clerkship in Toluca, Mexico. I chose this city based on the recommendations of a friend who had been there before and gave me good references about both, hospital and city.

I took a clerkship in the department of emergency medicine. I worked from 7 am to 3 pm, and I admit that I was quite surprised by the structural quality and organization of the hospital. Another thing that really impressed me was the trust physicians placed in us, allowing us to do procedures such as drawing blood, instrumenting central venous access, cleaning wounds, etc... all of which made us more confident.

My supervisor was Doctor Cristian Hugo Santos Gonzalez, Chief of Emergency Medicine. He showed me around and allowed me to observe an endoscopy procedure and a leg amputation surgery.

During my stay, I took the opportunity to know more about the city, take part in the social program, and read about some of the cases I encountered at the hospital. I visited the Botanical Garden, Central Square, Toluca Cathedral, the Mexican Cultural Centre, the Candy Market, School of Medicine (UAMex), Mexico City (the capital) and did some shopping Toluca.

The social program included parties at the students’ house, the NFDP, and a gala dinner.

My emergency medicine clerkship in Mexico was perfect: I made new friends, I practiced my Spanish, I practiced and learnt new medical skills, and I discovered a new country, a new culture.
“A doctor who knows only what relates to his specialty, in fact, remains a simple craftsman. Is it possible to look at life through the narrow slit of his craft?” This was said almost 30 years ago by the academician E. A. Wagner, whose name our Perm State Medical University proudly carries. He also argued “diversity of interests is a professional necessity for a real doctor.”

Reading these lines, we understand that everything is in our hands, both time and opportunities. But, most important is desire. And it certainly is. Today a great opportunity is given to us through IFMSA. Since I first joined during my 2nd year of medicine, and during the month of August of each year, I’m leaving for an internship in a new country. So far, I visited Romania, Denmark and Austria; today I am eagerly waiting for the confirmation for a trip to Italy. This internship has become a tradition: I can’t imagine my summer vacation without it. It is time for communication, new emotions, new people, new knowledge, new opportunities to enrich my experience, my skills, and of course to improve my English. This practice leaves a charge of emotions for the whole year.

Of course, the main part of the exchange is working in a hospital, usually for 6-8 hours a day. Supervised by their tutor, student get to examine patients, assist with surgeries, assist in the emergency department, etc… Equally important is communication with other medical students. Together, we explore the attractions of the country, visit museums, exhibitions and just spend wonderful evenings together, and I dare not forget to mention the NFDP.

We are all so different, but united by our profession. The one-month exchange with IFMSA is indeed and invaluable experience!
The annual Regional Meeting is always the highlight of the work within each Standing Committee on a regional level! The European Regional Meeting (EuRegMe) 2015 held last April in the beautiful, but cold city of Aalborg, Denmark was no exception. The exchange sessions gathered around 45 European NEOs, NOREs, LEOs, LOREs and general exchange members. We had the opportunity to meet for three sessions, lead by the wonderful Eva, the SCORE Co-Regional Assistant for Europe and myself, Philipp, the SCOPE Regional Assistant for Europe. We received help and guidance from the really experienced exchange members and Luiza, the SCORE Director, who facilitated some of the workshops and SWGs.

Participants were given an update about the current SCOPE and SCORE work on the international level, as well as the 1st European NEONORE Weekend & PRET in Montenegro.

As the EuRegMe is also a meeting for new exchange members, workshops were separated into parallel tracks for beginners and advanced members, in an attempt to help everyone get the most out of the sessions. The highlight of the sessions was undoubtedly the Students Exchange Fair (SeXfair), where NMOs had the opportunity to present their exchange programs to participants. People were running from stand to stand to gather information, meet the representatives and collect as many goodies as possible. A competition for best program was also held. The programs were judged by members of the SCOPE & SCORE IT, evaluating academic quality, promotion media, social program and the boarding and lodging of each NMO. AMSA Austria, SloMSA Slovakia and TurkMSIC Turkey claimed the top3 positions.

All in all, sessions were efficient and productive. We had a lot of time to meet the representatives of European NMOs active in exchanges, and had the chance to get to know each other better, share ideas and experiences and solve common problems. We exchanged Europe!

Special thanks to all facilitators for the amazing session; to the Organizing Committee for providing the necessary logistics; to Luiza and Omar, SCORE and SCOPE Directors for their help during the preparations; to Alberto, Regional Coordinator for Europe and the entire EuroTeam for the great organization of the EuRegMe; and of course, to all the European Exchange Members for their active participation and valuable inputs. We are looking forward to meet again at the next European Regional Meeting 2016 in Greece!
The year was 2014, and I was a 5th year medical student halfway through my midterm exams. Summer was coming and with it came the opportunity to do a Medical Exchange. Like many other medical students, I was aiming for a good quality clerkship, with a good curriculum reference, and a good intercultural experience. The Czech Republic came to my mind. It has great universities, a central location, and plenty of history.

I got my Card of Acceptance and was placed in the Department of Urology at Thomayerova Hospital in Prague.

A big challenge to many students on Exchange is the language barrier, but it became an opportunity to meet people and learn more from the doctors and patients. Surgeons at Thomayerova Hospital were very welcoming of the Exchange students and allowed us to help in many important procedures. Being able to learn fundamental aspects of laparoscopic, endoscopic, and open procedures in Urology reaffirmed my desire to become a surgeon.

The IFMSA Professional Exchange aims to be an integral experience: students are exposed to medicine in a different country, all while exploring the country’s history and culture, and having fun. The social program in Prague was the cherry on top of the pie. It included outdoor activities, sightseeing, and, best of all, a great contact and interchange with the other incoming students. Walking across Charles Bridge at night, listening to the cello quartet there, watching the clock change at Staromestska, going to legendary Reduta Jazz club and visiting the Prague Castle are a few of things we did.

Accommodation was really great at a student facility near Chodov.

My friends of the July 2014 Summer Exchange in Prague and I are thankful for all the efforts of our contact persons and the local committee for a beautiful experience. It was my first – and unfortunately last – opportunity to do a clinical clerkship with IFMSA, but I highly recommend and encourage students to do it. I would like to specifically thank Dr. Zachoval, Zalezky, Viktor, Jaroslav Jarabak and all the surgical team at Thomayerova.

Looking back to memories, I am certain that the IFMSA Exchange provided me with a better perspective of what medicine is, and what we are looking forward to as physicians. It definitely made me want to be a better, more responsible physician, working with the spirit of the IFMSA vision and mission to better our world.
My Exchange in Trujilo

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Last summer, I spent two months in Peru. At first, I was really nervous; I had no idea what to expect. Before leaving Austria, I talked with my contact person, who explained everything to me, and eased some of my doubts. He picked me up from the bus station in Trujillo, where I arrived to from Lima, and took me to my new home for the next month. I lived with a very nice family; the family of a medical student like me. We used to talk about everything, and I was surprised to know that we had more in common than what I had thought.

Five days after my arrival, I started my internship in the department of general surgery at the Belen hospital. One the first day, my contact person introduced me to the physicians, residents and interns, who were all quite helpful. Over the next four weeks, I spent everyday from 8am until 2pm in the Emergency Room. I also took a nightshift once a week. The doctors taught me a lot and I was allowed to see and evaluate patients on my own.

The social program was really well organized. Almost everyday, we either had an organized trip or we went somewhere to get a coffee or a bite to eat. For the first time in my life, I tried sand boarding and surfing.

I learned a lot about the culture of Peru and visited archaeological sites like Chan-Chan and Huaca del Sol y la Luna. And what can I say about Peruvian cuisine!

After my exchange in Trujillo, I spent an extra month in Peru, traveling around the country. I climbed Machu Picchu, danced with Titicaca Lake residents and learnt how great life there could be. I eventually returned to Trujillo for a few days before going back to Austria.

My time in Peru was simply amazing. I met so many extraordinary people, improved my Spanish and acquired new medical skills. I hope I get to return soon to where I felt like in home, to the place that will forever be in my heart.
My name is Eulàlia and I’m from Barcelona. I spent last July in the city of Cochabamba, Bolivia. Perhaps, some of you don’t know much about that incredible country. Neither did I, but let me tell you about it.

I spent four weeks there, completing a medical clerkship at the Viedma Hospital. The city is quite big, but you can easily go from place to place by bike or on feet, and you have everything you may need nearby. There were pubs, discos, restaurants and shopping malls all around!

I met incredible people in Cochabamba. I shared a flat close to the hospital with other international students; three from Mexico, one from Austria and two other friends from Spain. Other international students were living with different Bolivian families, but they all used to drop by and hang out at our place. Our hosts and contact persons welcomed us in the best way possible; they introduced us to the hospital staff, and they organized an awesome social program for us to get to know each other and learn more about the country we were visiting.

During the weekends, we traveled around. We visited ‘Salar de Uyuni,’ which is probably the most famous place in Bolivia, and definitely the most beautiful place I have ever been to! We spent three days there. We also went to the valley of ‘Toro-toro,’ located in the center of the country; it is a charming site with plenty of caves.

Work in the hospital was hugely beneficial. I was placed in the emergency department, and spent there almost 8 hours a day. I met excellent Bolivian students completing their internship; they always let us help with suturing and caring for wounds, doing ECGs, etc... I was also able to get into the operating room, where surgeons let me assist in two or three operations. I learned quite a lot; I did tasks, which I couldn’t do back home. I couldn’t be more grateful.

My exchange was an amazing experience! All of the people I’ve met in and out of the hospital are the best memory I keep from Bolivia. There are no words to thank them all! I only hope to return soon.

Everyone should visit Bolivia, a country so beautiful, hidden in plain sight on the map...
Have you ever thought of joining an international training about Exchanges, with IFMSAians from all over the world, all while snorkeling in one of the most attractive spots around the world, and setting off on a safari trip in the Sinai desert at sunrise? Well, this is not just a thought or a wish, but a reality!

IFMSA Egypt organized a memorable gathering of more than 70 medical students for its 3rd PRET & TNT, by the beautiful Red Sea Coast of Dahab, under the glistening sun of Egypt. This event gave participants the opportunity to attend a series of workshops, trainings and small working groups over a period of 3 unforgettable days. The trainings were facilitated by six of the most experienced and qualified IFMSA trainers, including members of the IFMSA Team of Officials international teams.

PRET included around 15 training sessions aimed at developing and nurturing members’ soft skills, which they would utilize during on their IFMSA exchange. These included communication skills, exchange advocacy and leadership, outgoing student selection, as well as academic quality and recognition. Participants co-coordinated SWGs trying to find creative solutions to problems faced in our Standing Committees on Exchange.

During this event, we also focused on Global health within exchanges. Since our first exchange in 1952, the number of participants has been steadily increasing every year. It currently stands at 13,000 exchanges across more than 90 countries. It is our responsibility to help exchange students understand new health systems.

We had a few special guests from other Egyptian student exchange organizations such as AIESEC Egypt and EPSF (Egyptian Pharmaceutical Students’ Federation). They joined us in our workshops to analyze the differences between our exchange systems and brainstorm for potential ways of collaboration.

Beside the workshops, SWGs and trainings, our participants experienced an unforgettable Egyptian social program, which included snorkeling in the blue hole, a desert safari, and a Bedouin dinner while enjoying the superb view of Sinai mountains. They also go to visit famous historic Egyptian monuments in Cairo (e.g. the Great Pyramids and the Cairo museum), as a part of the postPRET program.
1st European NEO-NORE Weekend
And PRET in Budva, Montenegro

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Exchanges are one of the pillars of IFMSA; working on them is always so exciting! NEOs and NOREs are the ones in charge of their NMOs’ exchange programs, and therefore fulfill the most essential tasks in order to provide every student with the best possible exchange experience!

Being a NEO or a NORE means a lot of work throughout the year, especially during GAs and Regional Meetings. Because of their workload, NEOs and NOREs often lack the time to simply meet each other and get connected! Aiming to give the European NEOs and NOREs the opportunity to connect, work together and solve common problems, and to further develop our programs even further, and honor the hard work of the national officers, we decided to organize the 1st European NEO-NORE weekend!

MoMSIC Montenegro was elected as the host for this special event during MM15, and they decided to host a PRET at the same time. The event took place in the beautiful city of Budva between the 21st and the 24th of May 2015.

In total, 40 people from across Europe (as well as the EMR and the Asia Pacific regions) took part. Two trainers facilitated the PRET: Patryk (NEO-Out, IFMSA Poland) and Jess (NEO-In, MedSIN UK), while two others facilitated the NEO-NORE Weekend: Julia (NEO-Out, AMSA Austria) and myself, Philipp (SCOPE RA for Europe). The venue consisted of two really nice rooftop seminar rooms, with a great, but as the sky turned sunny and clear, we decided, on day 2, to move the sessions to the beach. The braver ones among us even dared to take a swim in the really water.

Sessions were productive and efficient: we managed to solve a list of common problems, got updates about what’s going on at the international level, and discussed current SCOPE and SCORE issues. Additionally, we produced innovative outcomes from SWGs at the NEO-NORE Sessions. We can proudly say that PRET participants are now semi experts in.

Aside from the sessions, MoMSIC organized a fantastic social program, which included a huge beach party with many well known Balkan singers, a city tour, and an amazing NFDP!

Altogether, we all accomplished a lot. I can only say, we are all already looking forward to the 2nd European NEO-NORE Weekend!
Ras El Hannout

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I have never tried such a flavour. It’s a recipe I cannot compare to anything else; a taste I will never be able to accurately describe, and definitely never forget. Its secret was not only the ingredients but how well they were all seasoned. Ras El Hanout, which is Arabic for “head of the shop,” is a mixture of the best spices, delicious but impossible to define. It is not only the showcase of delicious Moroccan food, but also a metaphor of the whole country itself.

If I were asked to describe Morocco, I would use exactly these words; it is a mixture of a colourful culture, heterogeneous climate, uneven landscapes and last, but most certainly not least, amazing people. This exchange opportunity landed me in Casablanca, Morocco as well as the capital city of Rabat where I had the possibility to explore new knowledge in pneumology at the “Sheikh Zaïd” Hospital. I was impressed by the modern cities, marvellous hospital and all the staff working there. Surprisingly, it was not as hot as I had assumed it would be – I even had to wear a sweatshirt at night! Our hosts provided us with a lot of insight into their homeland. On the first weekend, they took us to visit the dazzling city of. The second weekend trip was to Chefchaouen – the “blue city” in the mountains, tranquil, surrounded by beautiful valleys and waterfalls. I also had the opportunity to visit Fez and Meknes... So many lively places, so many memories!

Thanks to the amazing people of Morocco, I had an I had the insider’s look to Moroccan culture. I tasted delicious cuisine: tagine, couscous, harira and of course, sugarcane juice!

Variety is the spice of life – check, maybe yours is “Moroccan Ras El Hanout.”
In this section, you are going to meet SCOPHeroes who save the day through their Orange activities. Enjoy learning about various public health initiatives. Whatever your interests, you are sure to find something that captivates you.
Introduction
from the SCOPH International Team

Skander Essafi,
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Dearest SCOPHeroes,

I am very happy – but at the same time sad – to write this second and last welcome SCOPH letter for MSI this term. Our Public Health Journey has been full of achievements, challenges and struggles, all of which have made it unique and lovely. I must say that it has been an honor for me to serve this Standing Committee and to keep it as true to its mission as possible.

International activities on Public and Global Health were diverse and promised for a better commitment. We had several Workshops during our IFMSA events: “One Health,” in collaboration with the International Veterinary Students Association, Healthy Cities, Universal Health Coverage, Food and Health, Alcohol and Health, Global Surgery, as well as Public Health Training and Universal Health Coverage Workshops on the sub-regional level.

SCOPH Sessions at the five Regional Meetings and at the General Assemblies have been successfully carried out by the magnificent members of the SCOPH International Team members and support persons, to whom I am extremely grateful.

SCOPH was also present at the external level on several occasions: The Prince Mahaidol Awards Conference in Bangkok, the World Congress Public Health in Kolkata, The World Health Summit in Berlin, the World Health Conference on Tobacco and Health in Abu Dhabi, the several climate change discussions and high-level meetings, the Global One Health Conference in Madrid, and last but not least, the WHO Conferences including the World Health Assembly and the global coordination mechanism on NCDs.

A new change was brought to our federation and we applauded the development of the IFMSA Program on Healthy Lifestyles and Non Communicable Diseases (NCDs). Lots of efforts have been put on it as we are aiming to come up with all the necessary tools to reflect the activities taking place worldwide, and resonate the great impact created and showing the example for the implementation of further similar programs.

Furthermore, to focus on setting standards for our beloved standing committee, we are aiming, by the end of this term, to amend our SCOPH Regulations and adopt a new SCOPH Strategic plan as well as guidelines for Public Health Exchanges and Trainings. Stay tuned for more news! You are welcome to consult most of the documents on those meetings and workshops on the SCOPH Database available on our servers and website!

I would like to thank every single person who has made of SCOPH an incredible source of motivation towards improving global public health and wish you a great read of Morning SCOPHian. If you haven’t joined the ride yet, our doors are always open. Keep shining, It is health that brings us altogether!

Orange Hugs,
Skander.

On behalf of the SCOPH Dream Team,
Arthur Mello (Liaison Officer for Public Health Issues), Cynthia Waliaula (Regional Assistant for Africa), Sergio Menchaca (Regional Assistant for the Americas), Wonyun Lee (Regional Assistant for the Asia Pacific Region), Hani Hafez (Regional Assistant for the Eastern Mediterranean Region) and Pauline Bos (Regional Assistant for Europe).
Medical Students’ Mental Health

“Mental illness is nothing to be ashamed of, but stigma and bias shame us all.”

- Bill Clinton.

Medical students, live in an environment overloaded with stressful situations; we work under pressure from our seniors, face the fear of failure as well as the great expectations that we – and society – set for ourselves, and are burdened by the massive curriculum we need to master. Yet, we rarely hear the words “mental disorders” and “medical students” used in the same sentence. There seems to be no back-up system for medical students in Tunisia: depression is treated as a taboo and seeking help is seen as a sign of weakness.

Our project, Medical Students’ Mental Health, aims to (1) promote mental health across medical schools in Tunisia, (2) fight against the stigma surrounding the field of psychiatry, (3) improve the quality of everyday life for medical students, and (4) screen students for the risks of developing serious mental disorders. We are also working to establish a center dedicated to support medical students and their development; such a center will nurture student’s personalities by improving their life skills through trainings, and helping those facing difficulties through interactions with peers, professors and psychiatrists.

As an active member of Associa-Med Tunisia, and as a medical student who sought help when things got rough, a student who is not ashamed to speak up about mental health, I stand by such a project, which can save lives.

At first, it was essential for us to have an overview of the current situation, see what stresses a Tunisian medical student, and build up our plan accordingly. We sent out an anonymous survey with short- and long-term objectives. We then moved to promoting mental health and advertising our newly born center, which would eventually address students’ personal development and mental well-being, tackling subjects like psychosis, anxiety, self-expression, sexuality, etc…

Our launching conference was the first pillar, on which the center will stand and continue its work for years. It’s certainly a challenging project that not only requires a lot of human resources, but also depends on it. Follow-up is crucial in order to improve and to stay up to date.

Students who attended this conference, along with those who prepared for the creation of this center, have learned quite a lot about mental health. It’s safe to say that they feel more secure knowing that help is given to those who need – and seek – it. They realized the importance of mental health, the need to speak up about it, and to face the stigma surrounding it.
FMS-Taiwan held its first “One World, One Health” workshop, in collaboration with PSA-Taiwan (Pharmaceutical Students’ Association of Taiwan) and IVSA-Taiwan (International Veterinary Students’ Association of Taiwan), during the month of June 2014. Approximately one hundred and fifty students attended the workshop, which aims for a better future. One health has been defined as “the collaborative effort of multiple disciplines – working locally, nationally, and globally – to attain optimal health for people, animals and the environment”[1]. As emerging infectious diseases are posing great threats to global health, collaboration between different disciplines should be established as soon as possible.

Apart from didactic lectures, the workshop also had different interactive sessions, with the hope of generating dialogue between students of different disciplines. In “One Health Forum,” students were divided into eleven groups discussing different topics associated with One Health. Within their groups, students were assigned different roles to express their thoughts on the given topic. Students had to share their ideas only by writing, and each group was allocated 10 minutes on the last day to present their outcomes. In “D-MVP,” participants debated among themselves and tried to reach consensus on issues more or less controversial in Taiwan. Students were divided into groups and were randomly assigned a topic to debate.

During the workshop, we also arranged a visit the Taipei City Zoo. We were allowed to visit the zoo’s infirmary to have a better understanding of how emergency situations are handled.

“One World, One Health” is a first platform for students to start cross-discipline dialogue and build lasting friendships. In March 2015, we held the second workshop’s second edition. We hope to continue with our workshop in years to come; a stronger collaboration between medical, pharmaceutical and veterinary students can shape a better future for all.

Reference:
Brazil has the largest public organ transplantation system in the world; about 95% of procedures and surgeries are made with public resources. By law, only the family has the authority to decide about organ donation, which means that any written document is not valid if not agreed on by the donor’s family. This is why, it is very important that people let their families know about their wish to be an organ donor. According to Brazilian Society of Organs Transplantation (ABTO), 72% of families interviewed in the first half of 2014, denied the request for organ donation. Their reasons included: religious beliefs, poor understanding of brain death, non-acceptance of body manipulation, mistrust of healthcare systems, and fear of black-market organ sales.

Faced with this situation, a group of medical students at the Federal University of Acre, linked to IFMSA Brazil, organized a campaign to raise the population’s awareness about organ donation, brain death, the importance to inform their families if they wish to be an organ donor, as well as blood and marrow donation. Through a pre-campaign training, participating students learnt about the different legal and ethical aspects of organ and tissue donation. The campaign was then based on two different approaches: collective and individual. A video presentation about brain death and the importance of organ donation was prepared and displayed, for two days, in the waiting rooms of a public hospital. Students also approached people present at the university restaurant and talked to them about organ donation. Through these one-on-one conversations, people students would elucidate wrong concepts about organ donation and transplantation such as, for example, the idea of the body mutilation for retrieval of organs.

Another part of our campaign took place online. Both students and the general public were instigated to change their cover photo on Facebook into one that said, “I admit, I am an organ donor.” Our campaign reached hundreds (if not thousands) of people. The Internet proved to be a good and dynamic tool to spread ideas. We believe we have reached our objective of correcting misconceptions, especially that many people admitted to changing their minds about the possibility of becoming organ donors, and some actually decided to talk to their families about it.

References:
Live it UP! Project
Our Lifestyle is Our Greatest Weapon

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Over time, the world’s health profile has changed, and it still does. Chronic diseases are on the rise, and are currently among the major causes of death. This is of extreme relevance to actual medical practice since we now know that interventional and pharmacological medicine is not enough to curb mortality and morbidity, and improve patients’ lifestyles.

The Live it UP! project is based on the fact that nothing can be more effective than preventing disease and promoting healthy lifestyles. In fact, “at least 80% of premature deaths from heart disease and stroke could be avoided through healthy diet, regular physical activity and avoiding tobacco smoke” (WHO). Most risk factors are lifestyle related, and have a strong impact on the incidence and prognosis of the disease.

Our project is a tight collaboration between ANEM-PorMSIC, the Portuguese Directorate-General of Health, the European Society of Lifestyle Medicine, the National Youth Forum and other organizations working on similar subjects.

About the pertinence of the project, Romeu Mendes, MD PhD, Country Representative for Portugal of the ESLM said, “This project represents the paradigm shift of Portuguese medical students regarding the actual impact of non-communicable diseases. We aimed to provide students with tools to promote research, prevention and treatment of lifestyle-related diseases (cardiovascular diseases, diabetes, cancer, and chronic respiratory diseases) through nutrition, physical activity, psychology and public health.”

In the first phase, the project targets medical students. Our goal was to provide our colleagues with a solid professional training in non-communicable diseases, healthy lifestyles and behavioral changes in health, facilitated by the best investigators in this area. Sessions took place over an entire weekend, with trainings on communication and peer education. Trainings were held at Porto, Coimbra and Lisbon. A total of 90 participants were empowered to become the new doctors of the future, concerned with and conscious of this problem, motivated to act now, with all the necessary tools and opportunities to do so. Participants were evaluated and are now certified as “Live it UP! Monitors.”

In the second stage, Live it UP! Monitors will organize trainings and awareness campaigns aimed at popularizing scientific knowledge and raising awareness about healthy living. Cristiana Costa, 20 years old, is one of the new monitors who already had the chance to organize a session about alcohol for a group of teenagers. “Project Live it UP! is a quite interesting project for me. As a medical student and a future doctor, it allows me to know more about healthy lifestyles and healthy habits and with that information I feel much more comfortable talking about these issues in my community. It gives me strategies to communicate about these subjects and I hope that this could make me an informed, better physician tomorrow!”

A lot has been done to promote healthy lifestyles, but truth is, the real challenge is to go beyond people’s beliefs and have the power to change cultural mindsets: building a confident relationship with the patient, giving reliable information and raising awareness that will lead to lifestyle changes and a healthier living.
The number of people living in rural areas is 3,367,497,212; this accounts for approximately 46% of the world’s population [1]. At the same time, less than 38% of nurses and less than 25% of the physicians work in such areas [2]. People in rural areas lack access to quality healthcare, a tangible and very serious problem.

The problem is more evident in low-income countries and this is due to many reasons. First, there is a lack of health workers general. Second, there is a bigger proportion of inhabitants in rural, compared to urban areas, which increases health demands of such areas, making it more important to have an organized health system.

When living in rural areas, getting the care you need can be problematic, not only because of the remoteness of your residence and unavailability of health professionals. There is also a lack of a governmental plan to tackle shortages of health professionals in rural areas. With only a few exceptions, most medical curricula around the world do not include exposure to rural medicine and the special needs of rural populations, making it harder to recruit of physicians, medical students and other professionals.

Medical students actually have a role to play faced with such scenarios. In Croatia, we took it upon ourselves to organize a rural health project that will deliver basic screenings (such as blood sugar and blood pressure measurements) and basic medical education to rural populations. Topics tackled included how to recognize stroke and heart attack symptoms, mental health, healthy lifestyle recommendations, etc... Information was passed through interactive lectures given at schools and elderly nursing homes. The project takes place in Daruvar, a small rural town in central east Croatia. Medical students and volunteers have the opportunity to go to there to provide services to an underserved population.

The project has been a huge success with both the volunteer medical students and the population of Daruvar. It exposed the students to the rural environment and provided the population much needed medical education and basic screenings. The reluctance of seeing physicians, mostly due to the distance, as well as time and money to be spent, can be overcome by this approach.

The rural population is often left out of the conversations when it comes to health and health systems. It is our duty as future medical professionals not to overlook their problems and to make sure their needs are met in full.

References:
Currently, medical schools across Ecuador prepare future medical professionals by providing them with theoretical and practical skills to use in their future careers, focusing on only the biological aspects of medicine. One wonders if these are enough to deal with the reality of the public health system. Do we know which is the healthcare model that manages hospitals and health centers in the country?

In order to provide medical students with a clearer view of the Public Health system in Ecuador, we organized Ecuador’s First Forum of Public Health, in collaboration with the Ministry of Public Health, and under the theme: “The reality in Ecuador and implementation of the Model of Integral Health Care.” The project was born after our past NMO President met with the Ecuadorian Minister of Health, on the sidelines of the 66th PAHO Regional Committee Meeting. A common agreement was then signed between AEMPPI and the Ministry to ensure the comprehensive development of medical students, who master both the theoretical and practical knowledge of medicine and of the current public health system in Ecuador.

The aim of this project is to give the medical students community enough information on Public Health in Ecuador and the region, as well as an adequate preparation for them to provide better healthcare in the future.

The Forum of Public Health took place on March 20th and 21st, at the Central University of Ecuador. More than 150 medical students from different universities across Ecuador took part. The forum addressed diverse topics related to public and global health, but it mostly focused on the Ecuadorian reality and the existing system.

The conference hosted facilitators from the Ministry of Public Health, PAHO, and AEMPPI. Participants had the opportunity to discuss, through expositions and roundtables, and share their points of view and experiences in our healthcare system. Topics of discussion included: primary health care, public health, climate change, maternal health, non communicable diseases, access to basic medicines among others.

We expect that this project teaches medical students so they get involved in important issues related to the health of our country. We are confident that participants now have a new perspective of what is public health, how our healthcare system works, and what needs to be changed, and that they will develop strategies to tackle these issues.

This project will hopefully be reproduced in different cities of Ecuador to deliver this information to as many medical students as possible.

This project would not have been possible without all the support of AEMPPI’s board and the National Direction of International Cooperation and Relations of the Ministry of Public Health.
Smoking is thought to be the leading cause of preventable death in the world, with about 200,000 deaths per year in Brazil. The country is the second largest tobacco producer in the world, with 731,000 tons in harvest during the year 2012/2013.

Currently, most of tobacco consumption in Brazil is related to cigarette smoking, though a decline has been noticed recently, particularly among younger age groups.

There are other forms of tobacco, which can be prepared in several ways to modify flavor, smell and pharmacological properties. Note, however, that all forms of tobacco have in common the release and action of nicotine in the central nervous system. In particular, water pipe smoking (also known as hookah, narghile, shisha, etc…) has been dramatically increasing among youth worldwide.

Water pipes have been used to smoke tobacco and other substances by the indigenous peoples of Africa and Asia, for at least centuries. According to one historical account, an Indian physician invented the water pipe, during the reign of Emperor Akbar, as a purportedly less harmful method of tobacco use. The false belief that this practice is relatively safe is still held by many water pipe users until nowadays.

Contrary to ancient lore and popular belief, the smoke emerging from a water pipe contains numerous toxic elements proven to cause lung cancer, heart disease, and other diseases. A single water pipe smoking session may expose its consumer to more smoke compared to having one cigarette. Given that water does absorb some of the nicotine, and knowing that smokers tend to smoke until they get enough of the substance to satisfy their need, a water pipe smoker needs higher amounts of smoke to get satisfied.

Concerned about this scenario, the IFMSA Brazil local committee at the Federal University of Mato Grosso developed the campaign “Naguilé: largue, né?!” (Waterpipe: kick the habit), with the support of the Brazilian Society of Pneumology and Physiology.

We put a water pipe on a table announcing, “New flavors on sale. Come try it!” Passersby would come to our stand and we would inform them about the dangers of water pipes. We also handed out pamphlets and booklets about smoking and its negative impacts on one’s health.

As future physicians, we have an essential role to play in the definition of tobacco control policies and awareness campaigns. It is important to be aware of the myths and realities about using water pipes and to promote true information about smoking.

References:
Universal Coverage or Universal Access?

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Universal Coverage and Universal Access to Healthcare may look similar but, in fact, they are two very different concepts. The semantic approximation of both confuses people. Universal Coverage is an approximation of issues raised by social movements of fighting for health as a right with universal access in a historical context. The expression “Universal Health Coverage” has been widespread since 2013, but it has been originally present on discussions linked with health insurance before. Universal Health Coverage is the warranty that everybody can have health service with good quality when needed, without suffering financial damages. In contrast, Universal Access is a concept closer to health as a right. While Universal Health Coverage advocates the supply of basic health services, purchased by states, to only people who cannot financially obtain them, Universal Access is based on the public offering of comprehensive care to the entire population. That is, it’s the implementation of limits for individual spending on health in a process of exclusion by prices. In case of Universal Coverage, we distort the responsibility of health, passing from the estate to the individual and create a partial protection, where what’s important is the amount of coverage and not the real access or real capacity to meet the needs. It promises to give access to all health services, but makes a separation according to earnings. Those who pay more, have access to a greater number of services. This policy reduces the importance of health and people; the poor would receive a treatment different than that the wealthy do.

In countries with universal coverage, the state gives each person that seeks public services a maximum amount to spend on health care, which is purchased from the private sector. However, if the services needed exceed the forecast, then that person must pay for his/her own resources to make the difference. In a Universal Access system, the services provided are of equal access and free for all. In the private sector, health is a privilege only those who can pay for it are the ones with access to it. Health becomes then governed as a commodity, as in any business system, and so often examinations, diagnosis, hospitalization and even surgical procedures are carried out without a real necessity. Following this logic, many times we find companies competing for patients (“clients”), often selling unsuitable products just to have more costumers.

We can clearly see that the logic of profit does not apply to health; in Brazil for instance there are 75,916 complaints against private health plans, of which 75.7% are related to denial of coverage. It is extremely difficult to fight for health right when profit is involved. So, when we are talking about Universal Coverage or Universal Access, we can see the dichotomy about health: health as fundamental right and collective ownership, guaranteed by the state, or health as individual ownership, solved by the market provided by the state only when necessary. We need to decide what we believe in and what we want for the population.

References:
1) https://www.youtube.com/watch?v=qoavlMZrcwA
3) https://portal.fiocruz.br/pt-br/content/conquistas-e-desafios-do-sus-s%C3%A3o-debatidos-no-congresso-da-abrasco
Welcome to the world of SCORAngels! This section will provide you with much insight into the life of the delightful Standing Committee On Sexual & Reproductive Health including HIV/AIDS.
Introduction
from the SCORA International Team

Dear SCORAngels,

I am extremely proud to present to you this SCORAlicious section of MSI32!

The articles presented herein are just a reflection of the extraordinary work that our National Officers and Teams are doing across the world; we cannot be more proud and thankful for the huge impact your activities contribute to SCORA! We still face challenges with stigma and discrimination in sexual and reproductive health and rights issues, but as “difficult roads lead to beautiful destinations,” only by working together can we create a positive behavior change in societies... so keep up the great work!

The time since the March Meeting has passed by so quickly; we have been very efficient and very productive. We’ve conducted successful campaigns to celebrate the International Day Against Homophobia and Transphobia (IDAHOT) and the International Day of Pink against Bullying, Discrimination, Homophobia and Transmisogyny. We’ve also had, for the first time, workshops on Global Surgery in the field of Obstetrics and Gynecology during Pre-EuRegMe in Denmark, not to mention the extraordinary sessions at the Regional Meetings of Europe and Asia-Pacific.

During the March Meeting, we’ve seen two SCORA programs come to life: Comprehensive Sexuality Education (CSE) and Maternal Health and Access to Safe Abortion. Another three programs are to be voted on during this August Meeting, allowing us to cover all five of SCORA’s Focus Areas.

Your SCORA International Team has been working really hard to prepare great, outcomes-oriented sessions for AM2015. Together with the Sessions Team, we have prepared various activities, debates and trainings. I am sure both newcomers and experienced SCORAngels will find something to entice them during the SCORA sessions!

We will be also updating SCORA Strategic Plan, so your input will be very much welcome!

I am very proud of every single SCORAngel that has written an article for this section; I also encourage you to share your amazing stories, actions, workshops, and campaigns.

Last, but not least I would like to thank SCORA International Team - there are no words to express how grateful I am for your work and commitment to our beloved Standing Committee!

SCORAlicious Hugs,
Micha.
All the metaphors and similes would be of no worth, all the colors of a rainbow wouldn’t shine, all the stars wouldn’t twinkle and all the gold wouldn’t glitter if our mothers weren’t here with us. This bond is heavenly; she is oxygen for life, she is the smile on our face, she is the courage, she is the support and she surely is a wonderful woman we call “Our Ammi.”

In Pakistan, the statistics of maternal and infant mortality are very agonizing for a variety of reasons including lack of education, lack of resources, and lack of courage to find a solution. Being responsible human beings, we should not hesitate going the extra mile to save our mothers and our children.

According to the National Maternal and Child Health Program, the improvement in maternal and child health status is crucial to attain. The social sector aims for poverty reduction and this is part of all policy documents of the government of Pakistan, including the Poverty Reduction Strategy Paper, Medium Term Development Framework 2005-2010 and 10 years Perspective Development Plan 2001-2011. Pakistan is also a signatory to the Millennium Development Goals, of which goals 4 and 5 particularly focus on maternal and child health.

Health indicators regarding maternal, newborn and children (MNC) health illustrate that an immense effort is needed to improve these indicators. The table below shows a comparison between MNC Health indicators of different countries drawing attention of the government of Pakistan and all development partners to work vigorously to improve them.

In accordance with the objective of disseminating awareness, particularly among mothers, the IFMSA-Pakistan KEMU Local Council organized, under the careful and very capable supervision of Society President Arfa Ahmad and Director SCORA Isma Iftikhar, The Maternal and Child Health Program on March 17th, 2015. Kemcolians as well as students from other eminent colleges, enthusiastically participated in this event and helped us in our first step towards improving status of health in Pakistan.

The event started off with an introduction by the society President, followed by a briefing session by Imama Ahmad and Izza Bazigh (final year and third year students, respectively). They gave an excellent presentation highlighting the basic theme of the event, as well as how to communicate with patients at hospitals and convey to them information about the basic health of a mother and a child. Participants then flocked to the Patiala Ground for a group photograph and headed in groups lead by SCORA officers to their assigned wards at Mayo Hospital, Lady Willington and Lady Aitchison Hospital. Young doctors got in touch with patients and explained to them, in detail, the following points:

- Importance of Breastfeeding;
- Importance of Vaccination for T.B., Diphtheria, Whooping Cough & Hepatitis B;
- Personal hygiene of mother including clean clothes, pure water and dental hygiene;
- Self Examination of breast in females for any lumps;
- Importance of family planning;
- Common health problems in Children;
- Making of ORS (NAMCOL) at home.

The event was concluded with the distribution of certificates to participants and organizers, reflecting the success of the event.
The Need to Uplift Maternal & Child Healthcare Issues in Uganda

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Despite efforts made by non-governmental organizations (NGOs) and the government of Uganda to curb the various problems faced in maternal and child health, the millennium development goals, as of 2015, still remain unachieved.

Maternal mortality rate is still relatively high, with mothers dying due to severe bleeding, infections, eclampsia, unsafe abortions, and obstructed labour.

All pregnant women face some complications, according to WHO. “About 40% will experience delivery complications while 15% will need obstetric care to manage complication.” This, coupled with the inadequacy of human resources, keeps mortality rates high. The limited capacity of health centres to manage complication of abortions and miscarriages further complicates matters.

While the prevalence of HIV/AIDS remains a global calamity, it is a factor in poor maternal outcomes and it does not seem to decline among pregnant women, nor does the transmission to child, despite the advent of tools capable of Eliminating Mother To Child Transmission (EMTCT).

Malaria is still a leading cause of morbidity in pregnant women, though the government attempted prevention by using mosquito nets and prophylaxis during antenatal visits. This calls for an input of the citizens themselves to contribute to further improvement.

Maternal health challenges in Uganda are due to both inadequacy and inequality in the distribution of resources, with over 80% of doctors and 60% of midwives and nurses working in urban areas, leaving the poor rural citizens with no – or very limited – access to health services.

Uganda’s budget allocation to the health sector is a major contributing factor to health outcomes. With Universities producing close to 400 physicians per year, one would not expect to have such a shortage of health workers. But low salaries and poor work conditions push them to seek jobs elsewhere.

When it comes to child health, these innocent angels suffer just for being born in country with limited resources. Causes of death in children under 5, as per data from WHO are: neonatal infections (21%), malaria (15%), diarrhoea (14%), pneumonia (11%), and HIV 4%. According to inter-parliamentary union, the parliament of Uganda, and the partnership for maternal, new born and child health report, Uganda was ranked 19th globally deaths of children under 5, with most cases being due to preventable causes. The probability of dying between the first and fifth birthdays for rural infants is 45%. While infant mortality rates have declined between 1990 and 2008, Uganda is still not on track with the MDG 4.
The Brazilian population has been aging in recent years as shown by the demographic transition and the sharp decline in mortality and fertility rates. It was also noted that the topic of sexuality has become one of heated discussion among the elderly. However, shame, discomfort, and even prejudice from family member or the elderly people themselves, will deprive many from seeking more information about how they could improve their relationships and their sexuality. Added to that, the incidence of STIs, including HIV/AIDS, among the elderly has shown steady increase, due to non-protected sex habits of the aging population.

Faced with such a situation, the organizers of the Sexuality Project met with several elderly men and women, talked to them, and answered all questions in a relaxed, non-judging setting. Topics addressed included what sexuality is, the main physiological changes in aging men and women, myths surrounding sexual activity among the elderly, the various ways to improve sexual activity and the importance of protection against STIs.

Volunteer participants underwent thorough training with a gynecologist; they focused on developments in the concept of sexuality, and how these changes have repercussions on the sexual and personal lives of the elderly. It is currently inconceivable that sexuality is solely linked to reproductive function when it can actually be a liberating source of pleasure for all ages. The physician explained that the elderly may either surrender to conformity or live with creativity. The intention is not to return them to youth performance, but help cope with the physiological changes that accompany old age. In addition, she advised on how to address new forms of sexual satisfaction such as mutual masturbation and oral sex.

To address the increasing rates of sexually transmitted infections among this age group, it was necessary to raise awareness of the use of condoms.

Following the training, volunteers went to various Family Health Strategy (ESF's) in the city of Montes Claros. During each session, the elderly gathered in a circle with the volunteers and had relaxed, open-minded, non-judging discussions.

Results and feedback received were very satisfactory. The issues were well addressed; the approach was very placid; and both the target audience and the staff of the ESF praised the initiative. Volunteers promised to share their experience with others.

Knowing the theme "Sexuality in the Elderly" is overlooked by society, including health professionals, and faced with the increased incidence and transmission of STIs among this age group, our project aimed to convey information about prevention of disease, demystify sexuality, and encouraging understanding and affection between partners.

It is clear that it is absolutely possible to reach old age in a healthy way, expressing love and enjoying sexuality.
Sexuality Education for Girls: A Social Issue

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60% of young people aged 15 to 24 years do not know how to properly protect themselves against HIV. Very few adults have adequate knowledge about leading good and healthy sexual lives, making them vulnerable to sexual and physical violence, coercion, undesired pregnancy and sexually transmitted infections (STIs).

This situation is worsened by the fact that the most affected groups are also the farthest away from sexuality education; young women and children. Until today, parents try their best to keep their young girls from sexuality education, hopelessly believing this will protect them. As consequence, these children end up searching for information on their own, and - maybe - adopting dangerous behaviors.

Faced with such fact, the IFMSA Brazil local Committee at the Federal University of Mato Grosso developed the project Sexuality Education for Girls. Teenagers in a situation of social vulnerability, sheltered in a public institution under protection of justice, were the focal points project.

Over a period of seven months, gynecological anatomy, fecundation, pregnancy, menstruation, contraceptive methods, personal hygiene, gynecologist consultation, (STIs) and sexuality were discussed in a fun and easy, but also serious environment.

“We – the project members – are committed to be clear, responsible and respectful to the girls,” said Eduardo Diniz, a first year medical student of UFMT and also LORA. “Talking about such subjects may be uncomfortable and also embarrassing, but our job is to show that they need to ask about sexuality and they have the right to be answered.”

Going beyond just promoting health, we tried to create a link with the girls involved in the project, deeply exploring their doubts and fears about sexuality and its relation with social life, which may involve their family, friends or dates. Deconstructing prejudice and myths, it was possible to make of them women with better self-esteem, capable of taking care of themselves. We followed an approach based on their rights as humans, allowing for their empowerment so that they can make their own decisions.

At the transition between childhood and adult life, these girls might have some information gap in what their duties are and the temptations they would face. As they learnt more about sexuality, they were able of disseminating this knowledge through peer education, not only teaching how to prevent from STIs or maintaining adequate hygiene, but also to respect those with a different sexual orientation or behavior. Everything they need is being taught, oriented, stimulated, but above all, they are listened to. “They have a lot to ask, to tell, to be embarrassed of and it is pretty common at their age. Our main goal as future physicians would be treating, but that is impossible not paying attention to their actual needs; dialogue is meant to ease their doubts and satisfy their curiosity and I’m extremely happy and grateful for being part of IFMSA projects like this one”, said Eduardo.
AIDS (Acquired Immune Deficiency Syndrome) was only recognized as a disease in 1983; until then initial symptoms were not well clustered together. By suppressing the immune system of infected individuals, HIV claimed the lives of thousands of people around the world. Around this time, an outbreak of deaths among homosexuals and IV drug users, created a great wave of prejudice surrounding the disease, which continues to be relevant, even today. However, data shows that people living with HIV (PLWHIV) are mostly heterosexual; contraction of the infection has nothing to do with sexual orientation.

Since the discovery of the virus, scientists have sought – unsuccessfully – to cure it. Thus, prevention and awareness have become increasingly important in combating the infection. In parallel, policies against prejudice were put in place to minimize the suffering of HIV-positive patients. The IFMSA Brazil SCORA Local Committee at the University of Taubaté (UNITAU) organized a candlelight memorial to honor all AIDS patients who’ve died. It aimed to reflect about the disease, break the prejudice surrounding carriers, and encourage prevention.

In the city of Taubaté, there is a house of support for PLWHIV, "Casa mulher e vida" (in English "House Women and Life"). Visiting this local and talking to those in charge of it, was of paramount importance to understand the reality that PLWHIV face on a daily basis. Prejudice prevents them from receiving an arm, a kiss or any other type of approach, as if it really were a form of transmission of the virus. The disease has no cure, but living with the virus can be under control, increasing the patients’ chances of survival.

The campaign came about in order to raise people’s awareness. The committee had 50+ students of trained on HIV/AIDS, gathered at a public space, calling for the attention of passersby. Students used red candles to for an AIDS Awareness Red Ribbon; each candle lit represented a person who has shown interest in participating in the memorial. Students toured the square for more than three hours, talking to people, exchanging information and knowledge, listening to their stories, and trying to make them understand how important it is for PLWHIV to feel integrated in society, not judged by health professionals.

References:
Stereotypes, Prejudices & Discrimination: Reasons for Unprofessional Contact Between the Doctor & the Homosexual Patient.

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LGBT people in many countries still face many challenges and a lot of controversy. Often, people’s knowledge about LGBT communities is based only on information from the media, which is rarely accurate. The image of LGBT derived from mass media is often exaggerated and distorted. Another problem is the exclusion of this subject from medical school curricula. The issue of transgender people is becoming even more common, and the LGBT communities are increasingly becoming aware of their rights (e.g. dignified treatment to the doctor) and are demanding them.

Why is this important? Each one of us is going to be a physician in the future; we will inevitably come across LGBT patient in our practice. It would be helpful to have minimal knowledge about these communities, as well as the problems they may come to us for. But first and foremost, we should keep professionalism in all our activities and patient relations.

LGBT Medicine is a project that primarily aims to pay attention to health issues of LGBT patients: discrimination, health problems, risk factors, preventive examinations, HIV, etc... Through the project we also aim to educate our colleagues – the future physicians – as well as high school students, by promoting widely understood tolerance.

How do we achieve our goals? We want to focus people’s attention on the problem of stereotypes, prejudices and discrimination, still present in each of our daily lives so that we do not succumb to them. We also place emphasis on the correct understanding of terms such as sexuality, sex, gender identity, sexual orientation etc...

This project is certainly controversial and tackles a difficult subject. However, professionalism has to be manifested in doctor-patient relations, and this is what keeps us fighting.

We have organized the first edition of workshops this year. Participants were mainly members of IFMSA-Poland and the workshop was held in cooperation with the Campaign Against Homophobia in Warsaw. Participants learnt about human sexuality and shared their thoughts about LGBT issues. We plan to organize further workshops across different medical schools in Poland, targeting a larger group of students and young doctors.

We hope to contribute thereby to increase awareness about LGBT issues and affect the development of professional attitudes among physicians in their offices. We have still a lot of work to do, and we are looking forward to that.
The right to health in Brazil is the result of the struggle of the Health Reform Movement; it is guaranteed by the 1988 Constitution, in which health is understood not merely as the absence of disease. From this point of view, health is the result of people’s access public goods and services offered by universal social policies. Therefore, it is important to recognize the effects of discrimination and exclusion in the social determination of the health, especially in communities such as the LGBT community.

The National Policy on Comprehensive LGBT Health (2010) reiterates the National Health System’s commitment to universality, comprehensiveness and the effective participation of the community. It contemplates actions for the promotion, prevention, recovery and rehabilitation, in addition to encouraging the production of knowledge and strengthening the representation of the community in social control. This regulation articulates a set of actions and programs, which are concrete measures to be implemented in all NHS management spheres, particularly in the State and Municipal Health Secretariats. The Decree GM / MS n. 2803 (2013) deals with the SUS (Health System) comprehensive care for transvestites and transsexuals, not restricting or centralizing the therapeutic goal to reassignment surgery and other somatic interventions.

Both public policies, the result of the historical struggle of the LGBT movement in the country, are not effectively implemented in today’s health care system, whether in the NHS or its Complementary Network. There is no dedicated funding for the realization of the different actions of the National Plan and Ordinance 2803/13 yet. Municipal and State Health Departments delegitimize the actions proposed by the plan in their daily planning. And the actions of the federal government are still focused on prevention policies for STIs and Viral Hepatitis, further contributing to the stigmatization of the LGBT community.

The training of health professionals, predominantly under the cis-heteronormative regime allows for the inclusion of sexual diversity and gender debate in an attempt to sensitize health workers to the demands of the LGBT community. Curricula still treat sexuality in such a way overvaluing its reproductive function, ignoring the diversity of its ownership; gender and transgender identity do not make up the everyday vocational training (GUARANHA, 2013).

Even medical authority finds it hard to include this topic in their guidelines. The Resolution of the Federal Council of Medicine 1955/10, which regulates sex reassignment surgery, necessitating a diagnosis of “Gender Identity Disorder,” preserves the conflict undervaluing individuals in the process of forming their own gender identity (ARAN, MURTA and Lionço, 2009).

Health facilities, still fail to meet the needs and demands of the LGBT community regarding their reception and healthcare. The preventive work of the Family Health Strategy teams still is guided only on Sexually Transmitted Diseases (STDs), ignoring other elements involved in the overall health of these individuals.

References:
I have been advocating for the rights of people living with HIV (PLWHIV) for over 10 years already. Lately, during a Candlelight Memorial celebration organized by my Local Committee, I spoke (as a dedicated SCORpion with lots of love for SCORA and SCORAngels) about the most violated human rights of PLWHIV. These included, among others, breach of medical secrecy by medical staff, employment problems, medical insurance problems, etc... Talking about these issues made me think back at how different things are now, compared to 10 years ago.

I remember the times when antiretrovirals were hardly accessible; the times when HIV savvies told people to watch out because if it’s not treated well (always highlighting the elevated monthly costs of such treatment) HIV is an inevitable death sentence; the times when people were so afraid of HIV positive individuals... Now, ten years later, PLWHIV are not facing as much stigma as they did before.

That being said, one should note that not everything changed for the better. Many of us advocating for the rights of PLWHIV, say that “a properly used condom” protects from getting HIV in almost 100% cases. Yes, this is evident. Yet, we tend to forget that some infections are transmitted through other body fluids and, in some cases, the reasons scientists give cannot statistically prove. Just because it wasn’t statistically proven, it doesn’t mean it’s not possible. We, often describe such transmission events as “very rare” or “almost impossible,” so “no worries!”

We face a similar situation when it comes to medications. “New drugs allow people to live to a normal life expectancy.” That is true, but should we forget that the quality of life is affected? Most drugs have their own side effects, as mild as they might be. Going onto Google, It’s not hard to find many people openly speaking openly about that. I once read “well, I have to take the drugs, and let’s face it, these aren’t mints. I sometimes end up having to go to the hospital” Having a negative view of HIV is not our goal. But, being somewhat too positive about it, might give the impression that it is not a big deal, so we don’t really need to worry about a condom! I have met people who think like that. Is it possible that they give themselves more social freedom because they blindly trust in our advocacy work? We also forget about the costs here, which are extremely high.

I wonder where to go from here. Should we continue our advocacy in the same way? Or should we get in touch with people less fortunate to be experiencing treatments’ side effects and ask them to tell their stories? Is it possible that the way we advocate for rights of PLWHIV is also the reason preventing us “Getting To Zero?”

Please, don’t get me wrong... I am just thinking out loud. I don’t have a “stable” opinion on all the points raised. But I do believe some things are worth rethinking, and no one can do it alone. We have to talk, share our experiences and, then, we have to act. I hope this article is a good start.
Have you ever wondered what SCORE Exchanges are all about? Which countries you could go to? Or what research projects are offered? Find out more here in SCOREview, the publication that has everyone talking about research exchange.
Introduction
from the SCORE International Team

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Dearest SCOREans around the world,

It is with a lot of pleasure that we present you this edition of SCOREview.

This is the 2nd edition this term. Within its page, you can read about the experiences of fellow IFMSAians that took part in a Research Exchange, you can discover and learn more about some countries, have a sneak peek on some projects going on, and think about our ethics as medical students.

Presently, 68 National Member Organizations are SCORE-active. They offer over 3000 research projects, providing over 2500 medical students worldwide with the opportunity to participate in a research exchange program and learn the basic principles of medical research such as studying the literature, collecting data, writing scientific papers, lab work, and ethical aspects related to the medicine.

It is never enough to repeat that our mission is to offer future physicians an opportunity to experience research and diversity in countries all over the world. This is achieved by providing a network of locally and internationally active students that globally facilitate access to research exchange projects. Through our programming and opportunities, we aim to develop both culturally sensitive students and skilled researchers intent on shaping the world of science in the upcoming future.

How amazing is it to have the opportunity to do a research when you don’t have it in your own country? How enriching is it to learn about new cultures? How inspiring is it to live one month in a new country with other medical students from all over the world, each from a different background, and learn about techniques of research? This is SCORE!

We’ve been working really hard this term to improve SCORE, make it stronger, better, more visible and more credible. We hope the joint efforts of National and Local Officers, Support Persons and students make this program achieve its goals for this year.

It was a pleasure and an honour to dedicate this year to SCORE, to see our Standing Committee grow, to see more recognition from external partners, and to understand that the journey was worth everything.

We hope more and more people will join SCORE and realize how amazing it is and how big its potential is.

We invite you to go through these pages and try to feel what those students felt while writing those articles!

Big Blue Hugs,
Luiza

On behalf of the SCORE International Team:
Ivana di Salvo (Liaison Officer for Research & Medical Associations); Osman Aldirdiri (Regional Assistant for Africa); Ilse Ramirez (Regional Assistant for the Americas); Fajar Putra (Regional Assistant for Asia Pacific); Omar Hafez (Regional Assistant for the EMR); Evangelia Antonopoulou & Orhun Çakır (Co-Regional Assistants for Europe); Koen Demaegd (Development Assistant on Academic Quality); Benjamin Kamberi, Kwan Park, Marta Borys, Maysah Al-Mulla, Mirona Predescu - Romania (Supervising Board)
Travelling to Asia has always been one of my biggest dreams. Up until 2014, the eastern most point on the map I had the chance to visit has been Białystok (a northeastern city in Poland). Come July 2014, I was flying over 7,000 kilometers from my hometown to the East – the Far East – to do my Research Exchange in Taiwan. My dream was finally coming true!

I was accepted in a project about the genetic and functional study of the DNA repair system in relation to susceptibility to rheumatoid arthritis, carried out in the Department of Medical Research & Genetics at the China Medical University (Taichung) and under the supervision of Professor Shih-Yin, Chen.

I spent around six hours a day working in the lab: I took part as an assistant in all of the procedures done by Professor Chen’s team, which helped me gain both new skills and knowledge. I was working mostly with cell lines, establishing, caring and feeding them and, within four weeks, they started calling me “cell mama.” I also learnt how to perform DNA extraction step by step.

Every person I met in the lab was amazing! They were very patient with me and helped explain everything. They taught me not only about laboratory skills but also about Chinese food and traditions. Very quickly, I became a part of the team and I was really enjoying all the time I spent at the Center!

At the end of my research exchange, the team gave me one of the most surprising gifts I have ever received: my own DNA closed and sealed in a cute tiny bottle with a small red bow and it was prof. Chen’s idea! This is how I left my heart there and received my own DNA in exchange!

Taiwan is filled with countless breath-taking places and landscapes. From sightseeing to surfing lessons, from a weekend trip to a Chinese Medical Camp, the social program was packed! We would practice calligraphy, acupuncture and even Tai-chi.

I also visited night markets, famous attractions in Taiwan. As it was my first time in Asia, I tasted absolutely everything and I must say it is impossible to find these incredible flavors and fresh fruits in Europe.

I was really lucky to meet in Taichung people from all over the world, all of whom have become my international family. I would like to show my gratitude to all the people I met in Taiwan, for all their hard work to make me feel at home.
Peru is a country in western South America, located along the Pacific Ocean, made up of a rich variety of landscapes, from mountains and beaches to deserts and rainforests. Perú is known for its gastronomy, rich history, culture, climatic diversity, beautiful landscapes and the kindness and hospitality.

In IFMSA Perú, we take very seriously the academic quality of our exchanges programs. We currently have a wide variety of exchange projects. You can join research projects in the fields of pharmacology, physiology, endocrinology, gastroenterology and pediatrics, with and without lab work, all led by excellent and qualified tutors who are eager to welcome exchange students!

If you visit Peru, don’t miss our most famous tourist attraction, Machu Picchu - the “lost city of the Incas”, which is one of the most extraordinary and breathtaking places to visit in the world. It is built on a ridge between two giant peaks, with near-vertical slopes dropping away on either side. Consisting of around 200 buildings, which include dwellings and temples, the city was built nearly 700 years ago, hidden by jungle since the 16th century, only to be rediscovered by astounded explorers in 1911. With its intricate design and breathtaking views, a visit to Machu Picchu is definitely a trip of a lifetime.

The Nazca Lines, a unique place in the world, full with mystery, wonderful forms of immense figures and lines, of spectacular perfection, are a UNESCO Cultural World Heritage. Whether they were created as messages to the gods or as paths to spiritual enlightenment, the Nazca Lines rank firmly among the tourist attractions of Perú. These giant sketches are located in the country’s Nazca Desert and can only really be seen from the air. Amongst their enigmatic shapes are a monkey, two humans, a hummingbird, a tree and a spider. They spread over 450 km2 and it’s suggested that they were created by the Nazca Civilisation, between 500 BC and 500 AD.

Trujillo is known as the “City of Eternal Spring.” It is famed by the traditional celebrations of the National Contest of Marinera (Festival de la Marinera), the International Festival of Spring, Competition of “Caballos de Paso” (Peruvian “Paso” horses), Exhibition of “Caballitos de Totora” and much more. It definitely is an excellent destination for the archaeological and historical tourism.

During their exchange period, incoming students will be placed with a Peruvian family. This is a wonderful opportunity to learn more about our culture and have a good company. Our program provides two meals by the host family. Our recommendation: go out in the cities, feel the vibrant life and savor Perú’s gastronomic treasures. You will enjoy it!

Don’t miss the chance to learn, research and discover Perú, it will change your life!
One ocean, 10,000 kilometers and a 13-hour flight stood between me and the Republic of Panama, the southernmost country of Central America, and the only place in the world where you can see sunrise on the Pacific Ocean and sunset on the Atlantic Ocean. It is a place so different compared to my homeland.

“Hola amiga!” I was welcomed with a beautiful weather – over 30° C and zero clouds in the sky. All the tiredness from a long and exhausting flight suddenly disappeared when I met my host family. It is really incredible how complete strangers can treat you as one of the family. From the very beginning, I knew that I was in the right place at the right time.

My tutors were very professional and I did not face any problems of communication: I was lucky that my project was one of the few carried out in English. I was also able to learn basic words in Spanish from the native speakers and I have to admit that it was an awesome experience for me.

The main objective of my project was the detection of Mycoplasma pneumoniae in symptomatic patients. The first week I got acquainted with the methods of detection of the bacteria, which included molecular techniques (PCR) and managing bacterial cultures. Next steps were done in cooperation with an immunologist, taking samples from the pharynx of symptomatic patients.

I have gained a lot of new skills working in the hospital. I learned about different diseases, which are not as common in Poland. I encountered many people living with HIV, and I admit that it has changed my views and attitudes towards these patients and expanded my knowledge about this disease.

Panama turned out to be a really cheerful country. My exchange was also a great academic and cultural experience. Latin America is a whole new world for a European girl like me – different habits, different customs and a different lifestyle.

What else can I say? My memories will last me a lifetime!
The Americas Regional Meeting has always been the perfect platform for us to empower youth and create regional collaboration across diverse health areas. Two of the core areas – and greatest challenges – of our Federation are the professional and research exchanges.

During the exchange sessions at the Americas RM, we focused on capacity building and learning about available resources needed to create high quality exchange programs that could get recognized locally, nationally and regionally. We held trainings in many specific areas to improve exchanges.

I personally got the opportunity to learn so many things. One of the topics discussed during the sessions was totally new for me: Global Health. I discovered how our exchange program goals are actually focused on providing not only high quality experience for the participating students but also on raising awareness about the difference between the local and national healthcare systems worldwide.

Pre-exchange trainings for exchange students were discussed in detail, exploring actual problems and innovative solutions other National Member Organizations have used in the past. Improving academic quality was also a main concern. Through different activities we got to brainstorm about all the possible ways for improvement, including more collaboration with the student, the tutor, and the institutions.

In the Americas region, recognition of exchanges nationally and regionally has been difficult to achieve. Even though several of our NMOs have been working with exchanges, the differences between the medical programs have always been a barrier for official academic recognition.

Therefore it’s really important that we, as students involved in the exchanges of our respective organizations, try and accomplish our goals, and do our best to improve quality and achieve recognition of exchanges.

The best part of our meeting was the opportunity to meet all those motivated students actively involved and realizing that we are a new generation that has identified the sources of the current problems of our region – a generation ready to work towards excellence.
As the National Coordinator of the SCORE Pre Exchange Trainings and Research Workshops, I would like to talk to you about our experience in this field in IFMSA-Poland. So far this year, we have conducted 11 Pre Exchange Trainings across 11 Local Committees! More than 150 students took part in those workshops and they were not only SCORE outgoings but also students interested in research in general or motivated to join IFMSA-Poland. During those workshops, we delivered trainings on soft skills (Motivation & Presentation skills) with the help of the IFMSA-Poland Trainings Division; former outgoings shared their experiences and advices about laboratory work and writing of scientific articles. We also did presentations about Academic Quality and general preparation for the SCORE exchange. We were preparing Research Workshops since the IFMSA March Meeting 2014 in Tunisia when I had the chance to meet Diyana Belezhanska, the Transnational Project Coordinator of Research Workshop at the time. After intensive preparations, our first Research Workshop was held on April 18, 2015 at Silesia Medical University in Katowice. We focused on research related issues especially how to read and write scientific articles. Three lectures were delivered by professors from the university. The first was by Aleksander L. Sieron, MD, PhD, was titled ‘How to plan and effectively carry out research work?’ The second lecture, ‘Evidence Based Medicine’ by Tomasz Francuz MD PhD, left participants with a few good topics to brainstorm about during the short break that followed. Last but not least, we also learned ‘How to write properly bibliography to research work?’ during the final lecture with Ewa Rojczyk MSc. I would like to acknowledge the great help, training and motivation from Diyana Belezhanska, without whom we wouldn’t have been able to organize those workshops. I would also like to thank Julia Bors & Iza Orzel, Members of National SCORE Team, Barbara Kamzela, LEO of LC Silesia, Anna Rebeka Salomea Szczegielniak, President of OC of International Student Psychiatric Conference and Rita Sharma and National Officer of Research Exchange of IFMSA-Poland. At IFMSA Poland, we try our best to prepare our outgoing students for their SCORE adventures and I’d like to encourage other SCORE-active organizations to organize Pre Exchange Trainings and Research Workshops to provide the same opportunity for all outgoing students around the world!
The Role of Sex Hormones in the Pathogenesis of Renal Diseases

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2 years ago, I participated in a research project about the influence of sex hormones on the pathogenesis of renal diseases in Bratislava, Slovakia. Epidemiological studies have shown that being a male is, by itself, a risk factor for the emergence and development of chronic kidney disease and that was the focus of our study.

Fortunately for me, there was a direct bus between my hometown in Poland and Bratislava. Upon arrival, I was greeted by the Local Officer, Veronica. The dorms were in the suburbs of Bratislava and my room mate, Dilara, was a girl from Turkey and we hit it off as friends almost instantly despite the many cultural differences.

Bratislava lays at the riverbanks of Danube and the most breathtaking places for sightseeing are the castle at the top of the hill and the Slavin Monument, both giving astonishing views of the whole city. Bratislava is only an hour away from Vienna.

My tutors were Julius Hodosy and Lubomira Tothova of the Institute of Molecular Biomedicine at the Comenius University in Bratislava. I had just finished my second year of medical studies and fresh out of my physiology and histology classes.

The tutors were kind enough to teach me about inoculation loops and Escherichia Coli.

My task was to set a standard procedure on infecting mice with E. Coli and inducing renal diseases. Every medical student had to perform urinary catheterization on mice; imagine how hard that is when the mouse’s entire body is no more than 5 cm long.

I was the only SCORE student there so I joined a group of about 20 SCOPE students. I met people from Turkey, Greece, Spain, Mexico, Russia, and Taiwan, which was a very interesting experience, learning about so many different cultures. I was able to compare many different aspects of medical education all around the globe, and tried different traditional.

All the people I have met were amazing and I am still in touch with them. It has been one of the best experiences of my life!
Kazakhstan is an independent Republic, situated in Central Asia with a population of 16 million inhabitants. Astana is its capital: a beautiful and modern city in Central Kazakhstan, on the river Ishim. The country’s surface area is more than 2 million km² and we share borders with China to the East, Russia to the North, Central Asian Republics to the South and the Caspian Sea in the West.

Kazakh is the official language of the country, but Russian and other languages are spoken here, too, due to the hundreds of nationalities represented in Kazakhstan.

Kazakh people are known for their joy, good humor and love of life, which is reflected in their warm welcoming to visitors.

Another city worthy of note is Almaty (formerly Alma-Ata), known to the whole world as the place where the Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care (PHC) in September of 1978. The declaration expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote primary health care. It was the first international declaration underlining the importance of primary health care, an approach which has since then been accepted by member countries of the World Health Organization (WHO) as the key to achieving “Health For All,” with a strong emphasis on third world countries.

KazMSA is a young association in IFMSA; it has started working in 2014, with 9 local committees. SCORE-Kazakhstan will be activated this year. You can choose projects in the fields of microbiology, anatomy, infectious diseases, genetics, gastroenterology and many more in the near future. Our tutors are eager to welcome you and so are we!

Due to our continental dimensions, we can offer a huge variety of activities. Our social program is really rich, with literally thousands of places to visit, most worthwhile.

In Astana, you will find a lot of modern buildings, skyscrapers and old monuments. It is also the geographical center of Eurasia.

Most of the students will be placed in a students’ house or with a host family. Boarding will be provided by the local committee, either in the hospital, the university restaurant or with the host family.

Come to Kazakhstan, we will be waiting for you and hope you will enjoy your stay. You are the most welcome!
The Influence of the Pharmaceutical Industry on Research in Brazil

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The Pharmaceutical Industry plays a big role in Medical Research, being its biggest sponsor nowadays. It is well known, that research results can be biased on studies sponsored by the industry, presenting better outcomes when compared to those carried out by independent researchers. That should always be taken into consideration when critically reading an article.

Pharmaceuticals are known to be among the most profitable companies in the world. Proceedings of legal cases and published research provide insights into the nature of their influence on research and publication practices regarding the drugs they manufacture. This influence extends further from only financial support to sponsorship of opinion leaders who promote their drugs and groups that produce clinical guidelines.

The total number of research projects for the clinical development of drugs is significantly increasing. Between 2000 and 2004 there were 489, 75.7% of which were financially supported by the industry. More than two-thirds of the projects were done in academic institutions and about one-third were equally divided between public health hospitals and private health service/hospitals. Eight of the 88 drug companies involved were among the world’s largest and supported 38% of the projects. 59% of all the projects were within four therapeutic groups: anti-neoplastic/immunomodulating agents, nervous system, cardiovascular system and alimentary tract/metabolism. That shows how big the influence of Pharmaceuticals is in our research projects nowadays.

It’s undeniable that the financial sponsorship they give to a great range of projects helps them to develop. The most important question we have to answer now is whether they are a social weapon to provide our populations with its needs or just a massive marketing device. Why is it so hard to find financial support for research on neglected diseases, targeting poor and developing countries? Our efforts should be guided to the ones that need us the most, not to the ones who pay the most.

Independent research should be encouraged and financially supported by sources with no connection to the drug industry. Also, more rigorous regulation of the relationship between the pharmaceutical industry and medicine research is required. In IFMSA, especially in SCORE, it’s our social responsibility to take all that in consideration while we choose a Research Project. It is also our duty to guarantee non-biased projects in order to make the best of our students exchange program.

References:
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 the local, national and international levels.
Dearest SCORPions,

I’m excited to welcome you to the section on Human Rights and Peace of MSI32! Here, you will find wonderful pieces of writing from students all over the world, who believe in all humans’ equal rights. With increasing economic inequality, political extremism, and more people forcibly displaced than ever recorded, our world desperately needs people to speak up, stand up and take action. As humans, we all have the responsibility – as well as the capability – to take care of our world. This planet is ultimately our shared home, and humankind is ultimately our family. We have to act as one, for the benefit of all.

Seeing medical students unite to work for what our profession believes in – preventing and alleviating suffering, helping and supporting people in need – makes me believe in a brighter tomorrow. SCORP has been through some tough times during the past few months, in the transition between the old and the new director. Nevertheless, our members have continued to work, tirelessly and devotedly. Local projects have been conducted, regional meetings held and global initiatives taken. Each of our members is aiming to make life better for other people, directly or on the long run.

After being appointed as the interim Director one month ago, I was greeted by an overwhelming number of emails in the inbox. Overwhelming, but at the same time amazing. It was great to learn about the amazing activities going on all around the world, and to see the great interest in starting new projects and campaigns. NMOs from all five regions are planning, or hoping, to conduct TNHRTs (Training New Human Rights Trainers); there are also discussions about improving older projects such as the GoSCORP exchanges, and a lot of exciting opportunities connected to external organizations, conferences and meetings.

Seeing this positive development in spite of all the hardship in this world fills me with hope, and I feel honored to serve as director. I hope that you are as excited as I am for what the future SCORP will bring. I am sure that our family will grow bigger and stronger and better, with your help! The stories waiting for you some pages ahead of here will give you a taste of the importance, the impact and the fun in our work. I will not delay you anymore – I wish you a peaceful and pleasant reading!

Green Hugs,
Jessica

On the behalf of SCORP International Team
Moa Herrgård (Liaison Officer for Human Rights and Peace), Florence Mwende Kiragu (Regional Assistant for Africa), Daniela Meneses Valle (Regional Assistant for the Americas), Yamen Jabr (Regional Assistant for Eastern Mediterranean Region), Hana Awil (Regional Assistant for Europe).
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World Humanitarian Summit:
Our Chance to Protect Rights

Moa Herrgard
IFMSA Liaison Officer for Human Rights & Peace 2014 - 2015

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War, hunger, despair, misery and disease are the everyday reality that a large amount of people around the world live with.

“The death of hundreds of thousands of people and death of hundreds of migrants off the coast of Libya is not only deeply saddening – it should shock the global conscience. The Mediterranea is fast becoming a sea of misery for thousands of migrants, more than twice as many migrants have died at sea in the past year than on the Titanic”[1].

Those were the words stated by UN Secretary General Ban Ki-Moon in 2013, words that highlight one reality, which a successful World Humanitarian Summit (WHS) hopefully can solve[1].

The goal of the WHS is to find new ways to tackle humanitarian needs in our fast-changing world. This summit will be focused on setting a new agenda for global humanitarian action. In the two years leading up to the summit, extensive consultations will be held to gather the perspectives, priorities and recommendations of all stakeholders on what must be done to make humanitarian action fit for the future. Four major themes serve as broad categories to guide the consultations[2]:

- Humanitarian Effectiveness: This topic will explore how to meet the humanitarian needs of all people with timely and appropriate aid that is delivered in a sustainable manner[3].

- Reducing Vulnerability and managing risk: Support countries and communities build resilience to the changing nature of shocks and stresses[3].

- Transformation through innovation: This topic aims to bring about a major drive and commitment to invest in the proposed models for an effective humanitarian innovation eco-system in order to research, develop and scale up new and/or improved models that realize breakthroughs to humanitarian challenges[3].

“We need to ensure that the humanitarian sector is not a profit making environment. Humanitarians’ only mission is to ensure the best possible implementation of Human Rights to affected people, and take the first step to rebuild a resilient society.”

- IFMSA Member during the WHS Consultation at the IFMSA March Meeting 2015, Turkey.
- Serving the needs of people in conflict: This means to identify more effective strategies and methods of providing assistance and protection to people affected by conflicts around the world\(^3\).

The Universal Declaration of Human Rights in its third article states that everyone has the right to life, liberty and security of person. The World Humanitarian Summit was created with the purpose of upholding these human rights for people living in disaster affected areas\(^4\).

IFMSA, as a youth-led organization representing future health workers, is concerned about people, their lives, and security. We, as members of IFMSA, have to, as one of our top priorities, ensure access to quality healthcare for all people, without discrimination to ethnicity, nationality, sexuality or religious background. Nowadays, in this global society, there are thousands of people who do not even have access to minimum health care. Within disaster settings there is a growing need for help and the humanitarian sector currently cannot keep up the task of ensuring basic needs to be covered.

IFMSA is a humanitarian association and will do what we have capacity and mandate for in order to ensure a better world for all. We have officially joined the work of the WHS, using this opportunity to provide innovative solutions and bring light to areas of priority to be addressed within the humanitarian settings. Together with governments, non-governmental organizations, academia, etcetera, we aim to build guidance and structure where the today’s resources are better used to meet the needs in disaster settings.

The WHS is our chance to ensure that the field of humanitarian action is set to meet the challenges of tomorrow. You are welcome to join us.

Be young, be a student but first and foremost be human!

References
3. https://www.worldhumanitariansummit.org/whs_Conflict

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ACTION (Asian Collaborative Training on Infectious disease, Outbreak, Natural disaster, and Refugee management) is a project within SCORP and, currently, the only transnational IFMSA project within the Asia-Pacific region. Our aim is to equip medical students with essential knowledge and skills required to prevent, relieve, and rehabilitate victims of disasters. In doing so, we strive to train a future generation of medical professionals that will become leaders in managing disaster situations in the Asia-Pacific region and thus contribute to capacity - and resilience building in the region.

During a disaster, the situation surrounding you changes completely from what your ordinary life is like. There is an overwhelming demand for aid despite an acute shortage of aid supplies. You are probably in the midst of chaotic confusion with little reliable information. Can you, as a doctor, save the lives of people in front of you in such situations? Now also think about the long process of healing and recovery within disaster-struck communities. Are the rights of all members of the community protected in their access to aid and care? What can you do as a doctor to help protect and reconstruct people’s lives?

The Asia-Pacific region needs to tackle these questions, and quickly. It is increasingly exposed and becoming vulnerable to disasters also with the problem of ongoing population growth and rapid urbanization. Disaster-induced deaths in the region increased more than three times in the past decade. Between 1994 and 2013, over 40% of the world’s natural disasters occurred in our region. You probably remember the Indian Ocean earthquake and typhoon Haiyan just to name a few. As future doctors in this region, we have an obligation to be prepared. Our countries also need to cooperate in our disaster risk reduction efforts.

ACTION is a place for medical students to gain their first experience in disaster medicine and to think about how to solve human rights issues in disaster settings. We hold an annual international summer camp in different Asian cities. In 2014, it was hosted in Fukushima, Japan where the Great East Japan Earthquake and a nuclear power plant accident occurred three years prior. The weeklong program consisted of lectures and workshops around the theme of “man-made disasters,” and delegates also had plenty of chances to discuss and work with those from around the region. During a fieldwork day, delegates had the valuable opportunity to gain first-hand accounts from evacuees, healthcare professionals and concerned citizens. This year, the ACTION summer camp will be held in Kaohsiung, Taiwan in mid-August with the theme “city disaster and evacuation.”

The value of our transnational project lies in the diverse experience, ideas, and perspectives that students bring. We can learn from each other about Asia-Pacific’s disasters and think together about how to enhance disaster risk reduction. Importantly, we also form lasting friendship during the camp. At the end of each summer, delegates return to their own countries to share the experiences and knowledge. We envision the knowledge passing on like a ripple within each of the countries. This way, we are creating future generations of doctors in the Asia-Pacific who are aware of human rights problems in disaster, have basic knowledge and skills of disaster medicine, and are empathic actors willing to and knowing how to help friends of Asia-Pacific when in need.

References:
Amigo Project

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Winston Churchill once said: “We make a living by what we get. We make a life by what we give.” Amigo is a voluntary work project undertaken by SCORP-MMSA, aiming to empower medical students from an early stage in their studies to make a difference in the life of others.

Who are we?
The Standing Committee on Human Rights and Peace (SCORP) within MMSA seeks to attain its objective of contributing towards a more tolerant and just society by voicing the needs of the oppressed, the forgotten, and anyone in the margins of society. Voluntary care services are undertaken by our members to improve the wellbeing of all persons.

Our Mission
Our mission is to replace boundaries with bridges, and this is the primary objective of our new project Amigo. It is a project designed for medical students who would like to voluntarily assist those most vulnerable in our societies. The project targets various segments of our society and reaches out to children, elderly, persons with disability, terminally ill patients, refugees and other persons in the society’s margins.

SCORP Malta believes that medical students value the wellbeing of all citizens in our society. By offering voluntary care services, the Amigo project aims to strengthen the doctor patient relationship. The project will expose and train the volunteering medical students to interact with vulnerable populations.

Why Amigo?
We are aware that there are various volunteering opportunities but we want the Amigo Project to facilitate participation and to fill in the gaps that currently hinder wider contribution. Medical students place high value to the wellbeing of every person and self-fulfillment is attained through volunteering.

Our Objectives
• Promote volunteering;
• Expose students to the various volunteering opportunities;
• Broaden participation to include all university students;
• Facilitate volunteering by finding suitable volunteer placements;
• Train participating medical students in collaboration with professional bodies and NGOs;
• Educate and motivate children and the society at large to become active volunteer participants;
• Establish long-term voluntary opportunities for students;
• Extend the project overseas by inviting international medical student associations to participate.

How are we achieving these targets?
We have identified target groups that are benefitting from students’ voluntary services. We shall establish partnerships with several NGOs, Local Councils, and Homes for the Elderly, Hospitals and Children’s Homes. Together we will co-ordinate activities to make a difference for the persons in need.

Furthermore, we hold skills development sessions for those who are interested in participating in the project. These sessions equip the volunteers with skills useful in and necessary to the delivery of care services.

The next step...
SCORP-MMSA would like to invite all NMOs to participate in the Amigo project. Together we will have the opportunity to share our experiences and successes.
Natural disasters are catastrophic events with atmospheric, geologic and hydrologic origins. They include earthquakes, volcanic eruptions, landslides, tsunamis, floods and drought. The 7.8 Richter Scale devastating earthquake that recently hit Nepal is a clear example that developing countries are disproportionately affected because of their lack of resources, infrastructure and disaster preparedness systems.

History shows that the likelihood of infectious diseases outbreak is high after a natural disaster. On October 19, 2010, ten months after the catastrophic January 2010 earthquake in Haiti that killed over 200,000 people and displaced over 1 million, the Haitian Ministry of Public Health and Population (MSPP) was notified of a sudden increase in patients presenting with watery diarrhea and dehydration which was confirmed to be a cholera outbreak, the first in the region in over at least a century. Years before that, during the Rwanda refugee crisis in 1994, an estimated 45,000 people died from a cholera epidemic. The 2005 earthquake in Pakistan led to a Hepatitis outbreak affecting almost 1,200 people. These and other incidences show that disasters and epidemics are linked.

Along with inadequate water and sanitation, poor access to health services, and sudden population displacement, crowding increases the risk of communicable disease transmission, mainly measles, meningitis and ARIs. Malaria and dengue outbreaks are common in floodings or during other situations when people sleep outside. Diarrheal diseases outbreaks occur following contamination of drinking water with Hepatitis A and E through faeco-oral route. Disease outbreaks can also result of weakened immune systems brought about by mental exhaustion in post-disaster settings.

WHO clarifies that dead bodies do not pose a risk of outbreaks following natural disasters. Rather, the risk of outbreaks is associated with the size, health status and living conditions of the population displaced by the natural disaster. When death is directly due to the natural disaster, human remains do not pose a risk for outbreaks; the source of infection is more likely to be the survivors than those killed by the natural disaster. Even when death is directly due to communicable diseases, pathogenic organisms do not survive long in the human body following death. Dead bodies pose health risks only in a few situations requiring specific precautions, such as deaths from cholera or hemorrhagic fevers.

In disasters, education on hygiene and hand washing, and provision of an adequate supply of clean water, sanitation facilities and appropriate shelter are crucial for prevention of infectious diseases. Proper hand washing can prevent many communicable diseases. Avoiding open defecation is another measure. Building temporary latrines using tarpaulins and bamboo is an effective way to ensure safety from outbreaks. Once the temporary settlement is no longer required it can be disinfected and covered with soil. Open storage systems for water that has collected as a result of rain, or used as reservoirs, should be discouraged. Such reservoirs should be treated to ensure that insects such as mosquitoes do not lay eggs in them. Ditches around the settlement areas should be covered with soil to prevent mosquito breeding. Drinking only boiled or chlorine-treated water and properly cooked food is another way to prevent water borne diseases. Drinking sealed mineral water and factory sealed food should be encouraged when boiling or cooking is not possible.

Focus has to be on re-establishing and improving the delivery of primary health care. Medical supply should
be provided, and training of healthcare workers and medical personnel on appropriate case management should be conducted. Public health responders should set up a rapid disease risk assessment within the first week of the disaster in order to identify disaster impacts and health needs. Practically, prompt and adequate prevention and control measures, and appropriate case management and surveillance systems are essential for minimizing infectious disease burdens.

References:

Health: Everyone’s Right

With the support of the Dominican Ministry of Public Health, SCORP-ODEM has developed the national project “Health: Everyone’s Right.” Through a focus on preventive medicine, the project aims to promote the Right to Health by providing free vaccinations to the Dominican population.

We have trained over 100 students from five medical schools and have administered vaccinations to more than 300 people of vulnerable and neglected communities. With successful campaign logistics and four operations so far, SCORP-ODEM looks to recruit new SCORPions by giving them the opportunity to develop their general and pediatric clinical skills, all while promoting a humanitarian perspective that recognizes inequality and protects rights in the doctor-patient relationship.

Our member and non-member volunteers were trained in history and progress of immunization in the Dominican Republic as well as fundamental concepts and vaccination techniques by the Expanded Programme on Immunization (EPI) on February of 2015.

In the future, we will extend the health initiative to include Las Caobas Medical Center in Santo Domingo from June to September 2015 before embarking to more rural areas of the country. Under the supervision of licensed nurses and medical residents, we aim to reach over 1,000 community members in 2015 by providing four main vaccinations: hepatitis B, diphtheria, pertussis and tetanus.

As SCORP-ODEM members, we consider it essential to develop community health initiatives that promote diversity; provide community members with access to high-quality health services by health professionals; educate community members about key health topics; and raise awareness among community members about their rights as patients.


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SCORP Sessions at EMR11

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A blend of knowledge, motivation and fun are words that serve as a reminder of the wonderful atmosphere and experiences shared among participants of the EMR11 SCORP sessions, held earlier this year in Egypt.

Over the course of 3 days, the sessions covered a diverse range of topics. Also organized were joint sessions and discussions with externals. Participants from almost a dozen EMR and non-EMR NMOs attended in what was as an intercultural exchange of ideas, creativity and never-ending passion for Human Rights and Peace.

Day 1 started with a brief introduction to Universal Health Coverage – the theme of EMR11 – by IFMSA’s LRP, in addition to group discussion on Migrant Health and relevant key points (i.e. groups of migrants, and worldwide statistics on migration), facilitated by Jessica Zhang. The day continued with an external session by MSF, highlighting violations against healthcare personnel and facilities in the MENA region. Participants also learnt how to advocate for access to healthcare as a human right. The final session consisted of project presentations, with participants explaining their work in SCORP.

Day 2 witnessed a SCORP - SCOPH joint session on public health concerns associated with refugees in the EMR. Participants had the opportunity to discuss these concerns in-depth, as well as means of tackling them through projects. The participants were then divided into groups to discuss case scenarios and questions revolving around the. Next, was an introductory session on IFMSA programs by the Projects RA for the EMR, explaining the reform process behind the new structure and how projects would transition into . Then, a session on SCORP’s international work with externals in the EMR was held by the LRP, and allowed for the participants to obtain more information on communication methods for better collaboration with externals in the EMR.

Day 3 started with a SCORP-SCORA joint session addressing women’s right and violations in the region (mainly Iraq). It highlighted the impact of gender-based violence, its constituents – such as FGM, rape and sexual harassment – and their violations of several articles in the Universal Declaration of Human Rights. The participants had the opportunity to draft a statement on ending violence against women in Iraq on national and international levels. This was followed by SCORP’s second external session: an open-ended consultation on youth involvement in the World Humanitarian Summit (May 2016) by a representative of the UN Office for the Coordination of Humanitarian Affairs (OCHA. Participants were able to give input on the priorities that ought to be addressed during the WHS, and how youth can become more involved and take action in addressing humanitarian causes. The final session consisted of SWGs where participants chose from about 5 different topics.

This amazing regional meeting would not have been possible without the help and enthusiasm of all facilitators, externals, or without all the passionate participants and their love for group photos. I am glad to have been able to coordinate and facilitate these SCORP sessions; they were truly ones to remember! Green hugs!
World Health Day
Celebrations in Pakistan

Give us an opportunity to have a say on Health, we would simply quote “Health is Wealth my friend.”

World Health Day is celebrated every year on April 7, to mark the founding of the World Health Organization, and stress the importance of health to be productive and happy. The day provides an occasion to draw attention each year, from all over the world, to a subject of major importance to global health. UN Volunteers have been helping achieve the Millennium Development Goals to reduce child mortality, improve maternal health and combat HIV/AIDS, malaria and other diseases. Today, 327 UN Volunteers are carrying out assignments in the health sector, as doctors, midwives, nurses, health, nutrition and reproductive health officers, health assistants, pharmacists, dentists, and UN dispensary physicians.

The wisdom of celebrating a cause globally, on a single day is to make the world collaborate on a single platform and create a feeling of unity and harmony among the masses worldwide. Discussing and advocating a unanimously decided issue together on the same day creates an atmosphere of peace. The world forgets the differences among nations and looks for solutions for common problems. This unity (and the peace associated with it) is the goal behind the working of SCORP.

In a press release on April 2, 2015 it was announced that “new data on the harm caused by foodborne illnesses underscore the global threats posed by unsafe foods, and the need for coordinated, cross-border action across the entire food supply chain. World Health Day will be celebrated on 7 April, with WHO highlighting the challenges and opportunities associated with food safety under the slogan “From farm to plate, make food safe.”

According to WHO resources, unsafe food is linked to the deaths of an estimated 2 million people annually - including many children. Food containing harmful bacteria, viruses, parasites or chemical substances is responsible for more than 200 diseases, ranging from diarrhoea to cancers.

New threats to food safety are constantly emerging. Changes in food production, distribution and consumption; changes to the environment; new and emerging pathogens; antimicrobial resistance - all pose challenges to national food safety systems. Increases in travel and trade enhance the likelihood that contamination can spread internationally.

WHO helps countries prevent, detect and respond to foodborne disease outbreaks – in line with the Codex Alimentarius, a collection of international food standards, guidelines and codes of practice covering all the main foods and processes. Together with the UN Food and Agriculture Organization (FAO), WHO alerts countries to food safety emergencies through an international information network.

The Community Medicine Department at the Combined Military Hospital Medical College, along with the team of IFMSA-CMH successfully played their part in contributing towards the day by holding an awareness seminar under the theme “From Farm to Plate, Keet the Food Safe,” with full media coverage. Lecturer Dr. Muhammad Ashraf Chaudhry (MBBS, DPH, MPH, M.Sc. FCPS) gave a lecture
Every year, new students enter university through various selection processes. Aside from university-organized reception activities, older (veteran) students often organize a special activity to facilitate integration. Such activities can range from regular, disciplined events to serious cases of violence and hazing, and are very common in Brazil. Although universities do not officially recognize “hazing,” they indirectly support it by not taking an official stance from it encouraging organizations to continue their practices. Hierarchy may be legitimized among students, who are required to comply with strict made-up rules, suffering retribution. Passive consent through the pact of silence among the students further empowers “the rule” of “veterans” who guide and influence students’ attitudes and practices generating inequality between freshmen.

The on-campus environment often transgresses everything established in the formal curriculum and regulations. We call this the Hidden Curriculum. With enough time, these actions may be “naturalized” and freshmen are forced to follow these traditions in order to “fit in,” be part of the community and not suffer the consequences of alienation and rebuff if neglected. The desire to be accepted, and also the feeling of embarking on a new stage of life, coupled with the “fun” idea of hazing, can stimulate the violent and humiliating practices.

To what extent does normalizing a practice that violates the rights of others could expose medical students – future doctors – to cases of physical and psychological violence, which they would come across in the future? What kind of doctor does society expect us to be? The answer would be a sensitive doctor who never physically or psychologically violates the right of his patients, respecting their vulnerability, as well as their color, religion, political position, gender and sexuality. These qualities contradict hazing practices, which often involve sexual abuse, rape, homophobia and racism.

Hazing is a ritual that does not prepare new students to integrate university life, but in reality promotes a false vision of the role and interaction of a social environment. Hazing will reflect in the professional future of these students – the types of relationships they establish with their patients, colleagues, and peers in society.
Humanitarian crises are some of the most extreme settings where health care must be provided. Nonetheless, it is a physician’s duty to tend to the wellbeing of the patient, especially in times of crisis. While technological advancements have allowed for life-saving medical procedures, they have also pushed the limits of warfare and contributed to climate change, thus increasing the risk of natural and man-made disasters. Over the past 10 years, the impacts of disasters have increased, with over 700,000 people losing their lives, over 1.4 million being injured and 23 million becoming homeless. Today, over 1.5 billion people live in countries affected by repeated cycles of violence. As health is a major determinant of development outcomes and is central to the wellbeing and resilience of people and communities, we need to address increasing demands and challenges to ensure proper access to health care before, during, and after disasters.

**Health Care in Humanitarian Crises**

As future physicians, we will be required to act whenever a humanitarian crisis occurs. Hospitals, as health facilities, often symbolize a safe haven where a community can seek protection and assistance, due to their neutrality and impartiality. Physicians, often seen as representatives of the entire healthcare system, are expected to be actively involved to ensure that individual patients and the community as a whole receive the highest possible level of health care. With such expectations, healthcare personnel and administration are main targets of public discontent whenever they fail to provide adequate and continuous care, especially in the immediate aftermath of a disaster.

Needless to say, discovering gaps in our healthcare systems should not occur only when a crisis occurs. Preparation is crucial to ensure that health is preserved before, during, and after disasters. During a humanitarian crisis, timely response is rightfully expected in the immediate aftermath of the emergency or the disaster that caused it.

Conscious of the responsibilities we have as current medical students and future physicians, and as affirmed by a Policy Statement adopted in 2014, the International Federation of Medical Students’ Associations (IFMSA) is committed to ensure that the future generation is well equipped with the knowledge and skills that are necessary for people and communities to have access to the highest level of care at all times.

**Preparing the next generation**

Given the current trends that are shaping today’s world, capacity building amongst today’s medical students is crucial to prepare tomorrow’s physicians for future challenges. We have partnered with global leaders in the field of disaster risk reduction and humanitarian response to regularly organize workshops around the globe and have so far hosted trainings, symposiums and panel discussions at international, national and local levels. Humanitarian crises, emergencies and disasters can affect any country at any time, which is why we aim to assist in capacity building in disaster-prone areas, countries torn by internal disturbances and war, as well as countries currently at peace.

**Violence against health care personnel: A growing concern**

An urging concern when working in humanitarian crises is violence against health care personnel. The International Committee for the Red Cross is warning that this reality is sadly becoming a common practice in conflict areas. Health workers are targeted in attacks, ambulances are being denied access at checkpoints or used as military vehicles, and pharmacies are being raided.

But access to health care is not exclusively under threat in countries with ongoing armed conflicts. Even in peaceful countries such as Sweden, ambulance personnel are facing a more violent environment, while emergency room staff is being trained in self-defense. Further East, the ongoing civil unrest ravaging Ukraine is a daily reminder that peace might only be temporary, emphasizing the importance of recognizing this issue even in countries that might seem distant from conflicts.

As future physicians, we can either adapt under these circumstances, or take a stand. Supported by the International Red Cross Committee, IFMSA has started the “Health Care in Danger - Ethical Principles in Conflicts and Other Emergencies (HCiD)” project. The project aims to raise awareness on International Humanitarian Law, the Universal Declaration of Human Rights and medical ethics. By knowing the rights and
responsible health care personnel, we can be better
prepared to advocate for access to health care in any setting.

Training for Emergency Response: The role of medical
students
Once an emergency or a disaster strikes, senior medical
students are likely to be called upon to provide supplementary
workforce to compensate for increasing needs. Despite
the lack of proper training in disaster management and
humanitarian response, students might be needed to play a
vital role in a new setting with different challenges, priorities
and technological tools. Unfortunately, this will most often put
both the medical students and the patients at risk.

“Instead of helping others, some of us became a burden
on the other rescuers and hampered the rescue efforts,”
wrote two final-year medical students from Pakistan when
recounting the 2005 Kashmir earthquake[2]. Providing health
care without sufficient training and preparation is not only
unethical, but also dangerous to the students on the ground. As
a consequence, many governments and scientific institutions
agree that disaster medicine education should be included in
standard medical curricula.

In order to better prepare students to the reality of providing
health services in disaster settings, simulation is increasingly
being used in medical education. With technological advances,
different scenarios can be created, where one
could have to manage a mass-casualty incident with limited
time, limited resources, and a wide range of teams and actors.
To make this possible, CRIMEDIM - or Research Center in
Emergency and Disaster Medicine - and IFMSA deliver
joint simulation workshops to assist in capacity building
amongst medical students. Through the use of highly accurate
simulations, students can immerse themselves in the reality of
a disaster and learn about mass-casualty management and
triage, safety and security, and as well as ethical decisions.

A Call for Future Action
In terms of sustainability, one cannot focus all efforts on
responding to humanitarian crises. From this perspective, the
parallel with health becomes obvious. Preventing a disease
produces much better health outcomes than treating its
manifestations and complications. Similarly, there is evidence
that disaster risk reduction (DRR) is the most-effective way to
reduce future costs and consequences associated to disasters.
An example for illustrating the importance of DRR can be taken
from the comparison of the 9.0-magnitude earthquake that
hit Tohoku, Japan in 2011 and the 7.0-magnitude earthquake
that hit Haiti a year earlier. In the latter, healthcare systems
almost immediately collapsed, putting a halt to years of
development efforts.

It thus becomes clear why in the last decade, DRR has become
one of the global priorities for a sustainable
future. By identifying factors of vulnerability
and strengthening preparedness, the effects of
natural or man-made hazards can have
less devastating consequences on social
development. DRR is thus currently one of the
main processes on the United Nations’ post-2015
development agendas.

The past two years have been marked by regular
consultations, ministerial conferences as well as
regional and global platforms to develop a post-2015
framework for disaster risk reduction that will be adopted at
the World Conference on Disaster Risk Reduction in Sendai,
Japan, this month. From the very beginning, IFMSA has been
heavily involved in this process to make sure that medical
students, and youth in general, are represented to contribute
to shaping the framework. IFMSA has taken a leading role in
facilitating summits, conferences, workshops and consultations
to create a platform for including the voice of youth in the
negotiations.

Recently, IFMSA has co-facilitated a youth event prior to the
“2nd Arab Conference for Disaster Risk Reduction” in Egypt,
one of the intergovernmental regional consultations for the
MENA region. Similarly, IFMSA has co-organized a youth
forum prior to the global Preparatory Committee in November
in Switzerland. Such consistent advocacy efforts have begun
to bear fruit. IFMSA was successful in advocating for the
recognition and involvement of children and youth in the Post-
2015 Framework for DRR, and its delivered statements were
included in the outcome documents of some of conferences[3].

Needless to say, IFMSA cannot solve this problem alone,
without the support of medical schools and governments
on the local, national and international levels. Therefore,
we will continue to advocate for the importance of disaster
risk reduction, strengthening of health care systems, as well
as the inclusion of disaster risk reduction and humanitarian
response in medical curricula. As future medical leaders, we
will continue to raise our voices to advocating for the right
to health care. IFMSA is in the movement and you are welcome
to join our efforts!

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Meet the Team of Officials
2014 - 2015

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