Crisis in Human resources of health

Innovative health financing under the SDG3 framework

MSI 36
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 136 National Member Organizations from 127 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,

We meet again! This marks the fourth and — sadly — the last edition of MSI, on which I have had the amazing pleasure of working as Editor in Chief.

Over the course of the past couple of months, a group of dedicated people has worked tirelessly to bring you this final product, which you now read. We have done all we could to bring you the best stories from across the world; stories that are written by medical students eager to share with you the activities through which they aim at improving our world. Surely, put like that, improving our world sounds grand, and the pragmatic ones among you would shrug it off as rather improbable, given the dire political and socioeconomic mess we are going through. Yet, a close friend of mine once told me that, even though we may not be able to change the world, we should, at the very least, strive to change our own tiny part of it, and leave it a better place for those who would come after us. This is — I bet — one of many reasons why we joined our local committees in the first place. And, so it should be!

Medical students worldwide have the duty to not only be the best doctors for their patients, but also be the best of themselves, as humans, for the sake of our world.

IFMSA prides itself to represent and bring together future healthcare professionals; it is a platform of collaboration, communication, advocacy, and education, which aims at shaping the better, culturally-competent, and skilled physicians of the future. All of this happens on the local level, through activities similar to the ones you will read about in the pages to come.

I truly cannot tell you how inspired I am having read through all the submissions we’ve received, and I can only wish you would feel the same.

Enjoy reading,
Firas.
Dear reader,

It is truly my honor to be writing these few words, to introduce you to the 36th edition of the Medical Student International (MSI). It is the official publication of IFMSA, and it is currently issued twice a year, in conjunction with IFMSA General Assemblies.

It is a great pleasure to see that this magazine is dedicated to such an important overarching theme as Human Resources for Health Financing within the SDG-3 Framework. This MSI showcases the best projects and articles written by proud medical students worldwide. In these articles, they are describing what inspires them every day, they are presenting their activities and their reflections, and they are sharing their most recent achievements.

Looking back at the time when MSI was first published as a printed copy of 16 pages in 1991, and was mailed via post services to our National Member Organizations, I can only be proud of the edition you are reading today. Surfing through its pages, we can recognize all the work the Federation is doing today, to connect, engage and unite medicals students for global health.

Finally, I would like to show my gratitude to the publications team for making this magazine happen, and to warmly thank everyone for sending us their articles. I would also highly encourage others to do the same for our next edition, as we truly are every time eager to read your stories.

Best Wishes,

Omar.
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Human Resources for Health within the SDG-3 Framework

Articles about the Theme of the August Meeting 2017
The world, with its humanity inside, suffers from a workforce shortage in the most needed parts of it due to humanity’s past wrong policies in health and health workers. Nowadays, humanity is trying to overcome this problem but is having trouble with it. The reason behind this may be due to the late discovery of that part which is actually losing blood while the other parts are not able to see the underlying cause of it. There we should stop and ask the proper question that could lead us to the expected solution: What is the main problem and what are we doing wrong?

The problem, in the most generalised form, is that the high income countries are receiving more and more professionals while the others are losing their few workers because these people are seeking for healthier, happier and more secure working places. This rightful demand of going to ‘more of everything places’ creates a positive feedback on our negative situation, builds a cycle in the low-income countries and the conditions in those countries are getting worse and worse. These areas of the world demand more workers, more medication, more money and as time passes they are facing more health problems due to lack of a good and successful health care system. In the end these countries are losing more professionals because even if they want to stay and work, they are facing severe problems such as HIV/AIDS or mental disorders and these unhappy conditions drive them to the inevitable end: They migrate to other countries and leave people who really need their help behind.

With this migration of the health care workers, our maps now show us an imbalance in the distribution of the health workforce. The pointy end of the needle is directed toward the low-income countries: The density of health care workers per 1000 population in sub-Saharan Africa is only 1, but it is more than 10 in Europe and North America where a good health service is already accessible[1]. The imbalance is not only on a regional level but also a more local level. Capital cities receive more health care workers than the rural areas even the population is much higher in rural areas than the capitals. Private sector receives more health workers than the public ones even people are mostly choosing public services due to low prices.

To prevent the imbalance of health care workers, international organisations like GAVI, UNITAID and Global Fund are working on raising funds and distributing them systematically to the low-income countries where it is most needed[2]. Systematically is the key word that we need to focus on. Because it is not only about raising funds but also about improving the mechanism of using those funds in an advantageous way. Otherwise we cannot get a long-term solution but a pool that we cannot use.

Estimates in developed countries suggest that each dollar spent in the health care sector results in US$ 0.77 contribution to economic growth[3], allowing the countries to take a step to stop the cycle which has no single beginning but a lot of consequences. However, it is not going to do any good to these countries if we cannot create a system to effectively use the already-found financial supports.

First step to create a system must be focusing on the health care workers who are at the centre of this catastrophic imbalance.

A lot of countries forget to think about the health workers or simply ignore them when they are making decisions, because they cannot see results immediately after they spend their money on them. There is one lesson that shouldn’t be forgotten: If you plant a seed, you should wait to see the amazing result.

The most important thing to make a long-term solution program...
and to increase the efficacy of the short-term solution programs is focusing on the health care workers. To focus on the health care workers, we need to understand their problems. To understand their problems, we need to listen to what they say – the thing we forget to do for most of the time.

Many of them are struggling with problems like infectious diseases and life-threatening non-infectious diseases while at the same time trying to protect their family from dangers and most sadly, watching their friends die. Unfortunately, most of them are losing the war and migrate to somewhere else not just because they want a better salary but also because they don’t want to die[4].

There are basal needs of healthcare workers, such as a secure workplace, a good mental status, a better salary and more incentives. Providing them and directing the financial support to that areas will create a positive work environment for the professionals and the other health care workers and make them feel comfortable while they are working. A comfortable health care worker in the workplace is a key factor for balancing the workforce distribution throughout the world. Therefore, both governmental and non-governmental organisations must analyse the negative factors for the health care worker in the workplace and create a scheme to minimize them.

Another very important factor that financial supporters do not care much about, that we should definitely focus on, is the training of these healthcare workers both with regards to their job to have more professional medical care in low-income countries and their motivation while they are working to maximize the effectiveness of the care.

Training of the health care worker is the main factor that stands against the loss of budget: There is a cost of US$ 500 billion caused by the lack of responsible use of medicines, which can be avoided by an adequate training of the health care workers in those areas[5]. A long-term benefit of the reduction of the unnecessary costs will result in more budget to be used to create an attractive workplace for the professionals and to maintain the workforce in these areas.

Organisations must act together to motivate health workers to work in low-income countries and to stay there voluntarily. In 2011, the United Kingdom’s Department for International Development (DFID) put great amount of money for health partnership projects, most of them with the countries of sub-Saharan Africa, Asia and Middle East. With these funded projects, they managed to reach more than 32,000 health care workers in low or middle income countries and more than 1.300 health workers volunteered to go to other countries to support their colleagues[6].

In a lot of countries, stakeholders like ministry of health, NGOs or private-sector organisations begin to work together to create a budget for a large web of human resources of health to reach health care workers, encourage them and to maintain a stable number of health care workers in the country[7]. By using this web, they are planning to increase the communication between healthcare workers and the organisations to react immediately to problems and as a consequence, to build a trust that can help people to be emotionally engaged to work.

At this point health care workers and their needs are the key elements of the problem. Probably need is not the right word to use, but right is. Because it is not about things they need, but it is about the things they normally should have.

We should cure them first.

Because we cannot expect health care workers to cure other people when they need to be cured first.

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Healthcare funding pledges and hospital budget cuts have undoubtedly become the commonest healthcare topics in recent years. Politicians urge for economic assistance for health, yet with the expanding ageing population and the disgruntlement of overworked doctors, it begs the question whether Sustainable Development Goal 3 under the United Nation’s “Transforming Our World: The 2030 Agenda for Sustainable Development” - ensure healthy lives and promote well-being at all ages - remains viable.

Hsiao W and Liu, Y[1] define health care financing as the mobilisation, allocation, and the method of acquiring funds. However, how much fund is sufficient? Certainly, it varies among countries: some may spend less on healthcare as a proportion of their GDP, whilst still maintaining a supply of “affordable and accessible health services;”[2] contrastingly, some despite using more funds may just be achieving similar results. The latter phenomenon is already happening in some developed countries, most notably in the US, where the cost of medical care has increased by 250% since the 1980s[3]. This Baumol effect[4] is alarming as it will only lead to further rationing and privatisation, with more diseases and suffering waiting to be solved. In view of the above, Savedoff recommends that countries should take the “budgeting approach,” which involves pinpointing what should be spent on before expending. He puts forth five basic questions to aid this process, which involves the identification of current health problems, health status, cost effectiveness of health policies and services, prices, and potential tradeoffs.[5]

Whilst it may not be possible to list out the answers to the said questions pertaining to every country, there remains similarities that this article seeks to highlight, in particular the problem concerning primary care. Its importance could be seen from Dr Margaret Chan’s speech in 2007 at the International Conference on Health for Development, where she noted that “primary health care is the best route to universal access, and the best way to ensure sustainable improvements in health outcomes.”[6] Its significance is also in its influence on health promotion and disease prevention, all the more important given disease burdens are shifting to non-communicable diseases.

Primary care physicians, in some countries like the US are declining owing to the “income gap between primary care and other specialties”[7]; in other countries such as Hong Kong, are either not frequented as a result of private-public imbalance and the need for out-of-pocket payments[8], or not fulfilling its aim of providing continuity of care due to a great deal of doctor shopping. Even if primary care were a stable part of a healthcare system, in the case of the United Kingdom, it still faces challenges, for instance, a deteriorating quality in their provision and an insufficient emphasis on primary and secondary prevention.[9]

It becomes obvious, then, that this problem has little to do with finance, but instead, more with the health care workforce. Widely noted in literature, the medical workforce is undergoing feminisation, with a surge of females entering the medical profession. This is especially prominent in the primary care setting,
where the number of female doctors doubled over the last 30 years.\textsuperscript{10} Thus it is imperative to prepare for this change of workforce demographics.

There is the concern that female physicians work less hours and see less patients when compared to male counterparts, thus implying a possible decrease in health care provision in the near future. There are several proposed explanations for these observations, including stereotypical female role in family and the need for adequate work-life balance, as well as devoting more time for individual patients\textsuperscript{11}. As Russo, Giuliano correctly points out, the said preparation should not be to increase male physicians through increasing their quotas in medical schools, as history has illustrated the deleterious consequences regarding to education accessibility\textsuperscript{12}, with the knock-on effect of worsened gender inequality. Instead, one should follow the trend and plan accordingly. For instance, taking into consideration family gender roles and child-rearing task, countries could consider family-friendly approaches that would allow for more flexibility.

There are still uncertainties with regards to the consequences that the “medical feminisation” phenomenon would bring, which necessitates further research. Yet one thing remains certain: policy makers should adapt to the prevailing trends in order to maximise the contribution the workforce brings to the healthcare sector, and not aim to forcefully alter existing behaviour or ignore the needs of the workforce to prevent further unsustainability.

\textbf{References:}


Crisis in Human Resources for Health: A Story from Pakistan

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

The WHO framework on health system performance assessment is based on the concept of health action, and encapsulates any set of activities whose primary intent is to maintain or improve population health, enhance the system’s responsiveness to the expectations of the population, and assure fairness of financial contributions to the system. To achieve these main goals, four functions are performed by health systems: financing, stewardship, service provision and resource generation. These functions will lead to a better and more efficient health system performance; although the core of all these functions is mostly human resources.

Human resources for health can be broadly defined as “the stock of all individuals engaged in the promotion, protection or improvement of population health.”[1] Today non communicable diseases are the leading causes of death globally killing more people each year than all other causes combined. Interventions from healthcare systems should be undertaken in order to save millions of people. A comprehensive health-system response should be the long term goal for all countries. Strengthening the capacity of primary health care and improvements in health-system performance can be achieved through strengthening human resources for health.

The main enigma of today is that we are lacking these resources in order to reorient existing organisational and financial arrangements for health-care system through conventional and innovative means.

The World Health Assembly recently adopted a joint ILO OECD WHO five-year action plan aimed at working with countries and key stakeholders to make progress towards expanding and transforming the health and social workforce to accelerate progress towards universal health coverage, emergency preparedness and response for global health security and inclusive growth, particularly for women and youth. So there should be a need to understand the causes of lack in human resources.

The global community is in the midst of a growing response to health crises in developing countries, which is focused on mobilising financial resources and increasing access to essential medicines. However, the response has yet to tackle the most important aspect of health-care systems—the people that make them work. Human resources for health—the personnel that deliver public-health, clinical, and environmental services—are in disarray and decline in much of the developing world, particularly in sub-Saharan Africa. The reasons behind this disorder are complex. For decades, efforts have focused on building training institutions. What is becoming increasingly clear, however, is that issues of supply, demand, and mobility (transnational, regional, and local) are central to the human-resource problem. Without substantial improvements in workforces, newly mobilised funds and commodities will not deliver on their promise. The global community needs to engage in four core strategies: raise the profile of the issue of human resources; improve the conceptual base and sta-
tical evidence available to decision makers; collect, share, and learn from country experiences; and begin to formulate and enact policies at the country level that affect all aspects of the crisis.

Central issues for health policy and health systems reform over the decade include the proper roles of governments and the private sector and the necessary actions by governments to improve the accessibility and quality of health-care systems. Inequitable occupational distributions by geographical location and by gender constitute, external migration of health workers due to poor facilities and financial support and imbalance in health policies lead to an incompatible health system.

Lower-income countries have health systems that are more private — in finance and provision — than higher-income countries. In Asia, and especially in India, health care is mainly purchased ‘out of pocket’ from private doctors and clinics. In lower-income countries; betterment of healthcare providers should be more achievable through better finance and provision. Equitable occupational distributions by geographical location and by gender can also improve health system. The absence of appropriate human resources policies is responsible, in many countries, for a chronic imbalance with multifaceted effects on the health workforce: quantitative mismatch, qualitative disparity, unequal distribution and a lack of coordination between HRM actions and health policy needs.

More than any other type of organization, health organizations are highly dependent on their workforce. The growth and development of any organization depend on the availability of an appropriate workforce, on its competences and level of effort in trying to perform the tasks assigned to it. Increasing the productivity of health workers through better financial support and facilities should be made possible. Assessing the education and training levels of the health workforce is a key element for policy-makers.

What we need today in order to improve the health-care system is a better health policy which will help our higher authorities to utilise our workforce in an efficient and competitive manner.

Sustainable development goal SDG3 ensures healthy lives and promote well-being for all at all ages. Under the SDG3 framework; innovative finance mechanisms enable us to achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Taskforce Working Group agreed on a broad definition of innovative financing, including not only mechanisms designed to raise funds in addition to conventional Official Development Assistance (ODA), but also mechanisms that improve the use of those funds. As defined by the Taskforce, innovative financing mechanisms are: “non-traditional applications of ODA, joint public-private mechanisms, and flows that either support fundraising by tapping new resources or deliver financial solutions to development problems on the ground.”[2]

As early as 2000, development partners embarked on a decade-long search for “innovative” or alternative sources of Official Development Assistance (ODA) to help finance achievement of the Millennium Development Goals (MDGs). In response, sovereign and private donors championed an array of initiatives: global solidarity levies proposed by France, frontloading future aid commitments by the United Kingdom, and results-based financing by various actors, including private foundations. Development banks also started issuing new types of bonds that link resource mobilization and development objectives, for example, debt offerings for sustainable investments with climate change-related themes. For their part, developing countries sought not only more financial flows but better financial solutions, for example, partnerships that mobilize private finance for public service delivery, risk mitigation efforts that promote private entry in the productive sectors, and support for carbon trading.

Moreover, The High-Level Taskforce on Innovative International Financing for Health Systems was launched in September 2008 to help strengthen health systems in the 49 poorest countries in the world. Chaired by UK Prime Minister Gordon Brown and World Bank President Robert Zoellick, the Taskforce released its Recommendations in May 2009, identifying a menu of innovative financing mechanisms to complement traditional aid and bridge the financing gaps which compromise attainment of the health-related Millennium Devel-
Development Goals (MDGs). The Taskforce completed its work in September 2009 and at the UN General Assembly in New York City, launched new initiatives to raise more money, and use money more effectively, to improve healthcare for women and children around the world. Development assistance for health has increased every year between 2000 and 2010, particularly for HIV/AIDS, tuberculosis, and malaria, to reach US$26 billion in 2010.\(^3\)

The continued global economic crisis means that increased external financing from traditional donors is unlikely in the near term. Hence, new funding has to be sought from innovative financing sources to sustain the gains made in global health, to achieve the health Millennium Development Goals, and to address the emerging burden from non-communicable diseases. We use the value chain approach to conceptualise innovative financing. With this framework, we identify three integrated innovative financing mechanisms—GAVI, Global Fund, and UNITAID—that have reached a global scale. These three financing mechanisms have innovated along each step of the innovative finance value chain—namely resource mobilisation, pooling, channelling, resource allocation, and implementation—and integrated these steps to channel large amounts of funding rapidly to low-income and middle-income countries to address HIV/AIDS, malaria, tuberculosis, and vaccine-preventable diseases.

So in a nutshell, there is a need to organize and understand this heterogeneous mix of innovations in fund-raising and financial solutions for development; seeks to provide, for the first time, a stocktaking of actual innovations that make up the international landscape; and highlights the World Bank Group’s role to date.\(^4\)

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The Case for Human Resources for Health in Realizing the Sustainable Development Goals

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In the past years and decades, many efforts have been taken to increase access to healthcare on a global scale, yet even today, one in seven people will never see a single health worker in their entire lives. In fact, the crisis in human resources for health (HRH) has recently surpassed health system financing as the most serious obstacle to realizing the right to health within countries, calling for urgent upscaling and a drastic change in global priorities.

The World Health Organization (WHO) estimates that, globally, over 4 million additional health workers are needed to overcome the health workforce shortages in the 57 countries with the most critical needs.\(^1\) However, the actual number is expected to be much higher (when including global disparities and countries with less critical shortages), with the deficits expected to rise to...
12.9 million health workers by 2035. In addition to the absolute shortages of healthcare providers, there is a severe imbalance in the distribution thereof between and within countries. Most healthcare workers, especially specialists, concentrate in urban areas, creating increasing challenges for rural populations to access healthcare services. As a result, one billion people worldwide will never see a healthcare worker in their entire lives, with the far majority residing in lower- and middle-income countries (LMICs), which are faced by (1) lower rates of training health workers, (2) fewer overall resources for health, and (3) brain-drain of trained health workers to high-income countries (HICs).

Today, modern globalization and resulting liberalization of markets lead to a complex workforce migration pattern from LMICs to HICs. Moreover, the demand for healthcare is rising as a result of the large ageing population in more developed countries and the increase in the world’s population. Simultaneously, low-income countries continue to struggle with an unfinished agenda of infectious and non-communicable diseases. As a result, the HRH crisis is sustained and expected to worsen in upcoming years unless urgent measures are taken. To work towards the attainment of the Sustainable Development Goals (SDGs), health workforce and systems strengthening is needed on a global level.

Scaling up human resources for health is key in addressing the third Sustainable Development Goal (SDG3: Ensure healthy lives and promote wellbeing for all at all ages by 2030), especially with a focus on reducing global maternal mortality rates, neonatal and child mortality rates, reducing the number of deaths and injuries from road traffic accidents. The WHO estimates that at least 23 health workers per 10,000 population are needed to achieve the SDGs, yet 83 countries still fall under this threshold. Of these, the African region has the highest burden in terms of workforce density, whereas the absolute shortages are highest in Southeast Asia, as a result of the larger population.

Despite reduced maternal mortality rates in the past few years (with a 44% drop from 1990 to 2015), 830 women worldwide continue to die every day, of which 99% occurs in the developing world and rural areas. In LMICs, mortality rates are as high as 239 per 100,000 live births, whereas HICs face only 12 deaths per 100,000. As such, the SDGs aim to further reduce mortality rates to less than 70 per 100,000 live births, through adequate antenatal care, availability of skilled health workers during childbirth (including obstetricians or trained healthcare workers if a caesarean section is needed), and proper follow-up after birth.

In the developing world, only little over half of all mothers and children have access to skilled healthcare professionals during and shortly after childbirth, not only putting a mother’s health at risk, but also that of the newborn. Neonatal (less than 28 days old) deaths account for 45% (2.7 million) of under-5 mortality, with 75% taking place in the first week after birth, and almost half within 24 hours. Of these, up to two-thirds could be prevented if access to skilled health workers was available, in order to prevent and limit complications (e.g., infections, asphyxia) and perform adequate health measures in the beginning of the newborn’s life (e.g., promote breastfeeding, keeping the baby warm).

When looking at all children under 5, approximately 5.9 million children continue to die on an annual basis worldwide, of which roughly half could be prevented through preventive or curative measures. These rates are much higher in LMICs compared to HICs, with, for example, sub-Saharan Africa suffering from 14x higher child mortality rates compared to industrialized countries. Access to health workers is crucial in reducing child mortality, through proper education, prevention (e.g., vaccines), timely treatment and surgical care.

Lastly, every year, 1.25 million people die on the roads and another 20 to 50 million people remain injured or disabled as a result. Shockingly, 90% of road traffic mortality occurs in LMICs, especially the African region, despite having “only” 54% of the world’s vehicles. Road traffic injuries pose a major economic burden, not only for individuals and their families, but also for entire nations, costing them up to 3% of their gross domestic product (GDP). Although prevention and increased road safety should be the main focus in addressing these mortality and injury rates, timely access to health and surgical care is needed to adequately treat victims of road traffic crashes and limit morbidity and mortality thereof.

If we are to achieve the health-focused Sustainable Development Goals by 2030, emphasis should be put on human resources for health, which are a key component in improving access to healthcare and the delivery of healthcare services. With a rapidly increasing world population -especially in those countries needing improved access to healthcare the most- urgent upscaling is needed on a global level in order to prevent the human resources for health crisis to turn into an expanding global nightmare.

References: please click here.
Stymied Health Systems: Is there a crisis in health human resources, or are resources themselves being managed poorly?

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A person can be precarious in a variety of ways: economic, social and even health. What we don’t realize, is that governments and health systems can be precarious as well. Nowadays, not only health systems, but any kind of system cannot function if it does not have the proper amount of funding. Do you think health professionals know how expensive an aspirin, a basic anti-inflammatory, is? In Ecuador it is around 8 cents of a US dollar. It may not sound much, but when one thinks collectively, in a public hospital around twenty thousand patients are seen and if we consider giving one of these pills to each, this cost turns into 1160 US$. Despite the fact that, not only are we considering the least expensive medicine, and that we would be giving only one pill per patient; we must realize that health is one of the most expensive aspects for a government to manage. Otherwise, leaders would not be focusing on primary health care and screening tests for their population, if it would not only be benefiting the people, but the system as well. Now, some governments do spend this amount of money on medication, but do they spend the same amount on everything that implies having trained physicians to prescribe them? It is fundamental that governments and high powers create funding opportunities and financing countries’ health systems and their human resources expenses, to achieve objectives such as the Sustainability Development Goal (SGD) 3 and create basic human welfare; by comprehending the importance of goals such as the SDG3, understanding the underlying problems or necessities of the specific country, giving education opportunities and promoting the creation of policies that support this goals.

The SDG 3 is to ensure healthy lives and promote well-being for the whole population at all ages and stages of life. This should not only be set as a part of the Sustainable Development Goals, but as a priority in medical education and medical application as physicians (UN, 2017). In countries, such as Ecuador, public health should be the first strategy to every health approach to the population given that 80% of our health problems could be solved in a first level medical facilities (Ministerio de Salud Pública del Ecuador, 2012). Not only prevention and promotion are better and cost-efficient ways to fight against diseases before they appear, they also create consciousness on general population of the importance of healthy life styles and the necessity of funding public health programs. Despite looking for financing opportunities may sound as if it is needed to convince governments to spend more money, it is tantamount to give them opportunities to save money. For example, a program called “With right foot: the future’s footprint”, meant an astounding amount of money as investment from the government, where newborns are tested for metabolic diseases such as suprarenal hyperplasia, hypothyroidism, galactosemia and phenylketonuria. Although it represented a high cost for the Ecuadorian government, in comparison it has saved a higher amount of money and time for the health system. These opportunities are exactly what people related to governments should look financing for, and maybe it is so, the problem eradicates in the fact that medical professionals rarely aspire nowadays degrees regarding these topics. As physicians and health related professionals, we should have a penchant for public health, and if we understood strategies such as the SDG 3 and their importance worldwide, then we would realize that human resources are extremely important to achieve them and how we could be a part of that.

Health financing refers to the way financial resources are “generated, allocated and used in health system” (WHO a, 2017). The main goal should be to create a universal coverage, by overcoming financial barriers to eliminate inadequate access to health, providing equitable services and raising the funds necessary to achieve this goal. These problems can be found worldwide, but
some countries have more emphasis in specific ones or with different modifiers that can create an astounding difference of how the problems should be managed; therefore, creating a gap that needs to be filled. Although some governments do spend high amounts of money in health systems, sometimes a harbinger that understands where to invest is needed, therefore creating annual studies could debunk current unnecessary expenses that could be redirected into other health system aspects that could be more cost efficient. These may sound as expense as well, but really, we need to eliminate the parochial manner of managing resources that has led us to this crisis in resources for health. Once we actually get to know the problem, then we can direct our efforts into promoting specific professionals that are required to achieve our goals and thwart unnecessary crisis and health system functioning problems.

Education can change everything, but the problem is that some people have limitations and do not have access to it. As a government, financing should definitely be directed to create education opportunities to create knowledgeable health professionals in different areas (family medicine, reproductive, maternal and child health, among others). Additionally, the process should be pragmatic and plausible for the population, by eliminating the barriers that limit them: financial status, absence of trained professionals in the country, disparate system to the necessities, etc. Funding for this purpose should not be restrained to the country’s government, because there are organizations worldwide or even people with a lot of resources whose purpose is to give education opportunities. We should not limit fundraising to taxes or the population expenses, but rather look worldwide for other roads that lead to our destination: Training and teaching people skills that can improve our health systems, by educating other professionals in the country and saving unnecessary expenses in the future.

Health is a fundamental element that must be considered when creating policies and governmental decisions. Laws can be directed in accomplishing different aspects at the same time, while fulfilling their primary purpose (e.g. Laws that are directed to alleviate the health system problems) or fulfill another while benefiting main social areas as health (e.g. Laws that are emollient in an economical aspect of the poorest families, giving them more access to the country’s health system). Not only are we capable of influencing the creation of laws that target specific objectives like reducing maternal mortality, end preventable deaths of newborns, end the epidemics, reduce premature mortality, strengthen prevention and treatment of substance abuse, reduce deaths from road accidents and chemicals, support research of vaccines and medicines, among other things; but also increase health financing for the “recruitment, development, training and retention of the health workforce” (WHO b, 2017). The problem is that the current creation of policies is directed to only one objective, not taking into account aspects that could be helped while achieving various objectives. A feral, in a positive way, is necessary; so that a reformation of the current policies can be made. Policies that are salutary are needed, and not only considered in a superficial way.

A reconsideration of how we are administering our resources must be made. Understanding SDGs, necessities of the country, providing education and getting involved in the creation of policies are some of the main topics to be considered as fundamental in the redistribution of funding in order to improve health systems and problems such as the human resources crisis. On July 2017, representatives worldwide will gather and discuss topics surrounding the Sustainable Development Goals with the theme “Eradicating poverty and promoting prosperity in a changing world; an opportunity for the world to create unfettered health systems based on new strategies by eliminating the current parochial idea. We must understand that, although SDG3 is important, all SDG indicators must be considered as a whole, and in order for them to work, financing should be directed not only to health but also other issues such as gender, sustainability, etc.

References:
There have been many improvements in traffic safety over the years. It can be noted by the latest implemented laws, such as the law that prohibits the driver from being drunk while driving, and the law that makes compulsory the use of car seats for babies and children under seven years of age. Laws like these, drastically reduced the number of road deaths. However, for the goal number six of Global Goals number three of the United Nation (UN) - Reduce by half, until 2020, deaths and global injuries on road accidents - be achieved, there is still much to be done. According to UN database, about 1.25 million people die per year due to traffic accidents, of which 90% occur in middle and low income countries. These accidents are also the main cause of the death of young people, with ages between 15 and 29 years. A fact that validates the idea that countries with better traffic safety, generate better living conditions for its population, which can produce more, having fewer health expenses. This stems from not being overly exposed to physical damage on the roads, which can cause deaths or can leave some after-effects, which makes it impossible for citizens to work, leaving them dependent. According to the World Health Organization (WHO), about 50 million people survive with some after-effects of traffic accidents, at a cost of 519 billion dollars per year. (Data from 2009). With this in mind, several private companies from around the world have created an innovative alliance to improve road safety and reduce the number of deaths and injuries from traffic accidents through the Together for Safe Roads (TSR) project. The purpose of this group is to apply the knowledge, data, technologies, and networks to promote the expansion of the safety of highways, vehicles, systems and users around the world, and work in partnership with global, regional, national and local entities with these common goals. They believe that while governments have primary responsibility for traffic safety, the private sector has an important supporting role to play and that several companies would benefit in a number of ways by increasing traffic safety. In order to achieve all these goals, the TSR says that countries must increase funding for traffic safety, especially in low- and middle-income countries. However, they point out that such traffic safety funding is not only focused on road improvements, as it involves the development of traffic safety management, improving road network design and networks, requiring safety features in vehicles, approving and applying Traffic behavior laws, improve data management, educate road users, and improve post-accident assistance. Whereas in developing countries they are hampered by the lack of resources and infrastructures for prehospital and hospital care. The project also highlights several analyzes that suggest three more traffic problems that need intervention: speeding, alcohol use, and the non-use of seat belts and helmets. Therefore, for these interventions to be successful, the provision of technical and managerial staff is needed to effectively plan, manage and evaluate these activities. The TSR states that for such programs to become effective continuous funding is required. To do so, they suggest that governments could increase tax collection through road, use fees from driver training and licensing, traffic ticket revenues, road fares, fuel prices, and so on. Another mind that they comment on in the project is through insurers, where a small percentage of the amount of their profit was directed to social investment funds that...
aim at traffic safety initiatives. With the combination of all these funding sources, perhaps, it will be possible to eliminate much of the resource gap for traffic safety in each country.

In the TSR funding project for traffic safety view’s, the plan for an innovative source of finance related to a small contribution from airline passengers was obtained. The aim would be to charge a rate for the purchase of air tickets, both domestic flights and international flights, to ensure road safety at its final destination. The total amount purchased by each country would be redirected to regions aiming at a larger amount for cities with a high traffic mortality. This money would be invested in traffic management, improved road planning, increased enforcement, traffic education, and improvements in automotive collision assistance. However, the ten countries with the lowest rate of road deaths would have to pass on a percentage to countries with this extremely high rate.

This model of innovative financing would be of great global assistance since the air fleets, according to the Air Transport Yearbook, released by the National Civil Aviation Agency (ANAC), circulated more than 117 million passengers in 2015 by Brazilian and foreign companies. Of the total passengers paid, 96.2 million were on domestic flights and 21.6 million on international flights. Such financing can become the largest aid tool to achieve the purpose of UN. The goal is to reduce in half the deaths and injuries caused by road accidents, by 2020.

References:
Achieving the Universal Health Coverage Milestone in Tanzania

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“The truth is that success towards achieving this next wave of targets will depend largely on how countries succeed in moving towards universal coverage, and the availability of funds for health is a fundamental question to all countries in order to achieve UHC.”

— Dr. Flavia Bustreo, Former WHO Assistant Director-General

The health related targets of the SDG3 can not be met without making substantial progress on Universal health coverage. It means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health service they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

The health systems should be strengthened and I will tell you exactly how to do that. Strengthening requires a coordinated approach involving improved health governance and financing to support the health workforce, and provide access to medicines and other health technologies, in order to ensure delivery of quality services at the community and individual level. You may notice not only is financing important, proper health governance is equally important.

Without good health, there can be no sustainable development. And without adequate financing, the poorest and most marginalized people around the world will continue not getting good health. Currently, 100 million people annually are pushed into poverty because of direct out of pocket health payments. Although public health spending has been increasing (from 3.4 to 4.1 percent of GDP across 190 countries between 1995 and 2013), there is a long way to go. To be able to succeed in this agenda, innovative means should be employed from other sectors other than the health sector. In fact, health can benefit enormously from investments in other sectors. Studies have shown that as much as 50 percent of the reduction in under-five child mortality across 142 countries is due to factors outside the health sector, such as education, access to clean water and sanitation, and women participation in politics.

From the agreement expressed in the Addis Action Agenda of 2015, the number one answer to the question, how should the health (and sustainable development) goals be financed is: first and foremost by raising additional domestic funds for health. Low-income countries have been already increasing their government health expenditures, from 1.7 to 2.6 percent of GDP between 1995 and 2013 (more than higher-income countries). But they are far from their own self-imposed goals: if African Union countries increased government expenditure on health to 15 percent as promised in the Abuja Declaration in 2001, they could together raise an extra US $29 billion per year for health.

Health care in Tanzania is available depending on one’s income (out-of-pocket) and accessibility. People in the in Urban have better access to private and public medical facilities. This has to
change!

While the government has made significant progress on priority health indicators, the limited “effectiveness” of health financing constrains its ability to achieve more. The total health expenditure of the Tanzanian government as a percentage of the GDP was estimated to be 7.3 percent by 2013, higher than the average of 5.3 percent in other low-income countries. However, Tanzania’s health coverage still remains low as compared to many other low and middle-income countries. With a total of US $49 per capita spent by the government on health, the health coverage (health insurance coverage of Tanzania is around 15-16 percent of the population according to the Health policy project 2013) should be higher or somewhat similar to that of a country like Rwanda, which offers a set of basic services to majority of its citizens through a system of health insurances at a cost of just US $37 per capita.

The above just implies that; increased funds alone will not on its own lead to achievement of universal health coverage and achievement of SDG3 without strong emphasis on cost-effectiveness. Efficient health systems and proper government spending with the right policies should be the main priorities by everyone in the public health field including medical students. Conservatively speaking, currently about 20-40 percent of resources spent on health worldwide are wasted, resources that could be redirected towards achieving universal coverage. It important that the right health policies are put in place by the governments so that efficiency is increased.

A more recent estimate of the cost of providing key health services, which was produced by WHO, suggests that the 49 low-income countries surveyed would need to spend just less than US$ 44 per capita on average (unweighted) in 2009, rising to a little more than US$ 60 per capita by 2015. The implication of this is that Tanzania is spending an amount (US$ 49) close to that required to provide the basic health services for all its citizens but yet majority do not receive the basics. This shows just how cost-effectiveness is much more important in this sustainable development goals agenda than thought initially. It must be appreciated however, that the current government is putting in efforts to improve health and well being of the people. Together with introduction of the subsidized community health fund, the ministry of Health, Community development, Gender, Elderly and Children plans to request an earmark of 30 percent of VAT and tax from alcohol and tobacco sales to be set aside for single national health insurer as part of increasing funding for health amongst other efforts.

While governments, development partners, and other stakeholders will rightly strive to increase the share of the financial envelope dedicated to health, we must focus on what should be done to provide more value from the existing funding. A good example for Tanzania to live up to is how Thailand was able to redraw the line in the health-care coverage. It offers prescription medicines, ambulatory care, hospitalization, disease prevention and health promotion free of charge to patients, along with more expensive medical services such as radiotherapy and chemotherapy for cancer treatment, surgical operations and critical care for accidents and emergencies. It manages to do all this for just US $136 per capita - less than the average health expenditure for low-middle-income countries, which stands at US$ 153.

As rightly outlined earlier in this text, many people are pulled into poverty by direct out of pocket health expenses, Tanzania stands at a point where 33 percent of its total health expenditure is contributed by the out of pocket payments! To be able to enhance the sustainable development agenda, again, health coverage should be utterly increased by ensuring that funding on health increases and more importantly be well allocated so that health care is easily accessible and affordable by all the citizens.

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The UN Declaration on the SDGs emphasizes that to achieve the overall health goal, ‘we must achieve universal health coverage (UHC) and access to quality health care. No one must be left behind’. This places UHC as the target that underpins and is key to the achievement of all the other health targets. The use of UHC to frame discussions on SDG3 helps make the health agenda more cohesive.

A central component of universal health coverage (UHC) is financial affordability and transparency in billing of preventative and curative health services, including the health workforce. The health workforce is a critical and integral element of health system strengthening and of universal health coverage, encompassing the multiple dimensions of availability, distribution, quality and performance. However, economic efficiency in the production and utilization of health workers to deliver health services is a shared challenge. It involves the identification of additional resources (more money for HRH) and maximizing the efficiency and effectiveness of current capital and recurrent expenditures (more HRH for the money). Addressing these challenges in the context of complex adaptive systems requires concerted action on several element of health sector and public policy at large, including effective intersectoral coordination and collaboration among HRH stakeholders. This is necessary to ensure that health workforce operate within an enabling environment and receive the required support by the health system. In order to adequately address the new needs stemming from the UHC objective, fundamental changes will have to be adopted by countries and by the global health community in relation to how health workers are trained, managed, supported, and to the understanding and role of the public sector in shaping health labour market forces.

Every member state should have the ability to protect the health of their populations and fulfill their obligations towards collective global health security envisaged in the international health regulations. No comprehensive plan can address all these diverse risks and drivers. It is also important to be realistic about the limited political influence of ministries of health. A more strategic approach needs to avoid over-reach and to look for areas where constituencies for change can be mobilized. Coordinating bodies such as planning commissions can be important allies if health is effectively represented and members are well briefed with convincing evidence.

The WHO Global Strategy on Human Resources for Health: Workforce 2030 reflects on the contemporary evidence on what works in health workforce development across different aspects, ranging from assessment, planning and education, across management, retention, incentives and productivity, and refers to the tools and guidelines that can support policy development, implementation and evaluation in these various areas. Given the inter-sectoral nature and potential impacts of health workforce development, the Global Strategy is meant to inform and inspire the development of national health and HRH strategies, but also the broader socio-economic development frameworks that countries adopt. The Global Strategy on Human Resources for Health has made policy options for WHO Member States, responsibilities of the WHO Secretariat and recommendations for other stakeholders on how to:

- Optimize the current workforce to accelerate progress towards Universal Health Coverage and the Sustainable Development Goals;
- Understand and prepare for future needs of health systems, harnessing the growth in health labour markets to maximize job creation and economic growth;
• Build the institutional capacity to implement this agenda; and
• Strengthen HRH data for monitoring and accountability of the successful implementation of both national strategies and the Global Strategy itself.

The health workforce is not an end in itself, but the indispensable means to achieve improved health outcomes. Recognizing the importance of measurable targets and accountability mechanisms around them in stimulating action, the Global Health Workforce Alliance supports the inclusion of an HRH-specific benchmark in the Universal Health Coverage framework and the post-2015 development agenda. This would contribute to foster collaboration between countries and global partners, and to focus policy actions and investment decisions where they are most required.

In addition to people, planet, peace and prosperity, the SDGs are also about partnership. Any national consultation would benefit from including a fresh look at the way partnerships with civil society, NGOs and the private sector can help in the achievement of the SDGs. The private sector is large, diverse and growing, included in economic sector. The focus in many countries has been almost exclusively on regulation – often with little effect. Exploring new avenues of collaboration in which private assets, resources and facilities can be harnessed in ways that benefit public health can pay dividends. Some NGOs have a good track record with reaching stigmatized groups and under-served populations. Civil society can be extraordinarily effective in influencing policy decisions in other sectors (for example in relation to trade agreements, food marketing or access to medicines). But nowadays, too many governments have little information about these potential partners. The private and NGO sectors are still often excluded from public health policy debate.

There are major opportunities to ensure a more effective and efficient use of resources by adopting a health care delivery model and a diverse and sustainable skills mix geared to a primary health care approach, and supported by effective links to the social services workforce and referral to secondary care. Similarly, major gains are possible in performance and productivity by improving management systems and working conditions for HRH, and by harnessing the full potential of collaboration with the private sector, incentivizing and aligning its operations to public sector health goals. Realizing these efficiency gains requires the institutional capacity for the implementation, assessment and improvement of HRH planning, education and management policies.

The coordination among these sectors can be enabled by establishing national mechanisms for coordinated HRH governance and policy dialogue among different sectors and constituencies. These should accommodate in the political decision making process the legitimate involvement and interests of a range of stakeholders, including civil society, citizens, health workers, health professionals and their unions or associations, regulatory bodies, employers’ associations, insurance funds, so as to broaden political ownership and institutional sustainability of HRH policies and strategies, while not losing sight of public policy objectives.

Eventually, when designing policies to achieve future development goals, impact across multiple sectors should be taken into account to increase synergistic effects and reduce detrimental results. In particular, health should be considered when designing policies in all of the allied sectors, and health outcomes included in the monitoring and evaluation of such policies. Some of these interlinkages should be developed and would be worth to be discussed.

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Rex Crossley Awards

Articles about the Theme of the August Meeting 2017
In Hong Kong, mental health is not of high medical priority, yet there is a growing prevalence of mental health illnesses in the city. In the first 7 months of the 15/16 academic year, there were 24 student suicides, including a third year medical student a month before professional exams. However, efforts to combat mental illnesses are further challenged by stigma and taboo of the subject - sometimes hindered by themselves; it is hard for people to reach help.

In light of these events, AMSAHK continued our efforts from 2016. In addition to alleviating stress and improving the mental well-being of university students, we also aimed at equipping medical students with knowledge about mental health, mental health disorders and facilities in Hong Kong which assist patients suffering from mental illnesses suffers; all to raise awareness within the medical student body.

In February 2017, we collaborated with New Life Rehabilitation Centre to offer medical students an experiential mental health program with tours of recovery housing, vocational sheltered workshops and sharing from patients in recovery. Quote from a participant “It made me more aware of the mentally ill in my community and showed me the different services provided for these people,” quoting a participant.

In March 2017, AMSAHK welcomed 5 Dr. Dogs from Animals Asia for a special visit to students of the medical faculties. Therapy dogs have been proved to lower heart rate, blood pressure and cortisol levels. In addition, we distributed leaflets promoting mental health self-awareness, motivational bookmarks and mental health myth debunkers. We set up a ‘Positivity Board’ to allow students to express their thoughts and spread positivity. Furthermore, we were honored to have our in-house counselors attending our event, allowing students to reach out to them during the event as well.

After conducting qualitative and quantitative evaluations conducted, the educational program increased medical students’ knowledge about mental health facilities locally and has changed certain participants’ attitude towards patients with mental health illnesses. Our Dr. Dog Fun Day was received with great enthusiasm, and boosted medical students’ mood and mental well-being.
The most difficult challenge of modern day medicine is prevention. How do you change someone’s deep-rooted patterns that may be causing their health-related complaints?

The Estonian Medical Students’ Association is taking on university students - the young people with the wildest lifestyles and everyday habits. Those habits and the choices we make as students will follow us for the rest of our lives. For this reason, it is important to shape our health behaviour from now - as students – so it would be sustainable and maintain our health.

There is a cooperation network in Tartu, Estonia called OLE ROHKEM (literal translation: BE MORE) that consists of 50 active and innovative student organisations, with more than 5000 members altogether, wishing to improve the health behaviour of their members but often lack the means to do so. As a possible solution, the Estonian Medical Students’ Association has created the Model for Healthy Student Organisations. It offers various guidelines as to how organisations in the OLE ROHKEM cooperation network should operate in order to provide their members with an environment that values their health and improves their lifestyle.

The Model covers five different areas which we consider the most important at this time: alcohol, tobacco and drugs; nutrition and physical activity; mental health; equal treatment; and sexual harassment. The basic level of the model contains requirements concerning all five areas and organisations must comply with every single point without exceptions in order to join the model. Additional levels 1 and 2 allow the organisations to improve and develop even more. For some examples regarding alcohol, tobacco and drugs, all organisations are required to restrain smoking and drinking alcohol on events aimed at underage people, nor will it be tolerated for adult members to present showing signs of intoxication. Additional level 1 requires organisations to refrain from using alcohol companies as sponsors for any events, while level 2 requires organisations additionally not to buy alcoholic beverages from their budget, offer them for free nor organise their sale in the event locations.

We hope to encourage student organisations to evolve and to re-evaluate the effects their activities have on the health behaviour of their members. Thus they could be role models for other student organisations and students. We hope to make everyone see the Model’s logo as a quality sign of organisation culture. Our aim is to see all the student organisations currently in the OLE ROHKEM cooperation network joining the model. Also, taking into account the approaching centenary of the Republic of Estonia, we find that the student organisations could gift Estonia a whole generation of healthy students.

Every week in Germany, an estimates one of two kids die of the consequences of child abuse. In 2015 the German police recorded 12,900 cases of child abuse, although the World Health Organisation presumes a dark figure of 1 million affected children in Germany.

This topic took a long time to become public in Germany, with the first child protection group was founded in the late 90s, 40 years later than in the USA.

Although nowadays there a several groups trying to tackle these issues, we still lack the broad awareness of the severity of the situation, especially in the education of health professionals. This is where our project Viola comes into play.

Voila is a young project with great plans and big dreams. The development progress consists of gaining more public attention and establishing local committees in every German faculty of medicine. Furthermore, Viola aims for a better integration of these issues in the medical curriculum and continuous training for health professionals and organisations working in similar terms of content. In a few years, every German medical students and doctor should be aware of child abuse and know how to react when facing it. The icing of the cake would be to establish Viola across national boundaries and make it an international topic of discussion.

Founded in 2016, this project focuses on several specific issues in the fight against child abuse:

- Educating (future) health professionals in detection of possible cases of abuse
- Training on communication skills for better handling of sensitive situations
- Raising awareness of the grievances in the broad public
- Interprofessional exchange and cooperation of different organisation working on this topic.

The project is based on local committees coordinated by a National Project Leader. They have various options to reach the aforesaid goals:

- Speaking at medical congresses in order to raise awareness
- Organising public events or campaigns (World Children's Day)
- Facilitating panel discussions, book or film launches and field trips to counselling centers or youth welfare offices
- Delivering workshops for (medical) students and health professionals to educate them and give them the necessary skills to deal with this sensitive topic.

Those workshops are the core of Viola and provide enough time to reach profound education for all participants. The combination of frontal teaching, small working groups and open discussions ensures an adequate skills training and is the base of good quality. By recruiting new members during such workshops, the project achieves sustainability. Peer-to-Peer Teaching as method of choice is very important.

Because when we care for the health of our children, we care for our future!
Villages Free of Hepatitis C
IFMSA - Egypt

Since the day parenteral treatment for schistosomiasis was dreadfully introduced, Egypt has been suffering from a threateningly high spread of HCV and even higher mortality rates from chronic liver disease, liver cirrhosis and liver cancer than neighboring countries as well as worldwide. Hence, this lethal killer poses an insurmountable threat against our lives, spurring our national, particularly we as medical students and public health advocates to commence the perplexing battle against this frightful disease. About 1 in every 12 people worldwide is living with chronic viral hepatitis which also makes it a phenomenal global health problem which economically overwhelms all facets of any suffering country, particularly its health care services.

Consequently, IFMSA-Egypt’s uniquely comprehensive outreach to 23 different cities all around Egypt inspired us to target 15 underprivileged villages for our activity, especially because of the remarkably high prevalence of Hepatitis C in rural areas due to lack of access to healthcare and spread of endangering habits and risky behavior that further enhances the mode of transmission this silent killer. Yet, our chief goal was to create a comprehensive field study on Hepatitis C in these specific villages through pre and post-awareness surveys parallel to delivering simple and efficient public health messages highlighting each and every significant aspect of Hepatitis C and its prevention. We also had access to a variety of universities and hence decided to include university students as well. Luckily our partner, Egyptian Liver Research Institute and Hospital, aided us with a rapid screening tool in multiple governorates where we screened a total number 1400 people with 110 positive cases that were referred to the hospital to get the treatment. Surprisingly, we reached 16 villages and received 3600 pre-questionnaires and 1800 post, that are thoroughly analyzed by our competent research team to formulate a well-designed study emphasizing such a phenomenal burden for a multisectorial approach before it cripples our nation.
Medical students mostly observe diseases in tertiary care teaching hospitals and not in primary care setting. For purposes of ease and understanding tertiary care setting is the ideal teaching setup but the diseases that present in tertiary care have already passed the stages of primary and secondary care, it can be easily said that the most diseases that present in tertiary care are already in their advanced stages. Students get to observe ideal signs and symptoms but what they don’t get to see is development of disease or start of the disease. For that Primary Care is very important and exposure of medical students to the primary care setting is more important.

Keeping this problem in mind and the fact that primary care setup is not that much developed, we worked out a free medical camp, by involving professors of teaching hospitals, in a rural area in periphery of Lahore, where people could come for free treatment, medication and investigations and medical students would visit on voluntary basis to help out and to observe the diseases.

Goals:

• Have medical students get primary care experience on regular basis

• Have primary health service accessible to the peripheral areas of Lahore

• Have institutes recognize that a regular approach to primary health care is important for medical students’ development

Objectives:

• To have at least 500 medical students attend Vision of hope camp

• To have at least 400 medical students give positive reviews about the camp

• To have at least 3000 patients get primary health care

• To have at least one institute officially recognize the efforts and make such volunteer-ship elective part of curriculum

A camp is organized in a trust school at the peripheral area of Lahore. Doctors from around the Punjab come to volunteer, covering multiple specialties such as ophthalmology, urology, surgery, ENT, internal medicine, family medicine, dentistry, cardiology, pediatrics, and gynecology.

The camp also offers additional services, from ultrasound to sample collection for baseline pathology labs and free medication.

The camp is organized on the last Sunday of each month starting 8:30 am until 2:30 pm.

Volunteer medical students are divided in batches and are distributed among the specialties present, rotating every 45 minutes. They take a brief history and do a clinical examination, which is discussed and explained by the relevant consultant.

Through this project we will have a good human resource distribution, a better primary health approach to the peripheral areas and medical students with better understanding of diseases.
What do pink lips mean for you? For us that is clear: femininity, force and freedom!

Nowadays, cervical cancer concerns 1.4 million women worldwide. Every year almost 500 thousand women get diagnosed with cancer of the cervix and nearly 300 thousands of them die. In Poland every single year brings 3300 new cases and for half of the women it turns out to be a death sentence.

Concerned by the facts we have decided to set up a pink border for this particular cancer.

During the European Cervical Cancer Prevention Week, taking place on the end of January we are getting people attention by a recognizably sign – pink lips.

The Pink Lips Project is an educational event organized by the IFMSA Poland which main purpose is to inform and focus on everything that can be done with the cervical cancer problem throughout young women. Our the biggest success is creating fan page which is observed by 4099 people and this number is still growing. Feedback has become greater than our the most positive expectations - approximately 1 million have been informed about cervical cancer last year.

We are really proud of getting the support many non-governmental organizations involved in cancer prevention, specialist in gynecology and oncology, medical universities, Polish bloggers, models and other influential people. Last year we also received Honorary Patronage if Ministry of Health.

In addition, several hundred events have been organized, for instance in shopping centers or at universities.

Basically, we tried to inform people of that prevention is free of charge but priceless in avoiding many serious problems and difficulties both ourselves and our relatives. Motivated the huge success of our campaign, we decided not only did not stop, but set a new, more ambitious goals.

Currently, we focus on the organization of street gear under the slogan ‘leave cancer behind’, during which women run out of lips painted in pink, climbing the miles, while own weaknesses in order to remind them of the need to perform other regular cytology, which is the best way before averting the development of cancer.

We are extremely proud that our project has been appreciated and we won 3rd place in the Activities Fair during XI EuroRegMe2014 in Warsaw.
Jeffrey Berman once said: “there is a lot of fallen angels and orphans out there”, and boy was he right! Lebanon nowadays suffers from an outgrowth in its orphan population as well as their institutionalization mainly due to impoverishment rather than the actual absence of parents. It is fair to make a generalization that most of our orphans are uneducated and unattended for medically. Around 23,000 children have been placed in the care of orphanages in Lebanon, the majority of whom are disadvantaged and aren’t properly engulfed with the attentive care they requisite in terms of education to thrive properly. Depending on the latter, we as intended public health leaders decided to endorse such a noble cause by targeting the lacking suffered by orphans when it comes to general knowledge about healthy lifestyle habits, NCDs and life-saving screenings. From there, “orphanage health day” idea was born and was proven to be a true one of a kind national activity holding in its essence enormous medical and psychological impact and mutually benefiting 650 eager orphans as well as 85 dedicated SCOPHian.

The event itself was set for 4 hours and devised into two main branches: one concentrating on the relevant awareness themes to be presented and the other founded on screening the teens for risk factors. The ages addressed were from 4 till 18 years and the topics as well as the medical approach were set according to these ages and to the modern issues and life hazards they are exposed to on a daily basis. That is why appropriate nutrition, eating disorders, dental hygiene, CVD, coping with stress, skin care, smoking and diabetes issues were all given to adolescents aged from 12 till 18 years of age. The screening tests were provided for this age group only and it covered BMI calculations, chest auscultation and pressure measurement and random blood glucose check-up. The tests aspired not only to teach the kids how to use the medical equipment but also to screen for any possible medical findings. As for the children from 4 till 11 years old, diet and exercise, hygiene and motivation were offered as awareness topics. These ages are the most critical to be nurtured, and most sensitive to their surrounding environment, even a minimal intervention can create an immense impression on health related decisions; that was felt by the volunteers that interacted and fell in love with those beautiful souls and got to be introduced in a short amount of time to the hardships they face and conquer every day and were captivated by their wits, courage and humor.

The template of the event was in the form of rotation tables, each depicting a topic where each group of orphans, attended by a supervisor from the institution, would circulate and acquire the intended learning outcomes. All the subjects were presented in fun entertaining games following prepared survival kits, ppts and visualized tangible materials on the separate animated and decorated tables. It was a true eye opening experience that held huge impact and paved the way for future similar activities.
Do you know how to properly hold the US probe? Do you know that what’s inside counts? Do you know what terms such as parasternal long axis view, B-mode, FAST, PoCUS, multiparametric characterisation, contrast-enhanced and elastography mean? If you do, then well done! You probably already know that it is only with ultrasound one can see rightly. If you don’t, don’t worry, you are welcomed to join the club. Large masses of Slovenian medical students suffer from a severe deficit of practical training in clinical skills, namely ultrasound imaging, because our curriculum leans more towards the theoretical side of the spectrum.

Ultrafest is an all-day marathon of ultrasound workshops aimed at medical students with the goal of acquainting the students with ultrasound mechanics, examination and imaging skills, as well as dispelling the fear of holding a US probe yourself. After UC Irvine, Ultrafest found its second home in Slovenia, where it has become a very anticipated event. Organised by the medical students for the medical students, Ultrafest is conducted as a flipped classroom workshop, meaning students receive learning materials beforehand and can spend their time as participants at the ultrasound working stations with a probe in hand. Under the watchful eye of Ultrafest instructors and with the help of brief overview lectures they learn the basic approaches and imaging skills by practic-}

ing on live models (representing normal human anatomy) and simulation phantoms (getting acquainted with pathologies). The workload is divided into 6 sections: FOCUS, AAA/DVT, Acute Abdomen, Lungs, eFAST and US guided vascular access, so students can rotate between each working station. It is a fun and intense learning experience with technical difficulty of the learning setting at a workstation tailored to individual participant’s prior knowledge and skillset. From basic anatomy and physiology to managing different imaging parameters and adopting different techniques, just ask a mentor and ultrasound away.

Ultrafest events are in Slovenia organised on a regular basis, providing as many medical students as possible with the possibility of holding (and using) the probe themselves. With each Ultrafest we take another step towards our vision - to have a curriculum, interwoven with practical skills and for students to confidently engage in clinical investigations in their further medical career. The goal is still a few steps (or soundwaves) away, but don’t forget - when feeling dreary and grey, use Doppler!
SCOMEdy

The Guardians of Medical Education share their stories
A Critical Approach Toward the Brazilian National Exam for Medical Students

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In Brazil, medical education is at a turning point. Last year, the government implemented a new evaluation for Brazilian medical students, called “Avaliação Seriada dos Estudantes de Medicina (ANASEM)”. This exam was announced without discussion regarding its characteristics, leaving the universities and stakeholders without an opportunity for consultation regarding content and composition. The result was an evaluation to be applied to all medical students in their 2nd, 4th and 6th years of undergraduate studies. This exam is limited to cognitive tests, without assessing practical skills. Furthermore, as taking part in the exam is a condition for students to graduate, the exam itself has become a compulsory component of the curriculum that is quite possibly going to be a parameter for admission to residency. With respect to examinations, DENEM defends an exam that allows students to manage composition, structure, and curriculum according to professional and social demands.

However, the current context creates several worrying possibilities. First of all, as a condition to graduate, this evaluation can prevent students from obtaining their professional license, which punishes students without appropriately addressing structural problems in their medical schools. Also, the examination has a strong potential to precipitate relevant curriculum changes. In this case, as Brazilian medical education requires change to meet the demands of society, an exam that moves in this direction could be beneficial for our education and health system. Nevertheless, the test remains limited to cognitive questions that are unable to measure and stimulate the development of skills and abilities required for our professionals and society, and will therefore fail to result in the necessary changes. Finally, there is a strong possibility of this exam being used as a parameter for admission to residency, which creates a market of preparatory courses for the exam. This step makes education move even farther from its condition as a right guaranteed by the state, instead creating a profitable commodity that marginalizes a great part of our society. This is not to mention the aggravation of competition amongst students, which can undermine our mental health and stimulate an individualist behavior.

Above all else, DENEM defends the policy-making process of an effective and fair evaluation, to ensure the involvement of all concerned parties: schools, including teachers and students; the broader population; health managers and government representatives. In this context, we oppose the possible punishment of students by restricting graduation. Also, we object to the use of this evaluation as a ranking for medical schools and residency admission, since this would lead to a model of medical education that would be geared towards preparing for a test, and not for adequate professional training. The final consequence would be the weakening of ANASEM’s evaluative objective, as well as strengthening the harmful market of preparatory courses.

Moreover, given the exam is constructed and standardized at a national level, DENEM worries that the exam might become an instrument for standardizing medical curriculum across the country, with no regards to regional differences. DENEM argues that regional particularities must be respected, with consideration of the continental dimensions of our country and great regional diversity. Finally, DENEM defends that this evaluation must retain its formative aspect, giving feedback to the students without punishing them for structural insufficiencies in the provision of learning at a school level. Also, it is necessary to ensure that the process evaluates all aspects of education in medical schools, such as the teaching staff and the physical structure, as a manner of inducing improvements in medical courses in Brazil as a whole, and not merely on an individual basis.
Why Medical Students Emigrate to Become Doctors? Nigeria as a Case Study

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Many a doctor of Nigerian descent has found it lucrative to emigrate to another country with a medical system that is presumed to be better and more advanced. This “greener pasture” seems to be the dream of most doctors in Nigeria, and the same can be said for medical students and would-be medical doctors. In 2013, the Nigerian Medical Association estimated that about two-thirds of Nigerian doctors practice outside Nigeria. Worried by this trend, I approached 5 random colleagues and asked whether they would, if given the opportunity, move abroad to practice medicine, all of whom suggested that they would. Obviously, major challenges exist in the Nigerian health sector that breed dissatisfaction among stakeholders, leading to a desire to practice elsewhere. These challenges are multifactorial in nature, and a proper discussion of the issues precipitating such an environment is important to ensure stability and growth in the Nigerian health sector.

Nigeria has faced many challenges this year, which together have made life almost unbearable. The health sector is not immune to such challenges, and has had its own fair share of burdens. The combination of recession and consequent frustration has made many medical staff disenchanted with the medical system, and has highlighted the viability and attraction of emigration. Like most Nigerians, medical students began the year with enthusiasm and enormous hope for improvement. Unfortunately, this hope began to wane as the year progressed. The cost of living has increased drastically, necessities have become luxuries and most medical students who were solely dependent on their guardians have found it extremely difficult to meet their basic needs. In particular, growing economic pressure on students and their families has been exacerbated by a lack of scholarship opportunities. The status quo for government workers (medical doctors inclusive) in 2017 has been to endure months of halved salaries and, in some cases, no salary whatsoever. The morale of medical students has since decreased, as there seems to be no reward for labor. Seeing senior doctors complain of entitlement deprivation (which has precipitated several cases of industrial action) sends negative feedback to medical students, thus decreasing their enthusiasm to practice under the same conditions and making emigration and practice abroad a considerably more attractive prospect.

It is assumed that medical students outside Nigeria have a better deal with respect to welfare and educational standards. Interactions with colleagues in other parts of the world have highlighted the significant contrasts between Nigeria and the rest of the world when it comes to medical education. While students abroad describe a friendly, gradual and productive medical education, Nigerian students complain of a rushed and stressed learning environment. The same international colleagues tell of the excellent psychological and academic support they receive in times of hardship, while such instances in Nigeria often result in immediate expulsion from medical school. Similarly, they tell of state of the art facilities and breakthrough innovations, while Nigerian medical students must practice without the same degree of innovation or research. These factors, among many more, regularly result in the average medical student seeking a better deal elsewhere when the opportunity presents itself, thus starving the Nigerian health system of capable and much-needed medical support.

The dream of any medical student is to someday become a doctor. On achieving this feat, the excitement is unparalleled, and a rapid social change ensues. As a doctor, friends and family place you at the top of the social strata, and pressure to maintain these expectations is high. Such an environment defines the extrinsic aspect of a young doctor’s existence. On the other hand, the young doctor is introduced to a whole new world of struggles; seeking a house job, for example, which is seldom acquired immediately
after graduation, followed by settling down and applying for residency, which may itself be futile. Simultaneously, the new doctor must see casualties on a daily basis that are the result of an absence of necessary medical facilities, while coping with delayed, halved or even absent monthly benefits. These factors define the intrinsic aspect of a young doctor’s existence. The synergistic relationship between the intrinsic and extrinsic aspects makes the average young Nigerian doctor’s life almost unbearable, resulting in frustration and either depression or the “greener pastures” complex of emigration. On the sidelines, medical students observe these trends while asking: is the stress worth it?

The doctor to patient ratio in Nigeria in 2016 was 1 medical doctor for every 3500 patients. This figure poses an enormous burden to the average doctor, who barely has time for anything beyond attending to patients. For young doctors moving into this environment, the pressure is intense, and often results in strained relationships with seniors. In a typical Nigerian health setting, senior colleagues in the medical profession are authoritarian; patients, on the other hand, are very demanding and seldom give any compliment to the physician, rather sometimes choosing to pose a difficulty to doctors rendering their services. The young doctor is caught between these two difficult situations, and often opts to practice in a more favorable environment. Consequently, emigration has become the status quo for Nigerian doctors, but must be addressed if we are to ensure long-term stability and growth in the Nigerian health system.

Why Should We Study Medicine?

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Let’s take a moment to imagine a world in which there are no exams at the end of each school term? How would we study? What would we study? And perhaps most importantly, why would we study medicine?!

Here is the answer by the British General Medical Council (GMC): “Medical students are tomorrow’s doctors. In accordance with good medical practice, graduates will make the care of patients their first concern, applying their knowledge and skills in a competent and ethical manner and using their ability to provide leadership and to analyse complex and uncertain situations”[1].

So, in fact we are not studying for exams, but rather we are studying to serve the patients of our community. This is why governments allocate considerable amounts of the annual budget to medical education and medical institutes; indeed, beyond a community-orientated curriculum, medical teachers and students have a responsibility to focus the mindset of medical education on the community itself, a notion that belongs to the concept of social accountability (SA).

In 1995, the World Health Organisation (WHO) defined SA as: “the obligation of medical schools to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have the mandate to serve. The priority health concerns are to be identified jointly by governments, healthcare organizations, health professionals and the public”[2]. Thus, each medical school must consider its local community needs, common diseases, healthcare system and health resources before designing their curriculum, and should organise appropriate education in consultation with national health entities. Furthermore, the notion...
of SA is important when considering the mindset of each student towards medical education. Students should be motivated to join medical school by the future role they will occupy within the community as health leaders; such a mindset has a considerable effect on the manner in which we engage with medicine and medical education. This approach will alter the way in which students perceive their education: studying will change into learning, medicine will become enjoyable rather than a chore, and students will become health leaders even before graduating.

Although SA is not a new concept in medical education, it has now become a global trend, coinciding with the latest accreditation guidelines and deadlines. The Association for Medical Education in Europe (AMEE) established SA as a domain in which medical schools can be recognised for excellence, as part of the ASPIRE awards in 2017, the International Recognition of Excellence in Education Initiative. Such an opportunity should provide motivation for medical schools to consider the manner in which they address the community and engage with medical students to obtain feedback and recommendations as a major stakeholder in the education process. This is, however, a significant challenge: how can we, as medical students, provide feedback in these domains without adequate orientation on the concept of SA? How can we help our schools to become more socially accountable, without sufficient education to direct such efforts?

In April 2017, more than 450 individuals and organisations from around the globe participated in the World Summit on Social Accountability in Tunisia. Participants engaged with the concept of SA, giving input and providing feedback on the ways in which we can build capacity in this area. The participating students, led by the IFMSA, consequently established a student declaration on social accountability, built on the domains of leadership, competencies, partnerships and accreditation.

Here comes our turn!

Go to your computer, search the web, prepare to have interesting debates with your colleagues and faculty administration, start your own local plan for capacity building and get your step-by-step advocacy approach ready to upgrade not only yourself, not only your school colleagues, but medical education and healthcare services worldwide!

Let’s criticise our curricula, education systems and methods of assessment, research the motives of our colleagues for joining medical school, learn their competencies and future plans after graduation, and plan new national initiatives and local projects to anchor SA in our schools - to be, and help our schools to be, more socially accountable.

Now, we make it together!

References:

Check out IFMSA’s Student Toolkit on Social Accountability at http://ifmsa.org/social-accountability
A doctor should not only be responsible for the lives of patients, but must also assure them a good death. A “good death” was an expression used widely in the lectures held at the “I Journey on Palliative Care” series by Anhembi Morumbi University, but one that is rarely thought of and pondered on during graduating years. Medical students are conditioned to comprehend the mechanisms and methods that will cure patients. When this is not achievable, a chronic treatment is accepted and expected. However, to see the patient as irreparable and finite surpasses that which medical students receive as a formal medical education. For that, doctors must reflect on their own incapacity and limitations, and seek means to carry patients and families through the process of dying. With that in mind, IFMSA Brazil (Local Committee Anhembi Morumbi) partnered with Liga de Geriatria, Liga de Humanização and Liga de UTI to organize two days of lectures on palliative care.

Palliative care is concerned with the well being and care of terminally ill patients. It seeks to assure pain control as well as spiritual, emotional and psychological balance. Given observations regarding a lack of knowledge in students on this matter, it was felt that a series on palliative care was necessary, and consequently almost 55 students from varying health courses, including medicine, physiotherapy and naturopathy, convened on the 10th and 11th of May, 2017, for an introduction to palliative care. Dra. Fabiane Corrêa, a geriatrician from Hospital Beneficência Portuguesa, initiated the lectures, focusing on the role of doctors in palliative care, followed by Dra. Juraci Rocha, from Instituto Paliar, who presented her view on palliative care in intensive care units. Although the second day had fewer participants, all left with much admiration of the strength and love demonstrated by the speakers in their routine work. Dra. Rita Polastrini, a specialist in pediatric palliative care, was also present, and clinical cases were discussed by Dra. Priscila Machado, a psychologist; Dra. Érica Daud, family doctor and geriatrician; and Dra. Rita, a nurse. The great aim of this event was to bring together professionals from all areas of medicine, a fact which reflects the important multidisciplinary basis of palliative care.

Saving a patient’s life and allowing him or her to return to loved ones as healthy as before is not always possible. Sometime in their career, doctors will be exposed to terminally ill patients for whom the only option is to palliate, hold the patient’s hand and assure the family that he or she will be by their side during the process of dying. During her lecture, Dra. Fabiane told the story of two patients: one whose last wish was a glass of wine, and another who spent her last days in an induced coma and whose granddaughter did not get to hold her for a last time. ICU patients, attached to machines and filled with drugs and radiation, sometimes lack these small and simple moments of joy. If doctors could shift their perspective from providing simple treatment to prioritizing well being, a “good death” may well be possible for all patients. Palliative care is about understanding that medical practice is limited and that death is a part of medicine. It is crucial to sustain the family and the patient during the entire process and to avoid the curse of being surrounded by nurses and doctors in a nondescript hospital room during an individual’s final moments, even if this means carrying the patient home to spend their last days surrounded by family, or to have a nice drink and a final cigarette.

That was the reflection that the speakers at I Journey on Palliative
Care sought to pass on: through humanizing death, it is possible to humanize medicine. There are few palliative care programs in Brazil, and in order for such services to grow, IFMSA Brazil (Anhembi Morumbi Committee) calls on all students to become agents in the transformation of medicine by fighting to substitute the mentality of “there is nothing I can do” to “death is a day that is worth living”, as proposed by the palliative care specialist Dra. Ana Cláudia Quintana.

References:

Medical Hoaxes on the Internet

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Have you heard the latest news?! Apparently, Cancer is a lie! Oh, and so is AIDS! Don’t believe us? Then please continue reading.

Recently, the internet has played a huge role in improving medicine and taking healthcare to a whole new level. More resources and references are now accessible to doctors around the globe, making it more efficient to diagnose diseases and treat patients. Students are also able to gain information and learn through the new learning methods such as online videos and interactive courses.

Furthermore, ease of access to information, and the ability to interact with different physicians around the globe, allowed new knowledge to be conceived and spread. Initiatives concerned with research that depend on gathering information about clinical studies (e.g. The Cochrane Collaboration) have benefited from the World Wide Web.

However, the impact of the internet on health care did not always have essentially favorable and positive outcomes when it came to the general public. Certain sites (mainly social media) can sometimes convey misleading information concerning medicine and health to web wanderers. For example, some Facebook pages publish false medical information that can lead to incorrect understanding about some clinical issues, hence an increase in morbidity. A video claiming that cancer is just a myth, and it was simply a deficiency in a vitamin called “B17”, went viral on Facebook with hundreds of thousands of viewers[1], and some TV personalities in the Arab World actually shared the video on their pages. We also read a post that claimed AIDS is only a lie spread by pharmaceutical companies to earn money and it had a MASSIVE amount of shares and comments supporting this allegation. This spreading of wrong knowledge online can have dangerous consequences on individuals’ health and presents a big challenge for physicians and healthcare providers worldwide.

One of the main reasons for this issue is the occurring gap between medical science and the target public. Some health care-related problems are described and presented in a scientific language which makes them incomprehensible and complicated for the general
An Innovative Standing Committee Established in FMS-Taiwan

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This year, the Federation of Medical Student – Taiwan (FMSTW) organized a new Standing Committee for Government-Subsidized medical students, which aimed to promote cooperation between government-subsidized medical students all over our nation, and to promote health care in rural areas with medical student’s assistant.

The government-subsidized program for medical students in Taiwan, which was implemented by Taiwan’s Ministry of Health and Welfare (MOHW) since 1975, was a national policy to supply medical workers to rural areas. The program offered a full financial support; in return, the student has to go to specific...
specialty and go for rural services for 7 years after finishing residential training. However, the program was suspended in 2009 because of extremely low retention rate of these doctors, which was less than 1% over the past 30 years.

According to some senior doctors who had joined the program, they were desperate to and suffered from those days. They signed a 20-year contract with MOHW at the age of 18, but at that time, they were not mature enough to aware of the difficulties in the future, including unstable and unreliable policy, poor training quality in rural institution, significantly lower payment compared with non-subsided doctor at the same position, restrictions in changing serving institution, lacking of future career development, and etc. Though some of the doctors had stood up and requested for supporting measures, most of them failed to fight against the government.

We have kept an eye on this issue for years. In 2016, MOHW released the new generation of the government-subsided program for medical students, but the problems mentioned above were not solved. Thus, we want to help these freshmen to know more about the policy, and help this program successfully work.

As a result, in last May, we recruited these freshmen, who would join the government-subsided program, to form a working group. This group aims to do researches on maintaining medical human resources in rural areas, and to negotiate with MOHW for a better contract. We also held some interesting programs, such as a short-term internship in rural areas, interviewing senior doctors and online discussions.

In the past year, the working group had given some suggestions to MOHW according to WHO’s recommendation on improving the retention rate of medical staff in remote areas. In terms of attending conferences, we came up with some measures to help the government better the policy. Also, we wrote articles on the social media to raise the public’s awareness.

To sum up, we have tried our best in both improving the regulation and spreading the issue to the public.

Fortunately, we had fruitful achievements—the freshmen got a much better contract. On the other hand, they learned how to unite and cooperate to speak out loud for their rights. And finally, they decided to compose a standing-committee representing themselves to promote long-term participation.

As the leader of the Standing Committee of Government-Subsidized Medical Students, I am very proud of what we have done in the past year. We tried our best to urge the public on the issue, and provide a better environment for these government-subsided medical students. In the future, we will keep working on the project and sincerely hope to create a sounder system for government-subsided medical students, and to benefit those who live in rural areas.
PeriSCOPE

Travel with SCOPEans on their Exchanges!
Dreaming Big in SCOPE

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Not so long ago, I thought that becoming a Regional Assistant (RA) was something you only dream about. Something that could not happen in real life. One night, with a surge of adrenaline coursing through my body, I decided that I had nothing to lose and submitted my candidature. To my shock, I was selected, and until this day, I cannot believe it! A big part of this journey has already passed and now, the time has come to think of the new RA. I recall that, when I had applied, filled with fear and doubt, I hoped I had some type of encouragement telling me that there is nothing wrong on dreaming big.

If you are thinking about applying for the Regional or General Assistant position, I wish that this summary of my experiences, will give you the final push you need to finalise that decision.

As an RA, I fell in love with my region during our Regional Meeting. In both the Pre-RM as the RM itself, I encountered, from all over the Americas, participants that hungered to learn more about exchanges. Even better, I engaged with participants that brought solutions to the problems of the region and were willing to improve their exchanges by prioritizing Academic Quality. The RM was also a place to charge energy, I got motivated and remember the importance of IFMSA in every medical student’s career.

It is incredible to look back and think that this event took place almost 6 months ago. It is incredible, to see myself smiling in the mirror remembering all of the memories from my Regional Meeting. It is unbelievable to see all of the potential that the IFMSA Exchanges have.

After all five Regional Meetings, more and more NEOs participated in our “projects.” We had the opportunity to live an amazing Exchanges Week, where we shared and learned more about
each region and NMO. Even better, I had the opportunity to work in all of this with our amazing SCOPE IT, my team, and what has become my family in the federation. As weird as it sounds, I haven’t met all of them because I couldn’t attend Montenegro. I was afraid that I was going to be left out. Surprisingly, one day a group photo was sent to our chat, where the team added a stick figure to represent me. In that moment I understood that in the process of so many emails, projects, and reunions, we became more than a team.

Being an RA has been one of the most beautiful experiences I’ve had. I can’t explain it with words. It is like one of those feelings, when you come home after a really long trip and you finally see your family again. No matter how tired you are, in that exact moment, you are just happy. No matter how tired I am because of other things, each time I have a new message from a NEO or a new email from my team, I forget about everything else, because what I do, is what I love.

Although I have so many more experiences to share, all I can say and think of, is to give an advice to whoever reads my article. If you are thinking about becoming a Regional Assistant, work hard and do not be afraid to jump to this adventure. Being an RA is something magical, something you can’t really explain because you have to live it.

I am not going to lie, the work sometimes will be heavy, but the long nights will always be shared with your team. The work will soon be overshadowed by the great time you will have together, full of inside jokes and anecdotes. It will be overshadowed with the love you will build for your NEOs, for your region and for the Federation.

So what are you waiting for? If you have this really crazy dream of becoming an RA, do it! Do not afraid to dream big, because even better than dreaming is being able to achieve your dream and live it.
January in Israel

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In January 2017, I had opportunity and honor to spend one unforgettable month in Israel. During my stay, I was surprised how much “life” there actually is in that country! From history and culture to one of the most warmhearted people I’ve ever met, nothing could disappoint me. Of course, whenever you visit Israel, sunny and warm weather will follow you, even in January.

Through IFMSA, I was stationed at Tel Aviv Medical Center, in the heart of the city, at the department of Cardiology. The dorm room I was staying at was only a short bus ride from there. I had the opportunity to meet other medical students on exchange in Israel. The local staff was very helpful and provided me with all the needed information prior to my exchange.

On the first day at hospital, I was introduced to medical staff and it all went uphill from there. I joined the morning rounds with specialists and they explained to me patients’ conditions, showed medical records, gone through laboratory findings, and taught me how to perform a physical exam. Regularly we went deeper into discussing complex findings. We would even have lunch together every day, which made me feel as part of the team.

I had the opportunity to visit other departments as well. I benefited from echocardiography rooms, the intensive care unit and the interventional cardiology unit. Whenever I went, I was welcomed by the staff and received detailed explanation of performing procedure.

Israel has much more to offer. Tel Aviv’s street restaurants, with authentic food, will amaze you.

Of course, the old city of Jerusalem is must see! If you are interested in Jewish history I strongly recommend visiting the Yad Vashem memorial, which honours all the victims of the Holocaust. Further up north of Israel is the beautiful city of Haifa, also worth visiting.

During my exchange, I met a lot of people from different backgrounds and different cultures. Jewish, Arab, Russian and more. I was fascinated by the diversity this country has to offer. In Israel don’t be surprised if you hear in middle of department discussion between staff in Russian or Arabic!

Israel has excellent bus and train connections, so it’s very easy and affordable to move all across the country. A lot of places have free WiFi spots but for longer stay, buying a sim card is recommended. Same as with a monthly bus ticket.

My exchange in Israel was a great experience. I’ve gained a lot of new knowledge, experience and made new friends. It’s a completely different world from average media portrait. That’s why I recommend you to experience it for yourself.
I am very proud to have attended the Sub Regional Meeting (SRT) in the province of Imbabura, the mountain region of Ecuador, between the 26th to 28th of May, 2017. During the event we had the opportunity to participate in the PRET (Professional and Research Exchange Training), where medical students got a better understanding of the professional and research exchanges that our organization has to offer.

From my perspective, being part of the IFMSA as a Local Exchange Officer (LEO) since the first steps of the journey in my professional career, has been one of the best experiences of my life. It gave be more than just the opportunity to know more about the exchange, it made me aware of how the committee works worldwide.

It is important to consider that we are also medical students and we are exposed to many stress situations daily. The PRET made us better students and professionals for a near future, because it was not only focused about how the exchange committees work, but also on how to organize our time in order to prevent “burn-outs”. This training was very dynamic and we had the privilege to have two experienced trainers sharing their knowledge and support: the two exchange committee’s RA’s from our region, Andrea Falconí RA for SCOPE and current NEO OUT from AEMPPI Ecuador, and Erwin Barboza RA for SCORE and former NORE from IFMSA Paraguay.

The way both trainers taught us, made me realize one day I would like to be like them. They were very special in the sense that they both knew how to give different approaches to the committees. They taught us how to become a team and manage one, reduce the cultural shock for our students and the importance of how to give feedback and evaluation; which personally helped me to become a more inquirer, reflective and principled LEO and person.

The other trainees and myself were thankful for the hard work they put into the training and the knowledge they shared with us.

As a medical student from second semester, I highly recommend all IFMSA medical students around the world to participate in a PRET, because you will learn not only about SCOPE and SCORE committees, but also tools to be more organized and teaching you on how to become a better speaker.

Professional exchanges in Ecuador are improving every day. As a LEO, I see many students from my University interested in going to another country, learning their culture and practicing medicine in a different health system. This year, our NEO IN, Richard Medina and our NEO OUT Andrea Falconí, have been working hard so our Incomings and Outgoings have an excellent educational and a cultural experience. The NEOs and the LEOs from our NMO have been

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**PRET at Latitude 0° and Exchanges in Ecuador**

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working the whole year to prepare the LCs to receive Incomings and preparing our Outgoings, so they have a very good experience while they are in their exchange. Compared to last year, when we had just 45 outgoings, now we have more than 81 students from our LCs going for a professional Exchange!

Ecuador is a great opportunity to do an exchange, as we have prepared tutors that will guide our Incomings on how to handle patients and interact with them, making this a great educational experience for them. From the educational part, we are also getting prepared to do more Pre Departure and Upon Arrival trainings, which will for sure help our students during their exchange. Our small country counts with so much diversity in all of its regions, that we can give our Incomings the opportunity to experience our culture, visit our UNESCO Heritage places and enjoy our delicious gastronomy, because at the end all you need is Ecuador.

Memories of a Brief Trip to Asturias, Spain

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Of the fifteen countries listed in the exchange application form, Spain was my first choice and, luckily, I had my choice approved. This country would allow me to make and feel part of the multidisciplinary team, as long as I demonstrate ability and had proficiency in the Spanish language. I was very interested in Spain because I speak and write in Castellano since I was a child, from my family ancestry, I have a lot of appreciation for the local culture, and the possibility of practicing my medical knowledge acquired so far.

People from 13 different countries (Netherlands, Argentina, Tunisia, Poland, Turkey, Spain, Canada, Hungary, Austria, Italy...) and I stayed in a large two-story apartment in the center of the capital. Although it was old, it had everything we needed, and because we were between men and women in the same residence, I shared a room with a Dutchman, with whom I became friend and I keep contact until today. The interesting thing is that I was the only Brazilian and nobody else spoke Portuguese, so I had to communicate in English when I was in the lodging and together with my friends; and in Spanish when in the hospital with the preceptors. I’m sure that it has greatly improved my ability to speak in both languages.

I did my internship in the Internal Medicine Department of the Central University Hospital of Asturias (HUCA), a modern hospital complex, with capacity for just over 1200 beds. I have to confess I’ve never seen anything like it. The hospital is public, very contemporary (with elevators only for robots, bizarre!), full of accreditations and has facilities to envy the vast majority of private hospitals in Brazil. Everything is organized, clean, the rooms are lit with windows that offered a look of the region’s mountains, and with a multi professional team very cordial between itself and towards the patients. Being part of the Internal Medicine service, I was able to attend all areas of the hospital with my preceptors, because the service works with inter-consultations. At the same day I was in oncology or infectology, they also directed me to the stage of autoimmune diseases or cardiology, and so on, always challenged by doctors for differential diagnoses and clinical reasoning. I learned a lot, especially with Dr. Mauricio Telenti and Dra. Carmen Cienfuegos Basanta.
Even with a workload of 8 hours per day, there was time for fun, because in northern Spain the sun sets only at 10:30 p.m. in the summer. Every day we did something different: hiking trails, adventure tourism, rafting in the Descent of Arriondas, climbing on Naranco Mount, even exploring caves in Covadonga. Our group was very diverse, people with different personalities and cultures, but we got along very well. When we went to visit the south of Spain, I was with a certain group; when I went to the coast (Cudillero, Llanes, Luanco, Ribadesella, Cabo Peñas, Gijón, Avilés) in order to enjoy the summer festivals of the villages I was with another group. Oviedo has more than 1400 years of existence, so we visited frequently archaeological and fine arts museums, Gothic cathedrals, small castles and pre-Romanesque monuments.

I just have to thank the IFMSA, the University of Oviedo, my exchange friends and everyone who gave me this beautiful opportunity. The days that I spent in Spain were unforgettable. I was able to better know myself as never before, living with people of habits very different from mine and wake up speaking a language other than Portuguese. I networked with renowned professionals who can open the doors for me to return to HUCA someday, I got to know a public healthcare system that works incredibly well, which combines technology with the good and old anamnesis, values the physical examination and reciprocity in respect between the health team and the patient. I have perfected my clinics skills, I opened my mind to a new world living the local culture and enjoying the beauties and delights that Spain offers, I made adventures, I ate a lot, traveled a lot... I enjoyed everything I could and made this experience the best of my life.

The message I want to leave is: Be part of the Exchange Program! Well worth it! You only get to win! I can say that I came back another person, renewed, more willing to listen, to preserve what I have of good and to improve my weak points.
My Serbian Adventure

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The cold breeze of Serbian winter enters through the windows followed by sunshine, enlighting a new beautiful day at the enchanting Belgrade. This energizing atmosphere would reach you as you give your first steps out and hit the street in order to start your day, and the astonishing snowy view of the city would mesmerize you while you keep going on to start your activities. That was my environment and routine since the beginning of January until the middle of February of 2017, when I - a brazilian bornchild - decided to switch flipflops for white coat & scrubs and summertime to below zero temperatures for the dream of living an exchange experience at the far and cold lands of Serbia. Studying abroad has always been a goal for me since the beginning of my studies in medicine, as I have always seen it as a fantastic opportunity of making contact with new cultural aspects meanwhile I would improve my medical knowledge and expand my horizons, and Serbia seemed to be the perfect choice for its awesome culture and great achievements at the medical field.

Thanks to Doctors Goran Belojevic and Jasmina Maric Zivkovic and the whole organization of the Local Comitee of IFMSA Serbia, I can state that the professional experience I lived has been wonderful and unforgettable. I have been linked to the pneumology department of the Clinical Center of Serbia, where Doctor Zivkovic has been my tutor and gave me the opportunity to watch and participate on clinical practice on her speciality. Furthermore, on the following weeks, by contacts she managed to make between internal departments of the hospital, I have been invited to participate in activities at the departments of ophthalmology, cardiology and surgery as well, which has made of my exchange program even more diverse and unique, granting me a big variety of new experiences at different medical specialities. The structure provided by the University of Belgrade has been the best possible what also contributed to an amazing learning process and justifies the prestige of this great institution over the Balkans and the whole Europe.

During my stay at the city of Belgrade, I had the pleasure of experiencing an immersion on Serbian culture, learned a lot about their historical background, visited many museums, tried a lot of typical food and walked by all the most important sites of that big capital. At the end of this process, it was inevitable to fall in love with that enchanting place, full of cosmopolitan atmosphere and with such a beautiful history. The Serbs, as Serbians are commonly called, are lovely people whose hospitality and sympathy I will never forget. They made me feel at home even being so far from my native country, introduced me to the hotspots of the town and helped me with their language. Belgradians are full of joy and party enthusiasts, and it has been a great pleasure to be in their company.

My experience with SCOPE has been the best possible in many aspects. I already see a direct impact of it in my life as medical student and I am sure that it will certainly have a great influence in my future as a physician, for the great academic and professional growth enhanced by the experience at the serbian Clinical Center. Furthermore, at the personal and social relationships fields, it gave me the opportunity of knowing a wonderful country as Serbia, getting in touch with a whole new culture and making friends from all over the world. I strongly encourage every medical student to have an experience of exchange through IFMSA and SCOPE for the unforgettable moments and priceless teachings that it may provide you. I will never be enough grateful for having had this great adventure for all the benefits that it has brought to my personal & academic life and future career.
Every morning I wake up to countless emails, WhatsApp messages and missed phone calls. Ever since I decided to dedicate my life to SCOPE a little over a year ago, it has become a routine finding on my phone. I have probably forgotten the cardiac cycle but the Late CA and Late AF deadlines are etched into my memory. And yet, this past year has been one of the most amazing experiences of my life.

I still remember when I had to go on-stage to give my candidature presentation for the position of the NEO. I was pretty shy and never wanted to be the center of attention. But I stood there, in front of 500 people, discussing my plan of action for something that I had only a limited idea. It was far from perfect. I was sweating and speaking fast. My nerves had gotten the best of me. I remember being relieved once it ended. To my absolute surprise, I was appointed as the NEO of India - a country which had been active only for about 4 months. As I look back, I think I really underestimated what I was getting myself into.

Incomings had all sort of questions – one wanted to know how much does it rain in their city because they wanted to enjoy the Indian rains, one wanted to go to the Himalayas for a trek, another wanted to star in a Bollywood movie! Considering I had myself not done much of those, I usually had no answers. With the outgoings, it was still a lot of questions but completely different ones! They wanted to know whether they will get any Indian Food in their host countries and whether there was a well-established Indian community there. Some students found it hard to believe that the cost of the exchange was so less and started questioning our credibility. Probably the craziest experience I had was when a student’s Dad called me up asking why was I sending his daughter to another country. Having no answer to give, I cited network issues and asked my co-neo to speak with him instead!

I was in Mexico for my first IFMSA General Assembly just after my term had begun. I was clueless for the first two days and took some time to adjust to this grand event. The night before our first Contracts fair, we realized we hadn’t brought any contract forms with us. Let’s just say we made sure the hotel printer ran out of paper. Next day as the Contracts Fair started, more than 400 people gathered in a room to sign contracts, wearing their traditional costumes and giving away free gifts to one another. I was wearing a traditional Indian dress and the cultural exchange that I witnessed over there is something that will be close to my heart forever.

As exchange officers, we might not get much out of SCOPE in financial terms but we certainly get quite a lot in terms of life changing experiences. My outgoings often thank me for the best one month of their lives, they say this one month has changed their perspective about life and medicine. Some had never seen a PET scan while other one had just heard of Robotic surgery let alone see one. Even the incomings say the same and have the nicest of words to describe our diverse country. The smiles on their faces when they leave says the rest.

The past one year has been the most memorable part of my life. I have been to countries I thought I would never visit in my life. I have learned about different countries, their food, their cultures and their people – things I would have never experienced sitting at my home. SCOPE made me move out of comfort zone and for that I am grateful.

Personally, I have never been on an Exchange Program and I am sure a lot of Exchange Officers across the world haven’t either. We are happy and content with students from our countries going on Exchanges and having the best month of their lives. We live through the pictures that they put up on their social media. It is what motivates us to work towards improving our Exchange Program. But one day, I do hope to go on an Exchange and see what it is actually like but until then, I am happy that I have played a role in enabling many people to experience this magic.
Preparing Future Medical Students for Exchanges and Beyond!

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Every year, around 15,000 medical students like us pack their bags and prepare for an unforgettable experience abroad thanks to IFMSA exchanges. For at least one month, we are fully immersed in a new cultural environment and learn how to practice medicine or medical research in a new context. We develop friendships and experiences, and we have more than the daily recommended amount of fun. However, how prepared are we for such an enriching yet challenging experience?

Imagine you are a student doing his/her first clerkship in a country where there is a huge stigma on people with mental health problems. How would you behave in front of a patient with an undiagnosed mental illness? And how would you behave if your tutor required you to perform procedures beyond your competencies?

There is no easy answer to any of these questions, but it is in this perspective that IFMSA has recently developed a Pre Departure Training (PDT) in collaboration with the Chair of Bioethics to UNESCO.

Research shows that, in the current globalized world, health issues are becoming increasingly transnational (Battat et al., 2010)\(^1\). In light of this, it is extremely important for medical students to be up to the challenges of modern medicine, which necessitates adaptation to the needs of a new, multicultural society. Literature also shows that Pre Departure Trainings have a positive impact on outgoing students by giving them the skills to face ethical and cultural issues they may encounter in their host community (Anderson et al. 2012, Centre for Intercultural Learning, Canadian Foreign Service Institute 2005)\(^2\).

The new IFMSA UNESCO Pre Departure Training has been pioneered with the goal of increasing exchange students’ ability to face ethical and cultural challenges in their host countries with greater confidence and to protect the patients they will encounter. This also translates to a generation of future physicians better skilled at treating patients from cultures different from their own.

The training features sections on basic medical ethics, culture shock and cultural competence, exceeding level of skills, and basic research ethics. It is a combination of theory and case studies (12 case studies and 2 examples) that participants then discuss in small groups.

All the content of the training has been included in a presentation which is already made to be delivered. The goal of both SCOPE and SCORE International Teams, in line with their Strategic Plans, is to implement the PDT in at least 80% of NMOs by 2018.

If you want to know more about the new Pre Departure Training or receive suggestions on how to implement it in your NMO, please send an email to both ga.score@ifmsa.org and ga.scope@ifmsa.org.

References:
“Global Health is an area for study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide.” [1]

As physicians of the future, we must be aware that health and illness are not merely biomedical concepts, but rather embody also the psychological and social spheres of individuals. Our actions as health professionals and advocates can be really effective only after abandoning the biomedical paradigm in favour of a new, holistic approach to medicine.

Evidence shows that diseases not only have proximate causes (e.g. obesity and unhealthy diet for coronary heart disease, or smoking for lung cancer), but also ultimate ones (e.g. socioeconomic status, level of education, profession, organization of local healthcare services, etc.). This means health is determined by a wide variety of elements, from genetic and personal factors (age, sex, hereditary factors, personal lifestyle, etc.) to living and working conditions and more general socioeconomic, cultural and environmental factors. These are the so-called “Social Determinants of Health”[2].

Even though medical technology is improving enormously, improving health for all is becoming more difficult in our globalized and extremely interconnected world, and inequalities in health and society are widening. Climate change, Non-Communicable Diseases (NCDs), Mental Health and Migrants’ Health are only some examples of Global Health challenges of the modern times.

Through IFMSA exchanges, medical students have the possibility of spending one month abroad and work in a different sociocultural context and health system. By improving our awareness of the main present global health issues and paying attention to sociocultural determinants affecting people’s health, we can become competent and sensitive physicians who are able to effectively take care of their patients and promote health in all its aspects.

For all these reasons, implementing Global Health in our exchange program has become an important priority for SCOPE.

Global Health has been included within SCOPE mission statement in 2014. A strategy has been adopted in 2016, whose primary goal is to include Global Health as part of the SCOPE exchange program by focusing on a specific Global Health theme for the following three seasons. The theme for the period 2016-2019 is Social Determinants of Health.
For the current term, the SCOPE International Team is working on the implementation of the Global Health strategy on a regional and national basis. During March Meeting 2017, all participants to the session on Global Health in SCOPE were divided in groups according to their region, then they were asked to identify common Global Health issues related to their regional context and think about a way to talk about those issues within their national exchange program. The SCOPE International Team is currently working on the outcomes of the session and is helping NMOs shaping activities on the ideas that came out from the participants.

One important achievement for this term is also the publication of the Global Health within Exchanges guidebook, the result of a joint effort between SCOPE, SCORE and SCOPH started in the previous term. The guidebook aims at providing exchange students with a 360° overview on Global Health and its importance for IFMSA exchanges, with some tips on how to focus on Social Determinants of Health of the host country while on exchange.

It is also an important tool for all exchange officers, as it might be used as reference text for shaping educational activities based on Global Health and Social Determinants of Health.

The real success of this strategy however, comes from the engagement of NEOs, LEOs and students so, if you want to ask questions or give us suggestions or feedback, please send an email to both scoped@ifmsa.org and qa.scope@ifmsa.org; we will be happy to answer.

References:
The SCOPHian

Meet SCOPHeroes who save the world with their Orange Activities
Changing Demographics

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Smoking Tobacco has been a part of the Jordanian culture for more than twenty years. At the time, serving cigarettes on silver trays was one of the optimal traditions to show generosity in weddings and at funerals. Occasionally, some large farms were exclusively planting tobacco for industrial use. Even though tobacco was known to be a contributor to many diseases, people were not aware nor educated enough.

After the World Health Organization (WHO) released the Framework Convention on Tobacco Control (FCTC), majority of tobacco companies found refuge and investment options in less developed countries where the governments were in debt or in need of financial support and the legislations were not strongly protective of health rights. Unfortunately, within the past twenty years, several tobacco companies have opened their establishments in Jordan. As a result of direct investment and support by some governmental institutions in Jordan, tobacco companies found strong foundation and made it more challenging for Public Health advocates to counteract the disadvantageous results.

Due to the deteriorating situation, the prevalence of male smokers has reached high levels of more than 60% of adult males in Jordan. The number of female smokers went up to reach 10% in a matter of four years. The data clearly reflects the destructive effects of tobacco industries on the society’s health and the financial burden to educate, and advocate, and rehabilitate everyone affected. It had been a tough challenge, but the passionate work of multiple NGOs has manifested incredible changes. Dr Maria Christina, delegated by WHO, has done an outstanding work in Turkey in the field of Tobacco which facilitated an initiative to create an alliance of several NGOs to collaboratively fight tobacco.

We, Amman Greater Municipality (GAM) and Ministry of Health (MOH), have joined hands with the WHO and together we managed to take actions on multiple levels. The work was led by Royal Health Awareness Society as Chair of the alliance. The other participating NGOs have worked on different responsibilities defined among them. King Hussein Cancer Center (KHCC) took the initiative to build the Road Map on Tobacco Control for Jordan with MOH and WHO. They identified 13 points to work on following a plan that aims to decreases the number of smokers by 2020. Additionally, IFMSA-Jo has been an integral force in the alliance providing volunteers to any NGO upon request. The end result of this alliance was a significant change in the Jordanian Law regarding tobacco use and investment. The new legislations guarantee a defense mechanism and eliminated subtle loops that were manipulated earlier by Tobacco companies. For example, tobacco use is now prohibited in public areas with a fine that can reach up to 1,000 to 3,000 Jordanian Dinars (1277 to 3831 Euros). Also, tobacco advertisements are prohibited in all forms, even on social media. Besides, any form of tobacco products are prohibited from sale within 250 meters of any health or educational institution, including selling individual cigarettes.

These laws and legislations cannot bring change to the current demographics if we, as a community, do not implement them. Thus, we in IFMSA-Jo are now assisting the governmental institutions in implementing the new laws by reporting any unlawful tobacco advertisements, conducting regular site visits, and following up regarding any other penalties and violations.

We hope in the next couple of years to witness a clear drop in the number of smokers in Jordan. With the strong reinforcement of the legislation and continual follow up of the NGOs, our dream of “a smoke-free Jordan” can become a reality.

Every person has a role to play: If you are a smoker, quit now; if you are a decision maker, refuse the lobbying of tobacco industry and work for a smoke-free Jordan; and if you are a non-smoker, help those in need and spread awareness of the epidemic harm of tobacco. The change needs a strong will, action, and determination, and if we harness it for a good cause, we will be unstoppable.
World No Tobacco Day 2017

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As the leading cause of preventable death, tobacco use is estimated to cause six million deaths worldwide each year. It is the leading risk factor for mortality, causing cancer, respiratory infections, cardiovascular disease, and loss of taste and smell\(^1\). In addition to cigarettes, the electronic cigarette industry has become a worldwide business. According to the World Health Organization (WHO), manufacturers often market e-cigarettes to aid consumers in smoking cessation, but they need further regulations to reduce health risks for users\(^2\).

On May 31 of each year, WHO celebrates World No Tobacco Day to highlight the health risks associated with smoking and advocate for effective policies to reduce tobacco use across all ages. In efforts to reduce the demand for tobacco, public health advances in Australia, France and the United Kingdom have integrated the use of simple or standardized packaging with clear labelling of health warnings\(^3\).

In the Dominican Republic, the number of smokers between 13 to 15 years of age has increased, due to the fact that the consumption of cigarettes and e-cigarettes has become popular and fashionable in Dominican society\(^4\). Cigarette and e-cigarette consumption has been increasing, becoming a popular behavior in universities and on the streets, where 31.2% of the general population reported current use of e-cigarettes\(^4\).

On May 31 members of the Standing Committee on Human Rights and Peace (SCORP) of the ODEM-Dominican Republic, coordinated an educational stand in the Universidad Nacional Pedro Henríquez Ureña (UNPHU) of Santo Domingo. This health campaign aimed to educate the UNPHU students, professors and employees about the incidence and consequences of tobacco use, including cigarettes and e-cigarettes. Informational texts were disseminated in pamphlets and brochures, and detailed displays presented facts on the health effects related to tobacco and e-cigarette use. Standing in front of illustrative posters, participants posed for photographs, holding different health messages that promote saying “no” to tobacco use, and subsequently shared their photographs via social media.

This initiative, completed by SCORP members of ODEM-Dominican Republic, highlights the public health national burden of tobacco use and emphasizes the need for regular and sustainable preventive measures to reduce tobacco use in the Dominican Republic. In order to strengthen global tobacco control campaigns, activities should be educational, enjoyable and useful for persons of all ages. Although there are no simple solutions to combat tobacco and e-cigarette use, significant changes can be achieved through coordinated interventions with various stakeholders. Each person has an important role to reduce the global burden of tobacco use and improve population health. Together, ODEM medical students can continue to make significant contributions by developing health initiatives that aim to improve population health, such as reducing tobacco use, in the Dominican Republic and world.

References:
A Different Outlook on Alcohol Prevention

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Alcohol intake in Europe is one of the highest in the world. It has become a major risk factor for most of the noncommunicable diseases, consequently contributing to their overall morbidity. Various initiatives and projects target alcohol prevention, however, a lot of them are ineffective or even harmful. Recently, based on new research, a new outlook on effective alcohol prevention has been formed. Lithuanian SCOPHeroes decided to make a change by building on this new research and consulting specialists working in the field to create an evidence-based alcohol prevention project.

The whole project is 6 weeks of continuous peer-to-peer education. The target group is 13-14 year olds who are likely to start drinking alcohol. They are introduced with different activities every week ranging from life skills education to a huge alcohol-free party. These interactive activities are aimed at enhancing students’ social skills, empowering critical thinking, providing alternative alcohol-free ways to spend leisure time and involving students’ parents to make the children’s alcohol resistance stronger.

The project starts with a parent-teachers meeting where the activities and context of the project, including alcohol use statistics and harm, are introduced by specialists. During the second week, an orientation game among all the participating schools is organised. This is followed by three weeks of interactive activities in every school. Children get to know the main facts about alcohol and healthy lifestyle during “Brain games”, analyse alcohol commercials, learn how to manage their emotions, participate in a sports tournament, discuss the main myths spread by the alcohol industry, learn how to study more effectively and manage time. The project is finalised by an alcohol-free party organised outside the school facilities for all the participating schools. We created a neon theme party, where children could paint themselves with neon body paint and dance under UV light. As an alternative for more introverted children, we also created a “silent” room with board games. Foods and drinks were also provided for all participants. The star of the party was a physicist’s performance with liquid nitrogen.

During the whole project, we introduced two more continuous activities. Children participated in a photo contest. They had to make photos during various alcohol-free leisure time activities during the whole project. We also introduced a project tournament. Every class participating in the project got points for participation and win in every activity. In the end, the winners were awarded in the last party.

All in all, after reading the children’s and teachers’ feedback and evaluating the project we see this project as a success. Of course, there is some room for improvement (which we plan to take into account for the upcoming year). Projects like this are crucial for every community. They not only prevent alcohol intake but also promote healthy lifestyle and help children to develop important life and social skills, which are considered the main protective factors for many noncommunicable diseases.
Every year, the world celebrates World Health Day on April 7th. This year’s World Health Theme was Depression: Let’s talk. The World Health Organization (WHO) stated that depression can affect everyone, at all ages from any country. Depression leads to disturbance in daily activities, social relationship, as well as ability to work. Moreover, someone with depression may commit suicide. Currently, depression is one of the leading cause of death for people aged 15-29 years old.

In Indonesia, based on data from Ministry of Health of The Republic of Indonesia, within people aged 15 or more, there was approximately 14 million people suffering from mental and emotional disorder with depression and anxiety as its symptoms. To tackle this global issue and to celebrate World Health Day, CIMSA Indonesia held World Health Day Campaign. We collaborated with World Health Organization Country Office for Indonesia as well as Do Something Indonesia, one of Non-Government Organization in Indonesia. This campaign aimed to raise awareness about depression, the importance of sharing as well as deep understanding about depression itself that depression is normally happen, preventable, and curable.

This campaign consisted of several parts. The first one was campaign challenge “Support is all around you, depression: let’s talk”. It conducted through Instagram to reach more youth in Indonesia. We encouraged CIMSA members to join this campaign and to educate as well as raise awareness about depression. The second part was CIMSA online Talk through Twitter. We invited psychiatrist who is also CIMSA Alumna, dr. Rini Gusya Liza. M.Ked(KJ), Sp.KJ. She explained about depression, its symptoms, what we should do if we or our relatives or friends tend to have depression, how depression can be prevented and treated, and the last was relationship between sports and depression. It went well as she explained briefly yet very informative. The last part of this campaign was campaign challenge: #WeSweatForHappiness. Study showed that regular exercise can improve mood and decrease depression. Moreover, when exercising, human body releases endorphins, a hormone which can give positive feel, decrease stress, and decrease depression. At #WeSweatForHappiness, together with Do Something Indonesia, CIMSA Indonesia challenged all young people to do sports with beloved friends and take photo before or afterwards, then upload to social media. It aimed to encourage people to take exercise or sports as daily routine, as they can prevent and treat depression.

At the end, we hope that this campaign can give positive impact to society in tackling depression. Moreover, more people can be educated with depression, aware of depression, and know how to do with depression. We also hope that not only educated and aware, but people can take action and do something to tackle depression, such as sharing as well as doing sports with beloved ones.

“Depression can be prevented and treated by exercising regularly, even if it’s just a short walk.”
The medicine university course, although is greatly wanted to students, have disappointed many who have conquered this position. The reason why this happens is that the students pass through a progressive, multidimensional and complex process of adaptation at the beginning of college. Among the most important factors of this process are the difficulty to manage academic life and personal life, the shift of social circle, the increasing pressure of evaluations and, mainly, the use of non-adaptive actions in a spectrum of stressful situations.

Accordingly, a study using meta-analysis with 200 works, covering around 120,000 medical students in 43 countries to screen depression, symptoms related with depression and suicidal thoughts among students. Thus, the results have shown that the prevalence of depression or depression symptoms was 27.2% in the overall crude pool. Among the studies which has validated depressive symptoms, before and during college, it has been notice the median absolute increase in symptom was 13.5% and, finally, the overall pooled crude prevalence of suicidal ideation was 11.1%. However, the percentage of students who actually seek for psychological help is only 15.7%. Hence, the author concludes saying: “Further research is needed to identify strategies for preventing and treating these disorders in this population.”

Beyond medical area and besides specific factors of mental health, analyzing widely in the academic population, a study made with a pool of 6479 students from various courses of two notable Australian universities have found that the prevalence of mental disorders was 19.2%, in addition of 67.4% reports of Subsyndromal symptoms. This numbers are significantly higher than the numbers in overall population. The author’s conclusion is the same as the prior: highlight the need for a population health approach to the prevention and treatment of mental health problems in students.

Therefore, the UFRN committee, having perceived the problematic in our campus as well, has been developing for two years the project “BeHappy”, which has the objective of promote mental health and quality of life in/on the academic environment through monthly activities, which occurs during the semester. Thus, there are two activities in doors, two “Happy Days” and a final meeting, when we receive a feedback from the students about the project.

The first meeting is round table with the students and five professionals: a psychologist, Physical Education teacher, a pharmacist, psychiatrist and a nutritionist. They take a broad approach about mental health, accessing themes as the demystification of mental disorders, adaptive actions in stressful situations and the rational use of medicine. After this introduction, the students can make questions and usually this section goes until the university closes, because the group is always amazingly interested.

On a second moment, we have the first “Happy Day”, in which we take the participants to the beach, where we foment activities, which promote social interaction, physical exercise, and discussion about the theme, music, thoughtful texts or poems and, at the end, a break to eat health food.

The third reunion is called “CineHappy” and aim to develop some specific theme about mental health. The participants watch a film and, just after, a psychologist join the team to enrich the argument about what they have seen. This moment in particular is always a enormous gain of knowledge, the film encourage dialog and relevant discussions, Reaching its peak when the students share their life experience.

The second “Happy Day” is held in “Parque das Dunas”, a ur-
The “BeHappy” project has received excellent comments from the participants and we have been seeing great improvements in these years. Most of the students have report significant change of habits to achieve a better quality of life after live the experience of “BeHappy”. Furthermore, the high administration of the university has been making partnerships with the project aiming to grow mental health awareness and develop quality of life inside the institution. However, we still have some difficulties with adhesion due to stigma that follows the theme.

Suicide is the second most common cause of death between the ages of 15 to 44 years. Studies show that in each 45 seconds, a suicide is committed in the world, totalizing, every year, around 1 million deaths. And, to every suicide, there are 30 failed tentatives of self-murder.

The youth is the most vulnerable phase of life to self-destruction thoughts. It’s a time that requires lots of changes and adaption to social, family, physical and affective matters. Uncertainty and challenges raise the anguish and anxiety of young people, making it hard to achieve a state of internal equilibrium. Juvenile suicide is a worrying phenomenon due to its magnitude and severity.

Although the alarming numbers, suicide is a taboo in contemporaneous society. The subject has been neglected by the governments, that invest more money in prevention of less incident disturbs. Concerned about this scenario, IFMSA Brazil’s local committee at Faculdades Integradas Pitágoras de Montes Claros (FIPMoc) held the project “Somos tão jovens” (We are too young), focusing on suicide prevention in young adults.

Suicide Prevention Among Adults

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The capacity building began with a training provided by a psychologist, who taught the volunteers to perform a technique called psychodrama. This is a method based in the use of drama to address psychological issues. The second part, conducted by a psychiatrist, helped the students to understand clinical symptoms and how different people deal with suicide.

The first activity took place in a writing course located in Montes Claros city, that prepares for the exam to be accepted into university. This place was chosen because the students were in the risk age group of suicide and also they were facing a stressful period of time. Approximately 200 students were present in the day and the mainly objective was to make suicide a
theme that must be discussed. The approach started with a presentation of the statistics, ideologies and thoughts about the suicide. A second presentation tried to impact the students, showing the perspective of suicide in different contexts: family, friends, society, media and the view of the person that commits suicide.

This way of approach increased the proximity with the public, since we were able to adapt psychodrama principles to a larger population. The results were beyond expected, because many students shared opinions about the theme, reported on about their closer friends’ or family’s suicide and contributed to the discussion. It was fundamental to show us and also the participants, especially those who have never witnessed suicide cases in dear people, about how much current this theme is, although it isn’t reported at media all the time.

The second activity attempted to show the importance of the free listening to lower the stress, as we created an “urban confessional”. This movement consisted in standing on the streets and simply listen to anyone talk about anything. Through the course of this action we realised that when we listen without judgment, we’re not only giving the other person permission to express themselves freely, but we grown our circle of compassion and become better people.

From these activities it was possible to promote the discussion and consensus about suicide, to emphasize its importance and the need to be better addressed by society, since until today is a subject treated with fear. Thus, presenting ways to identify signs that may be indicative of suicidal ideation, such as assisting a person who is feeling depressed or even talking about the topic is fundamental to provide help. Our perspective is that, with projects like this, people start talking more about suicide and its complications, helping the prevention of future cases.

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Toxi-Posium:
Poison Prevention Campaign

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Over the past few decades, our modern-day society has grown to the point where a large majority of commonplace formulations are not only readily available, but for the most part inexpensive. Be it various drugs, pesticides, herbal remedies, toiletries, or oils, the ease of access is a radical improvement in the quality of life of our community, but the increasing use of these everyday items has often masked their potential for abuse and harm, and that potential has made the common household more dangerous than it should be, particularly in our already-divided society. Readily accessible and normally beneficial pain medication is being abused to commit suicide through self-poisoning, particularly by domestically abused women of our society. Pesticides and various herbs
and plants are being used against family members as homicidal agents. A substantial proportion of poisoning has been unintentional, with infant and child poisoning occurring through easy access to bleach, detergents, mothballs, other such household items and even certain plants and flowers which may contain fatal active ingredients. Use (and possibly overuse) of certain drugs by mothers such as oral contraceptives can cause side-effects which may be long lasting, and pregnant women using teratogenic drugs without proper knowledge of its effects can cause harm not only to themselves but also to their unborn child.

In the light that poisoning is one of the most common causes of death in Pakistan, an initiative was taken by IFMSA-LMDC in a collaborative effort with the Forensic Medicine and Toxicology Department of LMDC to have a Poison Prevention Campaign consisting of two main activities, spanning from the 13th to 15th March 2017. The whole college was adorned in posters regarding the event.

On Monday 13th March ‘17 an awareness walk on Poison Prevention was done at Lahore Medical and Dental College (LMDC). About 120 students along with faculty members participated in this event.

The awareness walk aimed at advocating the need for poison prevention measures to be taken by the general public and how medical students can work towards spreading this awareness motto amongst others and highlighting specific ways to prevent it. Faculty members and students, held placards with various messages. The slogans had statements like "Tobacco companies kill their best customers", "Only take medication from Doctors prescription", "Don’t go for self-treatment, Children can’t eat what they can’t find,"Don’t let another light go out", "Think before you eat" and " Zahr say agahi , mein hai zindagi". The walk was featured in Dawn News, which coherently made the word reach the nation.

On the 15th March, 2017 a Toxicology Symposium took place in the LMDC auditorium with an attendance of approximately 200. The event started with a word of warm tidings to everyone by the Principal of LMDC and by the Head of Forensic Medicine and Toxicology, Prof.Aamir Bashir. Welcome notes were delivered stressing the importance of toxicology and the need to have such platforms of discussion.

The presentations commenced; starting from student presentations. Mahnoor Mohydin from LMDC presented "10 Famous Cases of Poisoning, with detailed cases on Mustard Gas and Cleopatra’s snake bite" and Hira from KEMU presented the relationship of age and gender in types of poisoning as seen from studying autopsy reports. Notable presentations were also done by esteemed Professors. Prof. Khalid Gill presented the psychological aspects of suicide. Prof. Zahid Bashir shed light on the toxicological analysis. The HOD of Forensic Medicine Prof. Arif Rasheed Malik discussed Alcohol intoxication. The HOD of Forensic Medicine from FMH Prof. Khalid Chaudry talked on kerosene poisoning. The Head of Pediatrics LMDC Prof. Rizwan Waseem on Child Poisoning and lastly Dr. Saad on dental cases of poisoning. There was a huge variety of topics, which enlightened the students and attending.

There were small video clips which were played in between the presentations which depicted suicidal, homicidal and accidental poisoning cases.

The Poison Prevention Campaign proved to be a success and will hopefully inspire further poison prevention measures and awareness activities.

The presence of more and more potentially harmful substances has made it all the more necessary to educate both students and members of the community of the dangers that these remedies and items possess, to increase awareness of different methods to manage such cases and provide care to the affected person, and to increase diligence on the part of the community on the handling and use of these substances. These considerations will surely pave the way to making our homes safer.
Choosing your smartphone may be a matter of budget, newness, functionality or ‘what’s cool now’. You may have enough money to buy the latest smartphone with the latest functionalities and its personalized case. Or you may not, and then you’ll buy a cell phone which will work just fine, but may not be as trendy and noticeable as you expected. The expensive, luxurious smartphone that is over $600 is not essential to survive. But what if you had to take the one medicine that keeps you alive and costs over $1000 a pill?

Medicines are a complex product. Drug development is both an exciting and risky process, which ends up in failure for most molecules tested by researchers all over the world, or in very specific cases results in a real innovation that changes the course of medicine and patients’ lives. The relationship between innovation and its products - medicines and healthcare technologies - with healthcare systems and ultimately its impact on health is the core of the Global Health Summer School, taking place in Barcelona in July 2017. The Barcelona Institute of Global Health (ISGlobal) and the Students’ Association of Health Sciences (Asociació de Estudiants de Ciències de la Salut), in partnership with IFMSA (International Federation of Medical Students’ Associations), hosted this unique learning opportunity in Barcelona, July 16th - 21st.

It started with a lecture by Hans Hogerzeil, a global health professor at University of Gröningen and member of the Lancet Commission on Essential Medicines. Students had the opportunity to learn and exchange experiences during our 5-day course. This year’s novelty was the introduction of ‘Participant Project Development’ sessions, where students created their own project on a specific issue around innovation and access to healthcare technologies, putting into practice key concepts and strengthening personal and group abilities.

As we were saying, medicines are not smartphones, yet they fall under the same rules as smartphones, cars or music when it comes to intellectual property rights: patent owners have exclusivity rights and determine prices. Newly approved medicines tend to have higher prices, which may not be a problem in high-income countries, but are out of reach in low and middle income countries. Clarke Cole (Access to Medicines Foundation) was invited as a guest speaker to our course, to enlighten participants on effective tools to measure access to treatment, and its implications.

Limited access to treatment is now a problem that affects high-income countries: high-priced medicines are threatening the sustainability of healthcare systems, who face rationing or increased pharmaceutical debt in order to make treatments accessible. During our course, Natàlia Pasqual (UPF Barcelona School of Management) explored drug pricing and reimbursement models across the globe, and the challenges encountered.

Are there ways to develop medicines that are both reasonably profitable for pharmaceutical companies but that are not a barrier to access? A session by Elena Villanueva, a global health advocate, was critical to understand the current research and development (R&D) model - its flaws, its limitations, its successes - and its alternatives. Furthermore, Carolina Bolaños gave us her insight on Public-Private Partnerships (PPP), initiatives both praised and criticized. Trade agreements are also controversial contracts between countries or regions, which may affect healthcare, especially medicines, as Jaume Vidal explained. Students brought in their own knowledge on R&D initiatives and worked on it during Participant Project Development.

The course analyzed the complexity of biomedical R&D, includ-
ing thoughtful elements on access to medicines in various environments and the role of healthcare systems. Their impact on health - and ultimately the state of welfare - has generated an increasing demand from civil society to governments to ensure that R&D results in affordable medicines. Back in the 1990s, lack of access to HIV medicines triggered what some now call the “access to medicines movement”. Our course has included two sessions on activism, one led by Ludmila Maistat (Medicines Patent Pool) on the recent campaigns for access to affordable Hepatitis C medicines. The other one, conducted by Irene Bernal (Right to Health Foundation), focused on the advocacy for a new R&D model. These sessions fostered an interesting debate among students, including sociology, history, and even bringing innovative thinking to the table.

The closure of the course included a public hearing of Participant Projects: the perfect conclusion for the Global Health Summer School. Hopefully, students left Barcelona with a meaningful understanding of how access and innovation in healthcare are intertwined and how they impact on health.

See you next year for a new edition of the Barcelona Global Health Summer School!

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**Dentistry in Rural India**

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We live in an age where comprehensive health care is considered paramount. No matter what the health care system in our respective regions is, no matter the level on which active measures are being taken to make comprehensive healthcare a reality around us, it is no doubt being recognized. Despite the failings and the inconsistencies of the Indian healthcare schemes at the rural level, there is more awareness now among the young rural population than there has ever been before; these people know that healthcare goes much more beyond simply physical well being and this knowledge might well be the impulse needed to usher in a new era of progress and betterment in the constant challenges that the medical fraternity faces in rural India.

Yet, despite all the advances and surges that have taken place, one can’t help but notice that oral and dental health care share a very small and often unnoticed part in all these happenings. Somewhere in the quest for positive health in optimum conditions, dentistry as a specialty has been completely sidelined. Many might say that this is not such a big loss, that there are more important and immediate health concerns than one’s teeth and though it is true that many patients present with more severe health concerns than oral health issues, it is by no means adequate justification to ignore the field altogether.

In innumerable ways, oral health status reflects the general health status of an individual. The mouth serves as a “window” to the rest of the body, providing signals of general health disorders. For example, mouth lesions may be the first signs of HIV infection, aphthous ulcers are occasionally a manifestation of Coeliac disease or Crohn’s disease, pale and bleeding gums can be a marker for blood disorders, bone loss in the lower jaw can be an early indicator of skeletal osteoporosis, and changes in tooth appearance can indicate bulimia or anorexia. These are just a few examples of what all a dentist can observe and diagnose just by examining one’s oral cavity. More relevant perhaps is the fact that 40% of cancers in India are oral cancers, the incidence being high in rural
areas where habits of tobacco and gutka chewing (the main etiological agents of oral cancers) are rampant. Imagine what change can be brought about in the morbidity and mortality rates due to oral cancers if the condition is diagnosed early by a dentist. Poor oral health, untreated oral diseases and conditions have a significant impact on quality of life. They affect the most basic human needs, including the ability to eat and drink, swallow, maintain proper nutrition, smile and communicate.

The lack of dentists in rural areas is possibly one of the main causes for this situation. The physician population ratio was 1:2,400 in 2000 and is 1:1,855 at present in rural areas while the dentist population ratio is 1:10,000 for urban areas and 1:250,000 for rural areas. This stark difference in the physician and dentist ratios give a clear idea of what the situation in rural areas is at present for those who seek dental treatment. That, however, is not the only cause. When the primary health care systems were implemented in the 1980s, dentistry was not adequately included. This has left oral health far behind other health services. Since there are no dentists in government decision making bodies, dentistry is at the mercy of medical professionals who usually take for their own profession the major share in the meager amount sanctioned by the government. The costs of providing services are high compared to other areas of health care, the workforce is very limited and the potential disease levels have remained high over the years. Statistics present the grim reality, that 95% of the population in India suffers from gum disease, only 50% use a toothbrush and just 2% of the population visit the dentist.

Thus, it might be better to say that dentistry is not just under-represented in current rural health settings, it is practically unrepresented.

There is no miracle that can be worked to change this scenario nor is there a magic spell to fix this problem. Dental health awareness and care has to be slowly, painstakingly and diligently introduced and established in rural India the way medical health care has been. Although there are efforts already underway, like those of the National Oral Health Program, we are far from achieving an acceptable level of health and well-being in the specialty and until the day comes when we can proudly declare ourselves self-sufficient and at par with international oral health care standards, our efforts cannot cease.

**AEDE’s Sheriffs**

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Dengue, zika and chikungunya are diseases transmitted by the mosquito *Aedes aegypti*. In Brazil the mosquito is very common because it has found favorable conditions for rapid spread. This is facilitated by the urbanization process accompanied by poor water supply and sanitation systems and by the lack of concern about the indiscriminate use of non-biodegradable materials, potential reservoirs for the development of mosquito larvae.

The World Health Organization (WHO) estimates that 80 million people become infected each year, in 100 countries, from all continents except Europe. We can, therefore, consider that these diseases represent a public health problem in Brazil and that the existing policies are insufficient for adequate mosquito control. With that in mind, raising the population’s awareness
has become a key point in this struggle.

The community chosen to be addressed was the one that resides in the region with the highest number of cases of Dengue recorded that month, according to the Municipal Health Department. The aimed population was a group of children (7-9 years) from a public school in the area. The objective of the project was to awaken the sense of sharing of information and actions with the purpose of promoting the social transformation necessary for the control of Aedes.

The training for the medical students interested in participating of the campaign consisted of a lecture, given by a professor of the Department of Medicine of the Pontifical Catholic University of Goiás, a biologist, epidemiologist with a master’s degree in environmental and health sciences. Initially, a dynamic and playful presentation on microorganisms, the mentioned diseases (symptoms, treatment, forms of transmission and prevention) and the characteristics of the Aedes aegypti mosquito was performed.

The children were divided into five groups for participation in five workshops. All groups participated in all workshops. The first was the "Water Workshop" where water was provided with beads - representing the eggs of the mosquito. In it, children should be reminded of the places that are likely to accumulate standing water and proliferation of larvae (vessels, tires, bottles, buckets, etc.) and remove water and "eggs". The second was the "Garbage Collection Workshop", where various materials were placed on the floor. Children should be aware of the possibility of water accumulating in the trash, so they should throw the trash in the bin and cover it. The purpose of this workshop was to emphasize the importance of throwing garbage in the trash, since, besides combating the proliferation of Aedes, it assists public health in general, being a measure that is more easily learned in childhood.

The third one was "Right x Wrong Workshop", where two circles (one red and one green) and several pictures were placed on the floor. The images represented attitudes that help or hinder the prevention of diseases. Thus, children should put the positive images inside the green circle, and those that hinder prevention, within the red. The fourth was "Kill-Aedes Workshop," where colored balls were given to each student and three boxes were placed, each with the image of a different mosquito, one of them Aedes. Each one should have his knowledge acquired in class, identify the characteristics of Aedes and hit the ball in his box, "killing him". Finally, the "SOS Workshop". In this one, four academics used plaques referring to a measure to be taken if the child was found sick by one of the three diseases addressed. Only one measure was correct (seek the doctor), while the others were wrong (self-medicate, not take water, etc.). Children should run and hug the student with the correct nameplate. At the end of the action, the kit "Looking for the Aedes" was made, with bonbons, a primer with the information passed in the action and the star of "Sheriff of the Aedes", concluding the "training" of the new sheriffs. With the realization of the "Aedes Xerifes Project", the promotion of health education in a school environment was achieved with the purpose of encouraging children to contribute to the prevention of dengue, zika and chikungunya. There was also the approach of medical students of the community, an enriching experience for the academic formation; The establishment of links between the medical students themselves, through IFMSA Brazil; Qualification of participating academics regarding the management of the mentioned diseases and their impacts on society; Incentive to critical reflection and clinical-epidemiological reasoning, allowing the medical student and medical future to be a health promoter in an integral way when acting on the different stages of the process health-disease.
Welcome to the World of SCORAngels!
Women in Science Have the Power to Change the World

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In consonance with the United Nation’s campaign, the February 11th is the International Day of Women and Girls in Science, consisting in a perspective of denouncing the discrimination of women and of promoting gender equality in all spheres of scientific knowledge. Similarly, UNESCO reckons the goal of reaching gender equality in education, science and culture up to 2030 as a global priority. When it comes to this topic, it is essential to understand what really means to reach women’s empowerment in order to guide students’ activism.

First, one needs to acknowledge that women’s capacity is historically undervalued in our society. In western civilization, the patriarchal culture imposes several rules to women, such as being in charge of child-caring and monogamic. Such context impairs women’s possibility to reach their full potential at work, in universities, in their researches and other social roles. This phenomenon begins in early childhood, when girls are often discouraged and disbelieved in terms of cognitive capacity, which might have consequences in their future professional choices.

When it comes to the scientific environment, it is important to have in mind that it is part of a western capitalist system. In this sense, despite of being possible to notice a progressive insertion and acceptance of women as a result of feminist activism, the myth of meritocracy and the false idea of gender equality are still reinforced in spaces such as the academia, great research centres and in several other professions. As a result, according to recent data only 28% of researchers across the world are women.

In such context of aspiring recognition in either the scientific or the professional career, searching for wage and recognition equity and exacerbated commitment to scientific productivity, many of women’s subjectivities and sensitivities are forgotten. In this sense, regardless of the current advances on gender equality in science, there is a need for further understanding some aspects of this topic.

According to this perspective, some questions need to be raised: who benefits from this never-ending search for scientific recognition that often causes mental disorders? How can one balance academic demands, child-caring and housework? How can social actors struggle towards a collective way of fighting against gender inequalities in science and men’s privileges in this environment? Who bear the consequences of low self-esteem when society insists on showing its failures and exposing sexist behaviours? How can women actually have their own researches, being properly recognised as scientists? When is this going to happen?

Against such backdrop, it is evident that one day is not enough to “celebrate” or even remember the women who achieve great professional and scientific success despite the strong sexism. We still need a lot of research, debate and women empowerment in order to deeply transform both current medical education and science. More than that, it is essential to further understand the social structures which sustain the predominance of a sexist science, the maintenance of gender roles and the violence against the mental health of those women who are resisting. Therefore, we need to resist and to withstand, so that these commemorative dates do not need to exist anymore.
The Gender Equation: An Initiative to Fight Gender-Based Violence in Lithuania

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LiMSA SCORA has been working with a lot of relevant topics this year, including raising breast cancer awareness, HIV stigma, extensive sexuality education including full training of LiMSA members as well as lectures on better communication with LGBTQ+ patients. However, there has been one SCORA focus area which has not been properly explored since the establishment of our NMO, which is gender based violence. We believe it is crucial to discuss it as the gender roles are deeply rooted in Lithuanian culture, and this issue has lately caused many debates in both LiMSA and general society. In order to make a change, we’ve gathered a working group of 20 SCORAngels that were passionate about the idea. In the end, we have developed a series of events that we have called “The Gender Equation”. The aforementioned events were open not only to members of our NMO, but the whole society as well.

The first event was a public lecture called “Feminism 101”, held in a popular local café. We invited a famous lecturer of Vilnius University, whose main research focus area is gender studies. The lecturer explained the common myths and misunderstandings beneath the word “feminism”, talked about different types of feminism and also emphasized how gender roles harm not only women, but men as well. The café was packed with dozens of people of different age groups, and for those who could not make it, a chance to listen to the lecture was provided through Facebook Live. This event was the one of the most popular SCORA events ever in Lithuania as it reached over 2500 of people in a course of only a few hours. We believe this clearly illustrates the need of more discussion regarding the topic.

Afterwards, we organised self-defense courses following the example of other NMOs in Europe. While LiMSA continues its quest to diminish the rates of gender based violence in the future by providing sexuality education to every school that requests it, we also tried to make a difference in the current situation, as many people nowadays are subjects to both catcalling and sexual violence in the streets. The course was free and open to people of every gender; we received over 50 applications. It consisted of a theoretical part in which the instructors explained the basic principles of self-defense. After that, the participants had to put their knowledge to practice, simulating the situations that may occur in their daily lives.

Last but not least, an interactive discussion was held in Vilnius University with a renowned activist for gender equality, who is a specialist in the non governmental organisation Centre for Advancing Equality. The discussion focused on the domestic violence that can occur in any relationship, and not only in physical, but in a psychological form as well. Ways to provide help if one suspects a person they know is subject to domestic violence were also analysed extensively. The event attracted not only medical students, but also those of various other specialties and the issues on the topic were analysed with every member of the audience, providing their input into the discussion.

All in all, there is still a lot to be done relating to gender based violence in Lithuania, but we believe that “The Gender Equation” has made an impact on the way at least a part of society views the current situation (with about 2600 people reached either through live participation or internet). We firmly believe that every person counts when talking about this focus area. Although the event was originally targeted at students, there were plenty participants of every age group and occupation, which only further proves that gender based violence is important to everyone regardless of their gender, age or any other aspects. Next year SCORA will focus on even more ways to fight gender based violence and we hope that this initiative will continue to grow.
Maternal Health: From MDG-5 to SDG-3

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Background

The Millennium Development Goals (MDGs) were introduced and agreed on at the United Nations Millennium Declaration Summit in September 2000 with 189 countries, including Nigeria as signatories to the agreement. The eight MDGs had 18 Targets and 48 Monitoring Indicators with intentions that all will be achieved by the year 2015[1][2]. Three of the eight MDGs are directly related to health. These include Goals 4, 5 & 6. Most other MDGs relate to health in a broader context, in particular Goals 1 & 7.

MDG 5: Improve Maternal Health

Country context: Nigeria

In Nigeria, statistics show that the country has a high level of maternal mortality. With about 800 maternal deaths per 100,000 live births, Nigeria records about 37,000 maternal deaths annually, the third highest in the world (WHO, 2004). According to the National Health and Reproductive Survey (NHRHS 2003), the proportion of urban mothers (59%) that were assisted by skilled attendants at delivery was more than twice that of rural women (25%).

Progress on Goal 5 has been measured accordingly based on these indicators:

- Maternal Mortality Ratio (MMR)
  From 1000 deaths per 100,000 live births in 1990, the MMR consistently decreased over the years to 800 in 2004 and 545 in 2008. The downward trend continued to 350 deaths per 100,000 live births in 2012 and subsequently to its end-point status of 243 per 100,000 live births in 2016[6][9].

- Proportion of Births attended by skilled health care attendants
  Proportion of births attended by skilled health personnel improved appreciably from 36.3% in 2004, 38.9% in 2008 and 53.6% in 2012 to the end-point status of 58.6% in 2014[7][8].

- Contraceptive Prevalence Rates
  In 2004, only 8.2% of women within the stated age bracket used contraceptive measures for family planning. The percentage increased to 14.6% (about 78% increases) in 2008. It appreciated further in both 2012 (17.3%) and 2014 (18.5%)[9][10].

- Adolescent Pregnancy Rates
  Adolescent fertility rate (15-19) stood at 74 (per 1000 live births) in 2014 which was a decrease from 79 (per 1000 live births) recorded in 20128. This value was then measured as 122/1000 live births [DHS 2013].

- Antenatal Care Coverage
  In 2008, only 8.2% of the pregnant women attended antenatal for one visit while 44.8% attended for at least 4 visits. In 2012, 66.3% of them attended for at least one visit and 57.8% for at least four visits. The record in 2014 was that about 25% of the women that were pregnant never attended antenatal visits. At the same time, 68.9% attended at least once while 60.6% attended for four times and over[7][8].

- Unmet Needs for Family Planning
  In 2004, there were about 17% of women who had unmet needs for family planning. They increased to 20.2% in 2008, 21.5% in 2012 and 22.2% in 2014[8][9].

- Policies and Programs
  Primary to this success story were the following notable measures:
1. Implementation of the Midwives Service Scheme (MSS) and Village Health Workers Scheme (VHWs)
2. Adoption of the independent monitoring and evaluation system (FPN and OSSAP-MDG);
3. Partnership with unilateral, bilateral and multilateral development partners and the FMOH;
4. Engagement of faith-based organization in delivering child-spacing services, especially for Northern Nigeria;
5. The “Saving One Million Lives” Initiative;
6. Active participation in Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA);

Major areas of interventions were Family planning, engagement of skilled birth attendants (SBAs), Emergency obstetric and newborn care (EmONC), Universal coverage of antenatal care and post-natal care and an improved referral system.

Extent to which SDG 3 built on strength and weakness

The SDG 3 has been kicked off adequately by continuing with the unfinished business of the MDG 5 hence merging it with SDG 3. Adoption, institutionalization and consolidation of best practices that have emerged from the implementation of MDGs in the post-2015 development agenda, some of which includes:

1. Strengthening institutional frameworks and sustaining intergovernmental partnership;
2. Sustenance of an adequate M&E system;
3. Updated design of means of Implementation for the SDGs
4. Task shifting and sharing policy;
5. Provision of maternal health care services for the vulnerable population;
6. Data evolution;
7. Active engagement and commitment with international development partners;
8. Renewal of the commitment by the Federal Ministry of Health to increase CPR from 15.1% in 2013 to 36% by the year 2018;
9. More vibrant inter-sectorial relationship with non-health sectors in planning and prioritizing SDGs targets.

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9th Grade. Biology class. Chapter on human sexual organs. The teacher conveniently skips the chapter and moves on to the next one.

This is the current scenario of Sexual Education in India.

We choose to live in a bubble and believe there’s no such thing as sex, masturbation or child sexual abuse. Our school curriculum does not include sexual education and most Indian parents shy away from talking about it. So where do we expect our children to go to when they are curious? The internet today is full of information which is more wrong than right.

In a recent survey, commissioned by the Indian Ministry of Women and Children Development and carried out by UNICEF, interviewed 12,247 children and 2324 young adults in 13 Indian states. The study revealed that a shocking 53% of children between the ages of 5 and 12 have been sexually abused. Most often this abuse was perpetrated by parents, legal guardians or close members of the family. Further, the study disturbingly notes that more than half of all cases of sexual abuse and rape go unreported.

Educating children about their bodies and sexuality in an age-appropriate way can go a long way in helping them understand the difference between sexual and non-sexual touch. Such education can help children escape the guilt and fear that often accompanies sexual abuse and empower them to report previous or ongoing abuse. The current scenario of sexual education is depressing. This is reflected by the lack of knowledge about sex and sex related issues among young adults. Therefore, by targeting the pre-adolescent and adolescent age group we want to make sure that the next generation has better and complete knowledge of sex related issues from the right sources.

In light of overwhelming evidence that there is rampant sexual abuse of children in India and strong suggestions that sexual education for children can reduce the incidence and severity of sexual abuse, we at SCORA India organised a SWG to create content that included various topics of comprehensive sexual education that could be delivered to the government school children. Thus, our content was created keeping in mind the age group of 10-12 years. We chose government schools because it had students coming from lower socioeconomic classes. It is these children who are deprived of other sources of information and neither their parents have the time nor the knowledge to educate their children about these issues. The topics covered included basic anatomy of the body, pubertal changes, basic concept of intercourse and difference between good touch and bad touch. PowerPoint presentations, pre- and post-event questionnaires and pamphlets to be distributed to the children were de-
signed. The content creation was complete in a span of 3 weeks. We now decided to do a run through to find out the response we would get from the school authorities and the students. We initially faced problems getting permission from the authorities about such a sensitive issue. Finally, we found a school which was happy to have us. The seminar was delivered with the help of audio visual aids and we got a remarkable response.

However, my entire team and I noticed a girl in the class noting down the child helpline number and trying to hide her tears. This is what I had been fearing. We were not fully skilled to deal with a case of child sexual abuse. We informed the school authorities and they let us talk to the child one on one. Initially the child was very hesitant in saying anything but after a while she finally opened up. Her story was heart-wrenching and the fact that her parents were not listening to her made it miserable. She told us the abuse has stopped now and she hadn’t seen the man in a lot of months. We discussed this with the school authorities and made the girl understand that she could approach her teachers if anything like this happened again. It is such stories that make us want to work harder towards our goal.

We are currently working on training our team to deliver a better seminar and deal with various kinds of situations that they may face.

We dream of a day where no child suffers from depression and isolation due to pubertal changes and where every child can protect themselves from sexual abuse. We know this is not going to be easy but it’s going to be worth the try.

The Struggle for Our Sexual Freedom

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"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," according to the World Health Organization. But in the 21st century can we achieve this ideal of health? When we take this strand into the realm of sexual and reproductive rights, we face a society with a prejudiced and archaic view, which most often does not respect diversity and chiefly perpetuates with the idea of the heterosexual couple surrounded by children, in which the wife must always take care of her husband. Is this ideal that everyone wants? Besides, do we have the right to reproduce or not?

Reproductive and sexual rights are part of the broader set of human rights, which, since the Universal Declaration of 1948, are considered universal, indivisible, interdependent and interrelated. Primarily, it is important to differentiate them: sexual rights cover human rights that are already recognized in national laws, international human rights documents and other agreed statements. They include the rights of all people, free from coercion, discrimination and violence to attain the highest standard of sexual health, including access to sexual and reproductive health and care services. The right to information related to sexuality, sexual education, respect for bodily integrity, choose their partners, decide to be sexually active or not; having consensual sex, consensual marriage.

As far as the reproductive rights are concerned, they punctuate the capacity to reproduce and the freedom to decide when and how many times to do it. Implicit in this latter condition is the right of men and women to be informed and to have access to efficient, safe, acceptable and financially compatible methods of
family planning, as well as to other methods of fertility regulation of their choice and that does not contradict the law. Reproductive health provides the freedom of anyone to have their planning and in addition not having to necessarily reproduce just for a social issue.

Despite all the freedom we have struggled to achieve, we cannot neglect the role of the state in combating the spread of sexually transmitted diseases. Such control is of paramount importance for safe sexual freedom. Until 2025, the UN will have implemented measures not only to increase the capacity of women and adolescents to protect themselves from the risks of HIV infection, especially through the delivery of health care services, including sexual and reproductive health, but also by teaching prevention to promote gender equality within a framework that takes cultures and genders into account. This idea is important, not only health, but for the reduction of the discrimination that involves AIDS.

HIV - the human immunodeficiency virus - was responsible for countless deaths, especially in the 1980s. Today, with the great advance of medicine, it is possible to alleviate the symptoms, however the cure has not yet been discovered unfortunately. It is important to distinguish that having HIV is not the same as having AIDS. There are many HIV-positive people who live years without presenting symptoms and without developing the disease, but they can transmit the virus to others through unprotected sex, sharing contaminated syringes or mother to child during pregnancy and breastfeeding. Therefore, if there are advances in sexual health, we will have progress in combating STIs - Sexually Transmitted Infections.

We know that the adoption of a democratic perspective on right to sexuality does not automatically solve tensions about reproductive health and egalitarian sexual rights because this is mainly due to the patriarchal society to which we are inserted. However, it can provide a theoretical and legal framework for public debate, public policy design, legislative proposals and judicial decisions on sexuality. We know that the world must accept the differences and respect them, the sooner this happens, the more democratization of rights will take place.

The Hills of Wonderful Feminine Sexuality

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I could say that I remember being the little girl who asked questions like: where do we come from? How are babies born? My parents always told me the truth about how a baby is born, while other children were told by their parents’ wonderful stories about bees, storks and birds, even if it sounds crazy and unreal. But, the most magical part in my stories was what my parents called love. It took me a few years to discover a book called “The Art of Sexuality and Love”, that lead to ask myself: does all sexuality depend on conception? Because that book did not show it like that. And this is something your parents will not teach you, not even your school.

Parents and teachers use so many words to describe a common human act as sex with “birds”, “mama beard, papa beard”, “the flower” What was going through their heads? Why it is taboo to talk about something they might do every night? Or were they simply afraid that their children would ask something else?

Then, I came across to the fact that I’m a woman too. I had to eventually find the man of my dreams, and I shouldn’t accept whoever came. But I knew that before. Women have a special “feature” or at
least, that is what we have been told since the industrial revolution: "We are better women among the less couples we have." I’ve heard the idea that women are locks and men keys, and that a good key can open all the locks, but a lock that is opened by all the keys or by more than one, is what is called “an easy one”. This is what society has taught us, since exploring our sexuality and not to conform ourselves, is frowned upon. But when have we been able to do so? Are we stuck in the “sexual liberation”? We have been educated from girls with “mothering” as the center of female sexuality. But is it all part of it?

But what is the problem with female sexuality?

• We begin by understanding that we have something in the groin that does not hang us and we do not know what it’s called until we name it sometime in school or start getting blood out of there, and call it vaginal ignorance. But that is not the beginning of pleasure for a woman. Actually, as Helen Deutsch says, “the vagina does not perform any erogenous function until the first sexual intercourse”.

• Everything concerning femininity is the essence of masochism. As Lacan says, life of the woman is dominated by a masochistic triad: “castration - rape – childbirth”.

• The Oedipus phase in women, but not electra, mentioned by Freud. The girl moving away from the mother grows with the desire to have a child of her father, showing the first signs of eroticism. Seeing her father as protecting her and identifying with her mother, wishing to take her mother’s place. She realizes that society does not accept and repress for the first time his sexuality. The girl not only renounces the father, but also retracts her female role.

• Nature endows the woman with the gift of creation (motherhood), but that does not compensate for the wishes she had as a child. There is a space between being a mother and being a woman, and the organ should not be confused with sex.

Living in a masculinized society does not allow women to live their sexuality, given that we live in a world where sexuality is just sex. That is why SCORA raising awareness campaigns, activities to empower women and girls are needed, not just in Ecuador, but worldwide.

Let’s Talk About Pleasure

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Sexual history taking is complex but we believe it is an essential part in providing sexual and reproductive health care. It takes lots of practice to gather the confidence to approach a patient and ask questions such as: “Do you engage in sexual activities?”, “Do you use any protection? And contraception?”, “How many sexual partners do you have?”, “When was your last HIV test?” and as we have managed to include these questions in our doctor-patient-communication, we have opened the doors to inform our patient about the risks of STIs, the importance of protection and how to prevent unwanted pregnancy - in short: how to keep safe and healthy in sexual terms. We can give ourselves a pat on the back!

But aren’t we missing something?

As the WHO stated in 2006, “sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences”[1]. In WAS Declaration of Sexual Rights, sexuality is recognized as “a source of pleasure and wellbeing and contributes to overall fulfilment and satisfaction”[2].
While we are well-educated in paying lots of attention to our patients’ risk-profiles, we lack to address sexuality as a pleasurable experience and as “a central aspect of being human”[3] that contributes to a person’s physical, mental and social well-being.

Doesn’t sexual pleasure as one of the main motivators for sexual activity deserve more attention?

In order to fill this gap, the so-called “pleasure-approach” was developed and introduced by the Global Advisory Board for Sexual Health and Wellbeing (GAB) in 2016. According to GAB, there are six key enabling factors that make pleasure a great contribution to the protection of sexual rights and strengthening of sexual health: self-determination, consent, safety, privacy, confidence and the ability to communicate and negotiate sexual relations. These aspects should be taken into account as a whole to ensure comprehensive sexual health care.

The risk-based pattern of approaching sexual issues goes along with seeing sex as a danger to people’s health. It warns about the aftermath of unsafe sex while grading sexual activities on a scale from low-risk to high-risk. This reinforces the traditional and normative perspective that assesses risk by sexual preferences (e.g. “gay men are at high risk”) and not by actual behaviour (e.g. use of condoms).

Whereas the risk-based approach focuses on the prevention of negative consequences of sexual activities, the pleasure-approach wants to provide an open-minded and holistic view on sexuality with the focus on ideal (that is safe and consensual) sexual experiences.[4]

Choosing the pleasure-approach over the risk-based approach does not mean to neglect informing about STIs and safe sexual practices. In fact, it is supposed to be a “key ingredient for people to practice safe sex and use protection” and hence becoming a non-negligible aspect when talking about sexuality in health care settings. It is a way to find new entry points to the interview, assessing the physical and psychological enjoyment by setting up a tailored “brief sexuality-related communication” (BSC)[5]: asking reflective and pro-active questions, addressing needs or concerns, reasoning without pre-conditioned and stereotyped opinions.

“Is your sexual life going as you wish? What would help you to feel safer and satisfied in your sexual relations? How do you and your partner feel about condoms? Do you have any other sexual partners at the moment? How would you mark your self-determination in engaging in sexual activities from 1 to 10, what would help you to achieve a higher score?”

It is about changing our attitude and dialogue towards sexuality: “from fear and shame, to the factors needed to achieve sexual satisfaction, happiness and fulfilment”.

And what does all of this have to do with medical students? Besides the fact that we will be in this interviewing position one day, it is also a chance to acknowledge our social responsibility.

We can start with our role as sexual educators, since most of our programs - even if effective - are based on a risk-approach to motivate people to practice safe sex. The positive approach teaches us that safer sex and pleasurable sex are not mutually exclusive. There is growing evidence that promoting sexual pleasure alongside safety messages increases people’s awareness of the importance to ensure their sexual and reproductive health and rights.[6]

It is also a chance for us to get closer to our patients and recognise them for what they are: humans, living their own unique pleasurable sexuality.

References: Please click here.
Throughout the course of history, commercial sex workers (prostitutes) have always been the target of moral opprobrium.[1] As a social marginalized group, their healthcare routine is limited. They often only attend to health centers when diseases decrease their ability to sell sex.[2]

The main health concern about sex workers is their increased risk of sexually transmitted infections (STIs). This risk is reduced by the use of condoms, an inconsistent practice, since the clients encourage unprotected sex.[2] Other problems associated with prostitution are substance abuse, mental health concerns, such as self-destruction behavior, chronic diseases and extensive violence including physical, emotional and sexual abuse.[1]

Intrigued by this scenario, IFMSA Brazil’s Local Committee at the Faculdades Integradas Pitágoras de Montes Claros shot the documentary “Filhas do Preconceito” (Daughters of Prejudice), aiming to increase public awareness about the reality of sex workers in Brazil.

The project was conducted through visits to places where sex workers live. We obtained contact with the professionals through “GRAPP” - Group of Support to the Prevention and the Bearers of AIDS, a group that develops projects and provides support directed to this public. Since this institution has contact with these women, we have been able to develop the “Daughters of Prejudice” project more effectively.

Thus, five visits to these professionals were initially planned, to be carried out only by project coordinators and GRAPP professionals. During the visits, the interviews were made and filmed after signing the consent form. The filming sought to preserve the anonymity of these women. Therefore, a white fabric was used as a way to mask their identities, and the interviews were carried out only by the coordinators of the project.

After the interview phase, the participants were invited to perform the Pap test and colposcopy at previously scheduled dates. For the accomplishment of the colposcopy and Pap smear it would be necessary about 8 volunteers to do anamnesis, physical examination and to assist the collaborating physicians in the project in the accomplishment of the gynecological examination. For that, these medical students would receive the qualification, given by a doctor or psychologist, on how to approach sex workers. About fifty women were scheduled to attend, offering them additional psychological support if necessary. The documentary was edited by volunteers of the journalism course. When it was done, the final product was exhibited in a movie session to medical students and released on YouTube afterwards.

Although the objectives set at the beginning of the project were not all attained, the results obtained were very good. Non-adherence to medical care was justified by the fact that the women interviewed were already accustomed to making use of the care of the basic health units close to their residences.

On the other hand, the documentary was made with rich content. The women felt secure, because of their anonymity, to open up and talk about their lives and their professions. Medical students became very interested in the subject, which was confirmed by the great search for vacancies in the Documentary screening. The discussion afterwards was mind blowing, tackling the reality in which sex workers are inserted and their lifestyle were debated. Therefore, suggestions were made to increase their access to healthcare.

References:
Not Every Family Heirloom Is a Gift

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As a child is born, they are exposed to various means of information throughout life. This knowledge molds the child into the person they will be one day. We all have various sources of information that cater to our daily curiosities and help us formulate our own versions of wrong and right. Besides schools and colleges, internet, newspapers and magazines remain competent and extensive sources of information in most countries. In India however, even today a lot of families abstain from sending their children to school. In such families who have no access to the internet or books, the teachings of the elders of the family circulate from one generation to the other and form the most irrefutable, revered, sacred and most of the times, the ONLY form of education. While a lot of ancient knowledge such as about herbal medicine, mythologies, metallurgy, ancient traditions and culture is very enriching, a lot of it could be very hazardous.

1. “Feeding the child with nutritive food, counters the need for any vaccinations.” Because of this belief, a lot of families do not give the newborn necessary vaccinations. According to them, resorting to artificial means of protection reflects the family’s inability to provide for the child. This not only is very dangerous for the infant but also forms a huge constraint for disease elimination and eradication programs devised by the government.

2. “Using Contraceptive Pills will reduce the chance of conceiving a male child once the pill is stopped.” The desperate want ONLY a male child, and this still persists in some parts of India. Because of this belief, people abstain from using contraceptive pills. This adds to the ever-present problem of overpopulation in India and decreases the quality of life of the children that are born. It is also known to deteriorate maternal health due to a large number of pregnancies.

3. “If a child is not born by the natural way i.e. by cesarean section, he will grow up to be unhealthy.” Due to this belief, families opt against a C-section even during an emergency. This has led to various complications or even deaths of the mother and the child. Furthermore, a child born by conducting a cesarean section is stigmatized.

4. “If the mother consumes iron supplements during pregnancy, the baby will be born dark.” Many places in India, fair skin is directly associated with beauty. Many such direct relations are said to be present between the mother’s diet during pregnancy and the color of the baby. Because of this, the mother is deprived of many essential nutrients that are required for a healthy infant. And is later blamed for any ‘faults’ in the appearance of the child.

I have listed just a few false beliefs, related to Obstetrics and Gynaecology but the list is alarmingly large and is present in all fields of medicine. Although the government has been striving to spread health care resources even to the most remote areas, such resources are being underutilized due to such false beliefs. This has continued to be an impenetrable obstacle in healthcare development and furthermore widens the problem of Intra-national healthcare inequality.

While tackling this problem could be tricky and demanding, it is a hindrance that needs to be addressed. Firstly, it has to be dealt with a great deal of sensitivity for the local heritage and traditions to obtain cooperation from the target audience. Education should be imparted laying special emphasis on the harmful effects of such practices. Even though the elders of the society can be obstinate, children being more impressionable and flexible would be better receptive to such knowledge. This subject could be discussed in schools and for those kids who don’t go to schools, educational camps could be organized by the government or NGOs in villages. Such a process could be very tiresome and the effects could take a long time to be seen. But until this problem is not tackled at the very primary level, further development in the field of medicine in India could prove to be futile.
SCOREview

Did you ever wonder what SCORE Exchanges are all about?
Building Better Physicians Through Exchanges

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In an era where new information is constantly overcoming previous consolidates knowledge, learning only from textbooks has become obsolete as well as knowing just how medicine is practiced in your graduation country is no longer enough. With a globalized world as ours, medical practice is increasingly more interconnected, posing a challenge for new practitioners. That is why SCORE, the IFMSAs research exchange program, is so important for a complete medical student graduation, once it is a way of knowing how medicine is practiced abroad.

The sole idea of visiting another country always made me thrilled, and to have this opportunity linked to a learning program was just overwhelming. That's the way I felt about the IFMSAs exchange programs since I entered the university, and it took three semesters to this great opportunity become a reality. What also made this SCORE exchange special was the fact that being from an underdeveloped country I would have the opportunity to get to know how the basis of medicine worked in one of the most prominent countries in the scientific world, Germany.

The project I wanted to participate in was available in Jena, a small university city in East Germany, being called “Metabolism of membrane sphingolipids during inflammation and sepsis”, a branch of the Center for Sepsis Control and Care (CSCC), the biggest center of this area in the country. My tutor had this initiative in motion for over 15 years, which consisted in the research of determined blood markers and the role they played in septic patients and their future outcomes. It really was a great opportunity for me to get involved in a project that had already made important contributions on the understanding of such deadly, and yet still common condition.

As a third year medical student with no previous laboratory work experience, my exchange in Jena was proposed in a way to interact basic science with the work that was carried in the facility. In that way, the starting point was to get up-to-date with some of the latest papers in the field in order to posteriorly design my own practical course, where I could put in motion what I learned about the subject. After establishing the methods, the practical work began with cultivation of a previously frozen line of human hepatocytes, which were then further stimulated with cytokines to simulate sepsis and also inhibited with chemical compounds to analyze enzyme activity. An analytical part followed the processing of the cells, where I got the chance to learn about Thin Layer Chromatography (TLC), a technique used to analyze and quantify lipids.
There was not one single day during my stay in Jena that I did not enrich my knowledge, not only in medical sciences, but also in the cultural and linguistic way. The opportunity to know how basic science is carried in a developed country showed me new paths that I wouldn't be able to know just by staying in my university in Brazil. It also caught my attention to the possibility of choosing the path of molecular medicine as the one to be followed after graduation. Moreover, this travel also provided me with the chance of getting in touch with people from all over the world, who happened to be building their thesis at the Jena’s University, being that an opportunity of making new friends and also improving communication skills.

There are not enough words to describe how SCORE contributed with my academic development, not to mention the personal gain made possible by all the cultural learning when visiting different cities during my stay in Europe. Jena was a lovely city, the local committee made me feel at home, my project was amazing and my tutor was just the best. This was certainly one of the best months of my life! I’m looking forward to my next exchange experience!

Winter in Finland

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When I told my parents and friends that I had chosen Finland to spend a month in an academic exchange all of them asked me surprised “Why Finland?”, not understanding why possibly would I be interested to go there (and even the doctors at the University of Helsinki asked me that). I am really happy I did this unusual choice, and hope I can share a bit of this wonderful experience in this report.

As a Brazilian guy not used at all with cold winters and that had never seen a snowfall before, going to Scandinavia in December was certainly an unforgettable experience of many first things in life. First snow, first time ice-skating, first time skiing, first time using more than two layers of clothes. Getting to know this completely new way of life was certainly one of the highlights of my exchange. And the greatest thing was that I’ve experienced all of this as a local, living there an entire month, and the students that received me were always very helpful and patient since before the exchange started when I sent them many questions that probably made them laugh such as “Can you help me understanding these winter clothes?”. But it all went well and no fingers frozen.

The academic aspect of the exchange was also what drove my choice. I wanted to get in touch with something that was done very different compared to the Brazilian reality so I could learn from a successful experience. And that’s why I’ve chosen to spend a month on the Liver and Kidney Transplant department of the University of Helsinki, as Scandinavia has one of the best transplant systems in the world, very different from the Brazilian one that faces a lot of challenges and is still developing slowly, although there are also some great transplant centers in Brazil.

The experience in the Transplant team was very enriching, as I was able to participate in multiple activities that happened there. I could follow the coordinators work (those responsible to organize the system logistics) and to learn how the Scandinavian transplant system worked since its core organizational idea. In addition, I participated on the medical rounds, team discussions and surgeries, getting to know a lot about
liver and kidney transplant from the pathologies that lead to the transplant indication to the post-op complications and long-term immunosuppression. Nevertheless, the highlight of my academic experience was certainly being able to join an organ harvesting from its beginning when the initial contact with a distant hospital was made, and in the end travelling with the surgeon’s team to participate on the kidney removal surgery in the middle of the night in a city hour away from Helsinki. And as they needed help I was actually able to scrub in and join the surgical procedure. It was a thrilling experience that I never expected it was going to happen during my exchange.

Concluding, participating on this IFMSA exchange was certainly a great opportunity not only academic but cultural as well. This exchange format allows you to go to places and meet people you would not have the opportunity by traditional exchange formats. A big positive aspect of the program is its focus on practical activities, giving you flexibility to participate on what you are interested at, complementing our medical formation on subjects we are interested on getting to know. Also, it allows you to get in direct touch with the health system and reality of the country you are visiting. Understanding and experiencing the Finnish transplant system and the country culture was a very positive exchange experience.
My Research Experience in Germany

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When you think of quality education, a country that comes to everyone’s mind is Germany, so in this very natural way I have chosen this charming country for my research exchange with the idea that I would have a lot of study in my way. Thus, I was selected for the Department of Neurology at Heidelberg University in February of 2017 with a research on the Identification of autoantibodies in neurological diseases that I had chosen because I have a special connection and a big curiosity with neurology. Aroused by a large number of books that I have already read and subjects that I have studied at the medicine university, and as said, the renowned neurologist Oliver Sacks “A disease is never only neurological. It’s emotional, it’s human, it affects the family, society.”

Cultural shock is inevitable, even though I have already traveled to Germany, the experience of studying at a German university is extremely different than tourism. After all, it is literally enter into their culture and to follow correctly their rules inside a institution. I admit that we have certain stereotypes of the Germans, mainly related to punctuality, which is true and we can check it when using public transport, for example. I was waiting for a German tutor, but surprisingly he was Dutch, Dr. Caspar Grond-Ginsbach, of whom I have much to thank for the teachings and wisdom. He was always very attentive and he gave to me freedom with my work, showing me that sometimes it is better to stop and to restart better in the next day. He also put me on a project on molecular analysis of inbreeding in patients with stroke, with this, I have learned to use tools in computer to create new data from other studied, so an unpublished data. So the experience of dealing with such a new science shown to me, a young student like myself that there is always a possibility of discovering something original.

I was charmed with the possibility of being able to help my tutor, after all, I felt part of his team, because I gained freedom in the rhythm of my work, we always discussed the progress of the same, what I expected from the project, what he expected the results and also I had contact with other team members, a neurologist, a clinical analyst, a psychologist and a physicist, all German. In addition, my tutor always encouraged me to explain in a few words my study so that I could improve my ability to synthesize. In this way, every time that we met a new person I would introduce my research with the supervision of my tutor. Inside my internship I went to the ICU to make a daily visit with the neurologist and his team, I could see patients who had stroke with symptoms that I had never witnessed, which cooperates strongly in my medical training.

Although I have described a lot of my internship, I have to be honest about the reception I had from the local BMVD committee, we had a few moments of reappraisal and the ones we had were clear that there was not much interest in the exchange student, in this case, I. So I have nothing to say about them and my integration with medical students from Germany.

Finally, I made friendship with my tutor and his team that is fascinating to me. The experience of creating link with my co-workers enrich for my journey. I keep in contact with them until today and I have with me in my heart and in my house souvenirs that they gave me. I can still say that much sapience that they have taught to me, especially on the importance of moments of relaxation, even in the face of serious research.

In my opinion, every college student should have this experience of studying his area at a serious institution in another country. After all, as a quote from the father of psychoanalysis, Sigmund Freud, says - “We are not only what we think we are, we are more, we are also, what we remember and what we forget, we are like words we change, the mistakes we make, the impulses to which we yield, ‘unintentionally’.”
Doctor of Medicine... and Science? Why Research Is Important for the 21st Century Medical Student

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Let’s face it: despite how awesome our dark blue family is, students participating in IFMSA exchanges generally tend to choose SCOPE over SCORE (or at least in my NMO, that has been the trend for the past few years). This disappointing statistic is however not surprising: except for a few regions such as the United States of America and Canada, most students across the world enter medical school right after high school, which leaves them little time to learn about what research is about compared to students who have completed an university degree. Furthermore, because the medical curriculum is designed to train physicians and not scientists, there is little emphasis put on the basic sciences given the sheer amount of information that medical students need to retain for their future profession. In this context, it is generally difficult for students to see the pertinence to get involved in research, and even more so if the topic is about this pathway or molecule that was mentioned once in their pathology textbook.

I want to advocate that having research experience as a medical student is not only beneficial but essential in our future careers as medical professionals. While I do acknowledge that research is extra work and that not necessarily meant to be part of every physician’s practice, there are several advantages to knowing about research methods and basic sciences:

1. Having experience in research will help you better assimilate articles you read and provide you skills to criticize methods and findings. Medical schools usually offer little teaching on understanding scientific articles, and simply reading the abstract, as most medical students do, offers meagre information on what the research is about. It is essential as medical professionals to rely on evidence-based medicine while staying critical about the science we read. Also, most rotations do have some form of journal club or presentation session, so knowing how research works will aid you in preparing for those sessions.

2. Working in research can inspire new medical innovations and help you bring those projects to fruition. In an era of exponentially growing technologies, research is the basis of advancing medicine whether for new molecular discoveries, therapies or methods in medical education. Research teaches how to test out ideas in a rigorous, universal manner that will convince the scientific community of the value of your claims.

3. Getting involved in research projects will give you further insight on medical topics that have been glossed over in class. Research topics are generally very specific, and while it can seem purposeless to learn about something you might never encounter, having extra knowledge is never a negative thing. Who knows, that might be what distinguishes you from other students.

I am not advocating for medical students to get a PhD, despite that physicians with such academic backgrounds are a “rare species” in the medical world. However, I do think it is essential for us to get exposure to research in their undergraduate medical education. Now, how about an exchange with SCORE?
It is widely known and agreed that training our Officers is key in order to keep increasing the quality of our Exchanges. For this reason, PRETs (Professional and Research Exchange Trainings for those unfamiliar with the acronym) are a huge opportunity to motivate, prepare, and build capacities of our beloved SCOREnegades and SCOPEans.

During this term, we can proudly say, that the America’s work in Exchanges has been unstoppable. With an unbelievable number of 2 PRETs already done, and at least THREE more on the way, we want to offer life changing experiences to all of our IFMSA members, providing them with the best in both Professional and Research Exchanges.

We both participated in our second PRET of the year in the Americas, done in Ecuador between May 26-28. For me (Andrea), this happened to be the first PRET to facilitate, and what a better way to start it off than by doing it in my home country. Meanwhile, for me (Erwin), this was my second PRET to facilitate ever, only two weeks after the PRET in Paraguay, and also the first time coming to Ecuador, so it was bound to be an amazing experience!

During three full days, we spent time training members of AEMP-PI-Ecuador, and all we can say is that it was EPIC. Having the opportunity to work with so many motivated people, was really helpful to get things going easily from the get-go, and both the energy and commitment of all participants stayed throughout the whole event. We were really happy to have participants from all over the country, from active members to LEOs and LOREs, we had the opportunity to work with them, helping them understand IFMSA Exchanges to the fullest, through presentations, activities, energizers, etc. From my NEO perspective (Andrea), Ecuador exchanges have grown so much in the past two years and it was time to prepare more exchange officers, to improve our exchanges, making them even better than they currently are.

During our Event we discussed and prepare our students in various topics. Erwin and I had in mind, talking about useful things that will help all of our participants in their IFMSA, academic and personal life. That’s why, most of them were happy to know that we gave them tips about time management, presentation skills, group dynamics and problem solving, etc.

One of my favorite experiences through the event, was the training about handover. Erwin and I thought this was one of the most important topics that we had to discuss, and sometimes this topic could be hard to understand if you have never had the chance to experience a handover. As we mentioned the participants about this training, most of them thought that we were going to talk about “hangover.” As we laughed, we did this activity called “Monkey Handover”, where most of the students felt frustrated as we had only one group, able to talk to the native (in this case me) and gathered information on how to perform a task right. During the presentation of the monkey drawing the groups that were not able to draw the monkey, were thrown small paper balls. Some groups had really creative presentations, singing and dancing was part of it. After the activity, our participants were able to understand the importance of being organized and give details through a handover.

This PRET also happened to take place in the same time and date as other training workshops, such as a TNT, TMET, and IPAS, all within the SRT “Middle of the World” 2017. For this reason, we got to know so many people from so many different parts of the country, and even our region! Also, it was a really uncommon opportunity for three Regional Assistants from the Americas to meet outside of a Regional Meeting. We had a blast as both of us and Pablo (SCOME RA for the Americas) spent these days together, training and having lots of fun at the same time.

For both us, this was a life changing experience. There is not a better motivator, than see our participants fall in love with the exchanges committee. Also it was incredible to finally meet one of my team members after so much work done. Erwin and I are so proud to see so many Capacity Building Opportunities coming for our region, knowing that the Americas truly care about improving their incoming and outgoing experience.
The Pre-Americas Regional Meeting (pre-RM) was set in Trujillo, a tiny city at north of Peru where there was a strong historical culture since the Andean Empire until the last century dictatorship.

There were plenty of trainings available. The one that I have chosen to take part in was Global Health Within Exchanges (GHWE), a kind of Professional and Research Exchange Training (PRET). It is of my own belief that to have good understanding about how Public Health works worldwide is of severe importance for all students, most of all, for those who choose to take part in one of our SCORE exchange programs and that’s why I have chosen this particular training.

Our training started with our facilitators presenting themselves and with all of us establishing our Ground Rules, it was an important moment to start building good group integration. When we help create the rules of the places that we work, is easier for us to become a part of this place.

Afterwards, we did a “fears and expectations tree”. It was very important to show us just how much we had grown at the end of our experience. Furthermore, we had a motivational moment to talk about SCORE, SCOPE and about the IFMSA.

In the Academic Quality sessions, we learnt about how important it is to give the best Exchange experience we possibly can for our SCORE students. In order to fully enjoy the potentials from medical education in a different country it is very important to guarantee that the student logbook and handbook will be correctly filled up. It is also imperative to ask the LOREs to always remain in touch with the tutors and to explain the exchange program’s obligations to them emphasizing the importance of outcomes production. Besides that, we do have other tools: the Pre-Exchange Training (PET) and the Upon-Arrival Training (UAT). Both of them are training which prepare students to get more familiar with the exchange procedures and with the country they are going to.

We have also discussed many important themes. Between them, I would like to highlight, the Recognition of Exchanges and the Advocacy Training. Advocacy for medical students has extreme relevance, after all in our own SCORE Team we are always trying to convince someone of the reasons to choose our NMO for their exchange and also trying to convince the university deans of accepting our exchange. The deans allowance is quickly related with our Exchange Recognition because it is necessary to use advocacy skills to persuade the deans that our Exchanges are not only suitable but a great opportunity for their medical schools. So advocacy is a perfect skill for us to get Exchange Recognition in our countries.

Furthermore, at Global Health Presentations when each one of the PRET participants was showing how the Global and Public Health’s work in their countries I realized what an amazing opportunity those discussions are for us to get more integrated and get to better know about how the health public systems operate in each country of our region.

Moreover, there was still a Global Action Project Exchange (GAP Exchange) section which Rodrigo, the Scope-D, asked me to facilitate. It was a remarkably short presentation but even so we did manage to pass the message we aimed for: GAP Exchange are unique experiences for foreign students to learn more about...
Experience Life

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Exchange programs can be the greatest experience, not because everything is perfect, but because it’s not. Your plans may go wrong, but here’s the thing, you will have to learn with this. That’s what happened in my exchange program around Europe. I’ve learned how to overcome the challenges by my own and learn not only medical stuff but also how to grow.

From the moment I saw my name in the approved list to go to Prague, I was thrilled. I wanted so much to know Eastern Europe and since other 6 friends were also approved to go to nearby countries, we could visit each other! We traveled to Italy, Milano and Verona, then we went to Croatia and I just can’t describe how funny that trip was. After that week, I started my internship in Prague. I was anxious for the days to come because I’d have to do everything by my own from that moment on.

I arrived on a Saturday raining night, had no idea of any word in Czech, my English was rusty, and there was no Internet. Fortunately, my contact person was waiting for me at the airport. She told me that I was moved to another dormitory, further than the other. My room was quadruple, but there was only me there. Everything was old and dark, it didn’t have Wi-Fi, so I couldn’t talk to my parents. Things weren’t going right, I was afraid, hungry and alone. Then I met two boys from Malta (from IFMSA exchange program too) and they invited me to have dinner and find Wi-Fi, everything that I needed! On the way back, I met my roommates and luckily they were Brazilian, two really nice girls (they were like sisters for me during that month!). Everything started to get better; I bought a SIM card with Internet connection and I started to like my dorm.

To get to the university I had to walk, take a bus, take a subway, another bus, another subway and walk to the university, almost 1 hour. I used to stay from 9 am to 7pm at the university every day, but since my job was cool, time went by and the distance was no longer an issue.

After this GHWE experience, I am feeling more empowered to facilitate best sessions in my National General Assemblies and to do better capacity building meetings for my beloved LOREs. Everyone should do the GWHE for sure, It was an amazing experience.

August 2017
My internship was at Charles University, 1st Medical Faculty, on the Institute of Pathological Physiology, department of hematology. I was expecting to participate in a hematology project, but it wasn’t on course anymore. However, I did much more than I was expecting. My tutor was Karina, a woman PhD in Natural Science, she was so intelligent and so kind, and she let me help her in her project about Chronic lymphocytic leukemia (CLL) and the oncogenes micro RNA-155. I was fascinated by it, because this micro RNA is involved in several pathologies, in many tissues, and there are some studies reporting the relation with CLL. The micro RNA might be used as a biomarker in the development of CLL, as in diagnosis, prognostic, and also therapy. Unfortunately a month is too little to study something so complex, I’d like to have another opportunity to go back and see the results, or to search and study more about it.

Keeping up with this project wasn’t half of what I did there. I spent most of the time following a man that also had Ph.D in Natural Science, and he taught me how to work in a lab. We did laboratory procedures, as PCR, electrophoresis and Western Blot. He taught me how to work with animal model, mice, we did some bone marrow transplantations and autopsies.

I had the chance to meet many special people, all exchangers from different countries and people from local IFMSA. I also had the opportunity to live like the locals, know other European cities and for sure Prague is one of the best. Even my family visited me to celebrate my birthday! In the end, I spent one last week traveling around Amsterdam, Brussels and Frankfurt. Total of 45 days, 7 countries, a lot of friends and countless stories.

Everything was extremely different from what I was expecting, but I know I did the best I could to experience it, and if I could, I’d do it all again! Therefore, if I could give people an advice it would be to open your mind and your heart and see the bright side in every situation; so don’t miss the chance of going on an exchange program; you cannot imagine what is waiting for you!
The SCORPion

Learn about Human Rights & Peace efforts worldwide
Refugees in their own country!

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Under a tent, a malnourished mother breastfeeds an emaciated infant; children surround her sitting on the ground, looking starved and weary. Opposite, a health worker examines a child on IV diagnosed of marasmus; the groans of children in pain fill the air. Food is not in sight and clean water seems scarce. Behold a typical Internally Displaced Persons (IDPs) camp in Nigeria!

Nigeria’s displaced persons, because of the Boko Haram insurgency were forced out of their homes to take shelter at relatively safer camps, often overcrowded, devoid of food and basic amenities. Hence, it has become common to find young ladies trade sex for food, thus making underage pregnancy and its resultant complications frequent. These have culminated in a humanitarian crisis with health institutions struggling to keep up with the surging population making avoidable deaths inevitable.

Bagful of Care and Hope

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Homeless people are a heterogeneous group constituted by those who have in common survival by means of activities developed in the streets, familiar bonds broken, or fragile and absence of regular housing. According to the Brazilian national research on homeless people, amongst the interviewed, 18% were female in productive age range, most in reproductive period and slightly younger than men. Regarding their education, 21.87% are illiterate even though most of those women studied up until the 4th grade of elementary school, and 2.28% graduated high school. As for skin color, the top 3 cited by the interviewed were brown, white and afrodescendant.

Even though Brazil’s Unified Public Health System promises to follow the principles of universality, completeness and equity, there are issues on the access to health services by homeless people, such as financial difficulties, transportation and hindrance to schedule appointments. There was a significant improvement on the public politics regarding this population in 2009, but it’s still necessary to
advance in actions that actually meet their needs. Hygiene - which refers to conditions and practices that help to maintain health and prevent the spread of diseases - tends to be extremely poor on the homeless population, leading to higher risk of infectious diseases. Besides that, the illness cited the most amongst them are those of psychiatric nature (9%), hypertension (8.3%), diabetes (8.3%), visual problems/blindness (5.1%) and AIDS (5.1%).

On a research applied to homeless in São Paulo, 39.6% of the participants reported previous STI, 38.3% told they used condoms in every sexual relation, and a little over half of them (55.4%) had access to actions of prevention. HIV prevalence was 4.9%, from which 17.4% were also seropositive for syphilis. The groups which showed the biggest vulnerability were: women, drug and alcohol use as well as not having access to actions of prevention and social support. Those women also show 6 times more risk of developing cervical cancer when compared to general population.

In general, the singularities of the homeless are not presented to students during graduation, and even though they are cited in studies with risk population, the realities faced are still distant from several academics’ reality. Therefore, we face a lack of knowledge of their real situation and of certain illness they are more fragile or exposed to - that is what we hoped to change by doing "Bolsa de Mulher", or Lady’s Purse. Its training was led by a gynecologist who instructed us to approach broadly the health of the homeless women who inhabit on the traditional "Praca do Ferreira", in Fortaleza, CE, Brazil.

We were hoping to enlighten the present group of women about the importance of preventing sexually transmitted diseases and pregnancy by using condoms and the importance of keeping up with a daily hygiene routine. In order to encourage them, we collected donations and forwarded them to the women in the means of a purse filled with toiletries, besides clothes and a snack. In general, we hoped to aid the restoration of their self-care and self-esteem, when in fact they taught the students how to improve their empathy, solidarity, humanization and to rethink prejudices as pointed out by themselves in a survey after the event. The majority of the students (70%) claimed to have never engaged in activities aimed to the homeless and about over 90% of them thought the campaign was interesting, challenging and enriching.

Regarding the profile of over 30 women we met, it was found that it is similar to that found on the I Census, for example: age group between 16 to 65 years; low educational level, most with incomplete elementary school; unemployed. Most refer that the reason they wound up on the streets was family fights, financial problems or the use of drugs. Currently they maintain these issues, which creates a state of vulnerability - some reports of sexual abuse were mentioned to our team. The students prioritized active listening, promotion of health and general info best suiting to each case. Thus, the participants’ critical thinking was enhanced, such as the bond between doctor-patient while promoting health on an one-off approach, which we hope will have some positive effect on the future – the gratitude of the present we have already witnessed.

References:
Solidarity in Medical Education: “Haiti without Borders” Social Health Campaign

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Although Haiti was a pioneer nation in the abolition of slavery and in its independence, it is remembered worldwide because of its social ills and poverty. This situation worsened significantly due to the earthquake of intense magnitude that afflicted the country in January 2010, which caused 200,000 deaths and displacement of more than 1.6 million people due to the loss of their homes. Ten months later, the population was still plagued by an epidemic of cholera (1).

Due to the population’s difficulties of being able to immigrate to the global North States, Haitians, in order to escape the catastrophic situations of their country, went to the countries of South America. Among the destination countries is Brazil (2).

In Aparecida de Goiânia, Goiás, there is a colony of about 400 Haitians. With the ease of finding work and due to the expansion of communities in the country, more immigrants arrive every day in the city, an average of four to five, according to the Secretariat of Labor, Employment and Income of Aparecida de Goiânia. All immigrants are legalized and renew their documents every six months at the Federal Police.

Having become aware of this reality, SCORP coordinators from the Pontifical Catholic University of Goiás (PUC-GO) visited the Haitian community and realized the precarious health care of that population. At that point, the dream was born of making the “Haiti without Borders” campaign a reality. The campaign would be a great opportunity to provide assistance to others in times of need and vulnerability, assisting immigrants not only in health, but also in the social perspective.

During the planning of "Haiti without Borders", the SCORP coordinators partnered with several courses in the health area, seeking to carry out a campaign that would assist the community in an integral and universalized way. They had, therefore, the participation of academics of Physiotherapy (7), Nursing (8), Speech Therapy (15) and Biomedicine (15), beyond the medical academics (20). They also partnered with the Health Department of the municipality in which the colony resided, hoping that, based on the visibility that the campaign would bring health promotion, prevention and protection actions would be continued by the municipal service network.

The campaign was held on December 4, 2016, in a Basic Health Unit localized in Aparecida de Goiânia. To organize the service, the scholars were divided into eight commissions, each with a coordinator in charge of ensuring the operation of the action.
Approximately 200 calls were performed. The community underwent a triage, which approached life habits, personal antecedents, comorbidities and evaluation of the health profile. Together, data such as blood glucose, blood pressure and BMI were collected. The population also had rapid tests for syphilis, hepatitis and AIDS, as well as oral health care (cleaning and application of fluoride). For the pregnant women in the community, ultrasonography was performed. At the end of the visits, the entire population received guidelines on blood donation and healthy lifestyle habits.

The experience has shown that Haitian families did not receive health care because they did not recognize themselves as users of the Unified Health System (Brazil’s health system) or because of difficulty in accessing health facilities. The campaign was an enriching experience for the community, since in addition to health care, the population was oriented about the functioning of the Unified Health System, about the flow and about their rights as residents in that region. It is also a pioneering campaign for the assistance of this population, in which many experienced for the first time the opportunity to perform rapid tests. Satisfaction and enthusiasm of those served were perceived.

For the academics, it was a unique opportunity to recognize the vulnerability of others and to be able to assist them in an integral way, an experience that has contributed to the humanization of medical education and that goes beyond the curricular matrix and routine of the students.

It can be seen that the campaign “Haiti without Borders” made possible not only an action of health promotion, awareness of life habits and orientations about the rights of that community, assured by the own principles of the Unified Health System, cultural experiences for both involved. The campaign merited continuity, which is planned for the second half of 2017.

References:


SOS Women: Fighting Sexism and Violence

Violence against women is present in different forms and has different expressions, from emotional violence, with contempt and diminution of the feminine sex, to feminicide. Over the years, the murder of women in the country has increased exorbitantly, with a percentage increase of 111% from 1980 to 2013. In Goiânia, a city located in the Brazilian central plateau, the homicide rate is high, with 9.5/100,000 women murdered in 2013, the fifth worst capital to be a Brazilian woman (1).

In face of it, SCORP coordinators academics from the Pontifical University of Goiás (PUC-GO), knowing the reality of the city of Goiânia and, even more, the lack of knowledge about violence against women in university curricula (2), planned the SOS Women Campaign, in celebration of Women’s Day (March 8). The campaign was carried out in a Basic Health Unit located in a poor sector of Goiânia, aiming to alert and instruct medical academics, health professionals and women in the community.

Initially, the academics went to the City Hall of Goiânia and reported the idea of the campaign and the goal to the councilwoman Cristina Lopes, who is a human rights activist. She embraced the campaign and supported the role organization from the beginning to the end. In addition, the coordinators obtained support from the Popular Women’s Center of the state of Goiás, which is the oldest feminist group in Brazil and fights for gender equality and an end to violence against women.

The disclosure of the campaign happened at college itself during meetings of IFMSA Brazil and in social networks, such as Facebook and Instagram. At the Basic Health Unit, where the campaign was carried out, the disclosure was made by the Com-
Community Health Agents, which are responsible for the residence area of community residents. The training was made by a lawyer, member of Popular Women’s Central, at college, focused on medical academics, with the elucidation of how to deal with suspected cases of physical and emotional abuse that they may, as professionals, have contact with.

The campaign took place at UESF Vila Mutirão, a basic unit of health, on March 17, and was attended by the councilwoman Cristina. Campaign participants were gathered in the Unit auditorium to listen Cristina. She spoke about how she became a militant in the fight for human rights and acts in the care of burn victims. It happened because she was a victim of a nationally known abusive relationship, in which she had 85 percent of her body burned by her ex-boyfriend. It was one of the first such cases to be tried and her aggressor was sentenced to 13 years and 10 months in prison.

She concluded explaining about how sexism affected the way her family, society and herself perceived the crime that victimized her and how it is currently affecting in her profession. After Cristina, the representative of the Popular Women’s Central, Ângela Café, explained how the care and shelter of victims of domestic violence occur in Brazil, especially in the state of Goiás. Medical students and components of the family health team, such as Community Health Agents, nurses and the unit director participated, in a total of 35 people.

At the end of the campaign, “flowers” (made by the coordinators) were distributed with words that promote the complaint in domestic violence cases and the number of the service of 180, a Brazilian disclaimer to call for help. This service is really important for women’s safety and some of them do not have this information.

Lastly, the realization of the campaign made it possible to recognize the psychosocial context that violence against women promotes and that, in fact, it happens in Brazil, but the main obstacle to its control is its invisibility. In this context, the training and the lecture given by Dr. Cristina showed that the lack of reporting, triggered by some kind of dependence on the aggressor, and the lack of notification by health professionals, in particular doctors, inviablishe the real knowledge of this problem and its transformation into statistical data for further development of strategies aimed at its improvement. Therefore, it is well known that this problem should be more discussed, more exposed, in order to encourage women who are being beaten to report and to train professionals to fill out the notification. In this context, the campaign was highly praised by IFMSA’s national team, due to its social importance and its effectiveness in exposing information, which contributed to combating the invisibility of the problem.

References:

We Do Not Forget!

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This is about a little boy named, “Iqbal Maseeh”, a slave on the run, and who knew that a slave who escaped his masters could start something bigger than most of us can ever imagine. Four years after his birth in a suburb named Mureedke near Lahore, a dark haired boy was sold into bonded labour by his parents for a debt of less than six dollars. And just like that his life was decided for him to weave carpets from dawn till dusk for the rest of his life.

Growing amidst the linter of carpets and fatigue of a 12 hour working shift, one day Iqbal escaped from the masters and was caught up again and returned to the hellhole. But the kindled spirit of freedom took him to freedom ultimately with the help from Bonded Labour Liberation Front (BLLF). After acquiring basic education, Iqbal rose as a symbol of Strength for all those who were ever enchained by the shackles of Child and bonded labour. The efforts of Iqbal Maseeh helped more than about 3000 children to attain their basic right of freedom and have been recognized on many international platforms.

Despite the efforts of Iqbal Maseeh and many unsung heroes, Forced and bonded child labour is far from being eradicated. According to WHO, 250 million, or one in every six, children are currently afflicted with child labour across the globes. Among the countries, Pakistan is ranked third in order of having the highest prevalence, 12.5 million children according to ILO estimates of 2012, of child labour. To commemorate and praise the efforts and services of Iqbal Maseeh a seminar was organized by IFMSA Pakistan King Edward Medical University Local Council at a Local School Crescent Model High School. The seminar was to educate our younger generation about how a boy just like themselves helped in making this world a better place. The children were educated about the state laws that are in place against child and bonded labour. On the seminar we were joined by the CEO of PEHCHAAN Organization Dr. Naeem Zaffar, an NGO helping the less fortunate children for about a decade. A special lecture was delivered about how to take a stand against child and bonded labour and how to correctly approach the officials about such an issue. The session was followed by an hour long question answer session in which the students showed great interest. The seminar was followed by a week-long (15th - 22nd April 2017) online campaign spreading awareness through social media.

Freedom is one of the basic rights of every born human being and it shouldn’t be taken away from anyone. And what is the worth of some nickels and coins against freedom. All over the world, we should join hands to eradicate this nuisance form the world or in the words of Iqbal Maseeh “Children should have pens in their hands, not tools.”

Further readings:
When was the last time you looked at your reflection in the mirror and said to yourself that you are beautiful. If you haven’t ever done so, what has taken you so long?

Body image issues are real and often can have serious complications.

Having a negative body image can lead to developing Body Dysmorphic Disorder, which in itself can lead to seek cosmetic procedures, and develop social anxiety, depression, or even substance abuse, eating disorders and suicidal tendencies.

Some dissatisfaction with one’s body may be normal. When it becomes extreme or influences how you perceive yourself then there may be a problem.

One is never thin enough for that pair of skinny jeans nor that curvy enough for that perfect lehenga...

Before you convince yourself that you are not beautiful enough, it was who someone told you that you are not beautiful. We at MSAI India have carried out a year-long campaign to spread the message of body positive image. To contribute our bit in that no body type and no skin colour is made to feels insignificant, that every girl and every boy feels confident, conquers the world.

Conceptualized and co-ordinated by LORP Mr. Aditya Desai, it has been one of the most successful campaigns at SCORP India, with more than 10 on ground events targeting about 1000 teenagers and one online Facebook campaign reaching about 42000 Facebook users. Through immediate follow up studies we could find out that this awareness activity has about 96% positive impact.

This activity has helped the participants understand in detail the concept of Body Image both positive and negative, the beauty in diversity and individuality.

Aware individuals are better at guiding/helping friends who are disturbed by negative body image and are able to cope up with unrealistic social media & advertised body expectations & trends like thigh gap, size zero etc.

You are #BeYouTiful!
Prejudice, a joke?
Fighting Homophobia & Violence Against Women

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Prejudice is the set of beliefs, attitudes and behaviors that consists in assigning to any member of a particular human group a negative characteristic, simply because the person belongs to that group: the characteristic in question is seen as essential, defining the nature of the group, and therefore it adheres to all the individuals who compose it\(^1\). In this way, it is known that prejudice can be a “weapon of war”, becoming a trigger for discrimination, exclusion and violence.

Homosexuality has not always been inferior and a reason for discrimination by certain groups of people. During Greek civilization and even part of the Roman Empire, homosexual relations were fully accepted and they were intrinsic and unrestricted in society in general\(^2\). However, the closed and derisory concepts of the middle Ages brought oppression to any form of relationship that ran away from the principles propagated in the churches of the time. Since then, the stories of repression and inferiorization have not ceased. However, movements such as the post-Second War: "Movement of the Rights of Homosexuals" contributed to the consolidation of rights\(^3\). In Brazil, since 1985 the Federal Council of Medicine no longer considers homosexuality as disease, mental disorder or perversion.

Also, women were not always seen as “inferior” by the society. In Egyptian and Spartan civilizations women had a very important role in society and their presence was one of total equity, or even superiority to men. However, in Ancient Greece, for example, women had no legal rights, no formal education, and were barred from appearing in public alone. Since then, women have been fighting for their rights, and have overcome unimaginable levels of violence\(^4\). The belief of the woman as inferior has lasted for thousands of years, and is still is present in some closed minds.

Analyzing historical and current contexts, the struggle of women and the LGBTIQ population is far from over. Despite this, the battles are stronger and social rights and positions gain immense relevance in today’s society. Given that sexist, discriminatory and homophobic thoughts are rooted in innumerable daily attitudes and personal speeches. Therefore, it is important to emphasize that equality and non-discrimination should be daily goals, thus counteracting the presence of any form of violence.

Having all this in view the local committee of Unive in the south of Brazil idealized the campaign “Prejudice, a joke?”. The first stage had a talk with lawyers and doctors about the legislation, rights and strength in health of these two issues addressed. In the same, a questionnaire was carried out with the students and it was observed that the knowledge about such subjects was extremely low and increased significantly after the lecture. The days of the action were in the biggest mall of the region and were attended by medical students who work as clowns in hospitals. First, folders with relevant data on the rise of homophobia and misogyny were given and people were invited to sit down to watch a play. Thus, in the middle of the presentation the clowns found a newspaper with relevant news about violence in the re-
In Your Shoes

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A person with a disability is one who has long-term (at least two years) physical, mental, intellectual, or sensory impairments. And this condition could make difficult to them to have a full and effective participation in society on an equal basis with others (Law n. 12.470/31 de August 2011). In the history of mankind the image that many disabled people carried was the image of deformation of body and mind, and this point of view denounced the human imperfection. Often, derogatory criticism is more difficult for the person with disabilities than the possible difficulties coming from their state, because they greatly influence the attitudes and actions directed at this person.

In Brazil 23.9% of its total population have some type of disability such as visual, auditory, motor and mental or intellectual, and although some rights have been reached, there is much to be done in attempt to integrate and to make the life of the disabled ones as equal as possible. Thus, this campaign is important since the sensitisation together with its peculiarity, has great relevance in the attempt to know a little about the daily life of the disabled ones, contributing in the fight against the stereotypes, stigmas and the inequalities faced by the those affected by the local reality. A video was recorded with a physically handicapped person, another with an intellectual, auditory and visual impairment, totalling four videos that addressed the daily life of the disabled ones, their difficulties, how people deal with them and the achievements they have got. These videos were made available on social media in order to reach more people. An action was also carried out in the Faculdades Integradas Pitágoras of Montes Claros, where the students passed through simulations of some kind of the deficiency; they were blindfolded and challenged to identify objects and serve water in a cup to simulate visual impairment.

Thus, it is concluded that actions focusing on these vulnerable groups have extreme importance for the development of better people and decrease of inequality.

References:
some of them, had their hands immobilized by thick gloves and challenged to close a button-shirt, to simulate the physical deficiency; other ones were asked to answer a question without using a verbal language, to simulate hearing impairment; or to read a poem with a tongue on the palate, to simulate intellectual deficiency.

The main goal was achieved through the campaign, which was to raise an awareness about the daily lives of the disabled and the barriers faced by them. So the experience was able to stimulate a debate about the importance of defending the rights of these people, but so much more than this. It enabled to promote a change of thought and attitude towards the disabled ones. Andre, an academic who has a visual impairment, was part of the recordings, told us about the disregard that occurs with him, where many academics and professors occupy his tactile floor or position themselves purposely in his way, making his mobility harder. The campaign has reached a great number of people, mostly academics from a college that yet receives a small number of people with disabilities, but who face a variety of problems in their daily lives, even within the academic environment.

Dealing with people with disabilities is talking about an usual situation, but it is still stigmatized and subjugated. So we realized that with the campaign, the participants of the activity managed to put themselves in the place of the others, showing empathy. The videos, in turn, reached a large number of Internet users and we got positive feedback about the campaign. With this, we believe that we have achieved a significant change in the population’s way of thinking about disabilities.

References:
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2016-2017

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China (IFMSA-China)  
China - Hong Kong (AMSAHK)  
Colombia (ASCemcol)  
Costa Rica (ACEM)  
Croatia (CroMSIC)  
Cyprus (CyMSA)  
Czech Republic (IFMSA CZ)  
Democratic Republic of the Congo (MSA-DRC)  
Denmark (IMCC)  
Dominican Republic (ODEM)  
Ecuador (AEMPI)  
Egypt (IFMSA-Egypt)  
El Salvador (IFMSA-El Salvador)  
Estonia (EstMSA)  
Ethiopia (EMS)  
Fiji (IFMSA)  
Finland (FiMISC)  
France (ANEMF)  
Gambia (UnigaMSA)  
Georgia (GMSA)  
Germany (bmd)  
Ghana (FGMSA)  
Greece (HelMSIC)  
Grenada (IFMSA-Grenada)  
Guatemala (ASOCEM)  
Guinea (AEM)  
Guyana (GuMSA)  
Haiti (AHEM)  
Honduras (ASEM)  
Hungary (HuMSIRC)  
Iceland (IMSIC)  
India (MSAI)  
Indonesia (CIMSA-ISMKI)  
Iraq (IFMSA-Iraq)  
Iraq - Kurdistan (IFMSA-Kurdistan)  
Ireland (AMSI)  
Israel (FIMS)  
Italy (SISIM)  
Jamaica (JAMSA)  
Japan (IFMSA-Japan)  
Jordan (IFMSA-Jo)  
Kazakhstan (KazMSA)  
Kenya (MSAKE)  
Korea (KMSA)  
Kosovo (EMSA-Pristina)  
Kuwait (KuMSA)  
Latvia (LaMSA)  
Lebanon (LeMSIC)  
Lesotho (LEMSA)  
Libya (LMSA)  
Lithuania (LMSA)  
Luxembourg (ALEM)  
Malawi (UMMSA)  
Mali (APS)  
Malta (MMSA)  
Mexico (IFMSA-Mexico)  
Moldova (ASRM)  
Mongolia (MMLA)  
Montenegro (MoMSIC)  
Morocco (IFMSA-Morocco)  
Namibia (MESANA)  
Nepal (NMSS)  
The Netherlands (IFMSA NL)  
Nicaragua (IFMSA-Nicaragua)  
Nigeria (NIMSA)  
Norway (NMSA)  
Oman (SQU-MSG)  
Pakistan (IFMSA-Pakistan)  
Palestine (IFMSA-Palestine)  
Panama (IFMSA-Panama)  
Paraguay (IFMSA-Paraguay)  
Peru (IFMSA-Peru)  
Peru (APEMH)  
Philippines (AMSA-Philippines)  
Poland (IFMSA-Poland)  
Portugal (PorMSIC)  
Romania (FASMIR)  
Russian Federation - Republic of Tatarstan (TaMSA)  
Rwanda (MEDSAR)  
Serbia (IFMSA-Serbia)  
Sierra Leone (SL EMSA)  
Singapore (AMSA-Singapore)  
Slovakia (SloMSA)  
Sweden (IFMSA-Sweden)  
Switzerland (swimsa)  
Syrian Arab Republic (SMSA)  
Taiwan (FMS)  
Thailand (IFMSA-Thailand)  
The Former Yougoslav Republic of Macedonia (MMSA)  
Tanzania (TaMSA)  
Togo (AEMP)  
Tunisia (Associa-Med)  
Turkey (TurkMSIC)  
Uganda (FUMSA)  
Ukraine (UMSA)  
United Arab Emirates (EMSS)  
United Kinfgdom of Great Britan and Northern Ireland (Medsin)  
United States of America (AMSA)  
Uruguay (IFMSA-URU)  
Uzbekistan (AMSA-Uzbekistan)  
Venezuela (FEVESOCEM)  
Zambia (ZaMSA)  
Zimbabwe (ZimSA)