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 more than 140 National Member Organizations from more than 129 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.

This is an IFMSA Publication
© 2020 - Only portions of this publication may be reproduced for non political and non profit purposes, provided mentioning the source.

Disclaimer
This publication contains the collective views of different contributors, the opinions expressed in this publication are those of the authors and do not necessarily reflect the position of IFMSA.

The mention of specific companies or of certain manufacturers’ products does not imply that they are endorsed or recommended by the IFMSA in preference to others of a similar nature that are not mentioned.

Notice
All reasonable precautions have been taken by the IFMSA to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material herein lies with the reader.

Some of the photos and graphics used in this publication are the property of their respective authors. We have taken every consideration not to violate their rights.
On March 12th, I was on a flight coming back from Rwanda to Morocco. I’m quietly settled up in my seat, and preparing to nap for this long flight. My Headphone music got interrupted by an announcement from the captain: “the departure will be delayed”, he explained that the plane didn’t receive the authorization to land in Entebbe for our Technical Stop because of the new CoVID-19-Outbreak-related policy on restricting connection with some countries. We were pinned down, and I just started the conversation with the passenger sitting next to me that happens to be a doctor working for Médecins Sans Frontières. For more than 40 minutes, we discussed the virus taxonomy, the SARS experience, the MERS and other flu epidemics, we also challenged governments’ decisions, and we reflected on the World Health Organisation’s response. This debate and the escalation of the CoVID19-virus is trapping us at home and is definitely changing our conceptions about Health, Government, priorities, self and interpersonal relationships.

But I believe that this crisis can be an opportunity for us to stop, evaluate and reflect on our behaviors, our relationship with the environment, our Health Workforce and Health systems...

The novel coronavirus 19 is changing the world.

“A common danger unites even the bitterest enemies...” - Aristotle -

We are at war, not against some other nations, not against some extraterrestrial creatures, nor the Night King and his army. We are at war against a virion that not only has stirred a global crisis but most importantly awakened Human goodness, altruism, compassion, and generosity.

The fight against the pandemic also places the social animal in a conflicting dilemma: to protect the community, we must withdraw from it; to preserve the groups, we must individualize them, to protect our economies we should paralyze and rationalize our buying behaviors. However, Covid19- also allied itself to selfishness; individuals are still not taking the general interest into account, refusing social distancing, participating in disseminating fake news or engaging in all forms of civil disobedience. Unfortunately, this reticence is not new, it is only the fruit of years of rootless, and disturbed perplexity about public policies, that has ended up weakening the scientific community we are imploring today to devote themselves to the fight against the pandemic. I hope that as this crisis unfolds, we will remember the importance of Research & Development, funding health systems and preparing the Health Workers to the next pandemic, as they constantly and vainly sounded the alarm about Health, Climate Change or other threats for the Human race.
Reversing the pyramid!
Since 1943, The Maslow Pyramid conceptualized Human Motivation in a simple five levels (Physiological needs, Security and safety, Love and belongingness, Esteem, Self-actualization), it has been met with acceptance and praise and still considered as a valid model to decipher human actions. Regardless of our previous situation on the model, the virus brought us back to the bottom, by threatening and defying our safety and health and enfeebling our higher levels... Reading about the “One Ventilator for seven Million People Living in Sierra Leone” or the “65.6 million individuals forcibly displaced still living in Refugees Camps and facing all the Covid19-danger” muddles our minds and questions if the world is really able to face a truth that we were ignoring for years? Could we feed the physiological needs of our communities? How are we going to care about non-regulated jobs during this crisis? Could our Health systems deal with this epidemic? What can we learn from this crisis?

A New Hope?
Looking into the last updates we are just petrified by the effect of this outbreak, but it can be turned back. China, South Korea or other Asia Pacific countries have shown us that with serious efforts, an extraordinary sense of coordination and cooperation by the populace to all health mitigation policies, the contagion can be brought to heel.

Last, I hope that you will read this magazine while maintaining your social distances and that you will share the articles while sharing love and care for your friends and families in these special times. After nearly 30 years after the creation of the first MSI as a rejuvenation of the 70’ IFMSA Intermedica, we are proud and honored to present you the 41st edition of this tradition.

Let’s minimize our optimism bias, stay home, stay safe and enjoy medical students’ articles and stories worldwide!

Regards.
Of all the forms of inequality, injustice in health is the most shocking and inhumane.
To go or not to go to the doctor

Tazekout Noor
Université de Liège | BeMSA

One day, a French’s thought...
“To go or not to go to the Doctor”.

I was faced with a dilemma.
A very different one from what I was used to: this day it was not going to be *croissant* or *pain au chocolat* for breakfast. No, this day it was: to go or not to go to the doctor. My foot has been blue since the day before and it didn’t fit in my shoe anymore... Why the hell did that piece of furniture fall on my foot? Besides, 2 days before I get back! I sigh and my host looked at me with compassion, her furrowed forehead showing her concern. It was all my fault anyway, when I had prepared my travel, I had organized a budget for accommodation, food, school materials, souvenirs and even for not mandatory but recommended vaccinations! However, I hadn’t thought about medical emergency, it hadn’t even crossed my mind.

Why?

Because, of course, I was a big girl and hopefully not stupid enough to put myself in danger for the five very short weeks I will be on the other side of the world. Um? The Volcano hike? The Monkey Valley? The scooter?.... Well, you know.... sometimes life was full of surprises and new opportunities?

Anyways, in the worst-case scenario, I will go to the hospital, at least that was what I thought until I knew that here Emergency didn’t rhyme with free (I meant not literally!) and for all the inhabitants of this island, going or not going to the “Dokter” was a hard decision, an investment, involving all members of a family.

My world has been completely turned upside down while my eyes landed on my swollen foot. For less than that, people went to the E.R. in my country. We often forgot that healthcare was not a right accessible and guarantee to everyone everywhere and it was hard for me to imagine myself in a life where I had to wonder everytime if that hospitalization or that one was necessary or not and especially If I could afford it... or not. My eyes wandered over the children laughing and playing in the garden, over my host’s lovely grandma on her rocking chair making offerings to the gods, and then they went farther away, in that emergency rooms where people had someone they loved: kids, parents, family members or friends with traumas or chronic diseases and where those people were also hit by enormous bills. To know that in addition to the deep and heartrending pain of having someone you care about in the hospital, there was also the stress and the pressure of being able to pay for his or her care broke my heart. It was cruel, barbaric and unfortunately real, and to quote a historical figure that I admired:

“Of all the forms of inequality, injustice in health is the most shocking and inhumane.”

Martin Luther King Jr

So my question was: Who will stand up for them? For these people, human beings, parents, kids and friends? Who will raise awareness and sensibilize the international community on this issue?

Dr. Githinji Gitahi once said “Health is the most fundamental Human Right on which all other rights can be enjoyed. UHC is its guarantee” and it was true. How did you want to build a secure future if you could go broke if you got sick?

Thus this day I decided 3 things: I won’t go to the doctor, I couldn’t afford it so I will wait for my return in France, even if it meant wearing mismatched shoes (which is terrible for a parisian!).

I will become an actor of this world and reshape it, be part of an optimistic and hopeful army. I will take actions, vote, participate in leadership, contribute to world peace, share love and protect my planet until everyone everywhere could fully enjoy their life without worry about the fundamental: health’s cost. This will not be only a dream, it will be a reality, a future which was more or less close just waiting for motivated people to put it in place. IFMSA was one of those steps and explained why its work was central, essential and full of promise.

Finally, last but not least, I preferred *pain au chocolat.*
The Pact

Mouad Moutaoukil
Faculty of Medicine and Pharmacy of Fez | IFMSA-Morocco

A long time ago, long before creating negative, positive, vertical and lateral thinking, long before socialism, capitalism, feminism, radicalism and terrorism, long before homophobia, negrophobia, xenophobia and islamophobia; humans, in their assemblages, were suffering from relational problems and conflicts. It was totally natural; as our psychologies differ from an individual to another, differences and quarrels are unsurprising consequences.

In one of these assemblages, a group of eminent, reasonable and fair-minded people happened to be gathered. They were always discussing nature, humans, interactions and relations; they were discussing everything, they were always debating, meditating and mediating. They were referred to as the Dead Minds Society.

One day, because of an unbearable heat on a beach, a man killed another. It was new and unusual, it shook the life in the group and even reached other assemblages. People began to talk and think about it. That’s what pushed the Dead Minds Society to create something that would organize and harmonize human life. The erudite leaders, after numerous meetings, created a non-tendentious covenant. They named it The Pact. A pact that would suit all the societies, and all the times, since it was established from the bases of humanity, from the constant things in life.

They obliged themselves to respect it, and very quickly, all the people in the assemblage did the same.

The Pact became the regulation that Earth was missing.

Afterwards, everyone on the globe, regardless of their race, regardless of the color of their skin, regardless of their weight and height, obeyed its clauses.

It was passed from father to son. Like a lifestyle, like a language, like habits and religions, they believed in it, totally, applied it and spread it in their societies. Youngsters were learning it by heart at an early age. They were repeating, every day, in a perfect unwavering tone:

“All men are equal;
All that belongs to us also belongs to our brothers;
Before our ego, we must think of others;
Everything is free what’s on Earth
Water, plants and victual...”

The years passed, the centuries crumbled, The Pact was always respected and hardly violated. We could violate anything but the base of social life. Except that some time ago, it was thought that slight, totally unimportant and non-influencing modifications were necessary. Thus, The Pact became:

“All men are equal,
But some are more equal than others;
All that belongs to our brothers also belongs to us;
We must always think of others, but after our ego;
Everything on Earth is free,
Provided we pay a fee...”

And themselves, like their ancestors, totally respected it. They obeyed it, believed it without doubt, applied it without hesitation, like social media news, like a YouTube® video, a Facebook® post or a Twitter® dwarf text; totally, robotically and emotionlessly.
She didn’t decide to change her life because she was scared of death. She didn’t do it because I put forth some compelling arguments. She did it because she trusted me. She trusted that I have her best interests at heart.
The man’s hands fiddled through the papers. He was explaining something to my mother that I couldn’t understand. I did make out the words ‘resistance’ and ‘treatment’ he also said something about Penny Chillbin, or something. I couldn’t understand that one. What I do remember clearly is my mother walking out furiously. I remember how she told me that the doctor was a scam and he only wanted our money. That was my first memory of going to the doctor, but it wasn’t the only one.

There was that time when I broke my arm riding a bike. My arm was hurting like crazy. I think I broke it so hard that at one point it was bending like Harry Potter’s hand when someone accidentally made his bones vanish. The pain was so great that I was barely conscious of what was happening to me, but I remember a man in a white coat giving me a shot of something that made my pain go away. Not only did the pain go away, but I felt free. I was free from everything that I’d ever felt. I was free from every injury, from every hurtful thing anyone had ever said to me. The rest of the day was confusing. I couldn’t keep my attention on much, but I do remember some sort of black image of my hand that a doctor produced from a device, and my mother invariably screaming at someone.

It’s not that my mother hated doctors, but she was not the most trusting woman. She didn’t care if a doctor told her that she needed to change the way she eats. She’d just come home, say ‘That doctor has no idea what she’s talking about’ and go on cooking sausages in grease the same way women in our family have done for generations. Most of the people from our town were that way. And at the end of the day, if that way of life worked for hundreds and hundreds of years, what can some random person in a white coat tell them that they don’t already know? That’s how it goes in our town.

Despite the general disregard for doctors in our city, both my mother and our townsfolk were really supportive when I told them that I wanted to study medicine. I’m not sure what got me started on this journey, but I know that my mother’s declining health state was one of the reasons why I stayed on it. I guess that the general disregard for medical staff in our country rubbed off on me. I was motivated to make a difference. I wanted to change the system. But to do that, I had to enter the system.

In my first few years in medical school, I had no contact with patients. We spent most of our time studying everything from how the bones and muscles in our body overlap, to the basics of communicating with the patient. The last one came as a surprise to me. I always thought that I could talk to people and I didn’t need anyone to teach me how to do it, but I went with it. As time passed, it became more and more clear why that initial class in communication was there.

We spent so much time learning all of the medical terminology that it became second nature. We talked to each other using this terminology. We spent our time thinking and rehearsing this terminology. It seemed pretty natural that we should talk in that way to other people as well. We get so entrenched in this way of being that we do not realize that other people don’t understand what we talk about.
This reminds me of a case that I saw last week. There was this lady, probably not older than 43, that came to the hospital with an ambulance. She had a heart attack a few weeks prior. A colleague of mine and me were sent to talk to her. By this time, she was stable and able to talk to us but she wasn't too happy about it. Who could blame her?

We did a brief anamnesis. After getting over the initial reluctance, she did answer our questions. Well, most of them. She got really angry whenever we asked her about her medication, which, as far as I could tell, she didn't take, and her diet, which consisted mostly of the items you would find at a street corner's sweets and chips sections or the display menu of McDonald's. We didn't say anything to provoke her, and she soon stopped her shouting.

Then came the doctor. I'll never forget this scene. He asked us to present the case. When we reached the medication, the doctor was surprised when he heard that she didn't take any. He must have known since the lady had been there for a week or so, but he asked her.

"Ms. X, my students are telling me that you're not taking your medication. Is that true?"

The woman's face reddened and she started shouting in a manner that I'd only ever seen in my mother. Even though I'd never seen this woman before, there was something strangely familiar about her. She shared the same disregard for medical staff that all the people from my town shared. It was like she didn't understand that we were there to help her.

"You're just trying to get me to buy more and more of those meds. I don't need them. It's all just a sham."

The doctor explained to her with calm that I did not believe humanly possible that she almost died. He explained in excruciating detail how her lifestyle shaped the course of the disease she now had and how, if she didn't change something about herself, another episode might occur; this time one too massive to do anything about it.

It's always a weird experience to grasp your own mortality. It changes people. That moment when they realize that they’re not invincible, when the whole world does not depend on their existence. It changes you. For this woman, I do believe that it was a change for the better. She started asking questions. She seemed determined to change her life, but didn't know how. The doctor prescribed a few low effort steps that she could take in order to lower her chances of a new heart attack. She was supposed to take small but consistent action in order to change her lifestyle and she seemed happy with the steps that were proposed.

When we were done with her the doctor called us and asked us.

"Why do you think that, coming from someone who was so aggressive at first, she decided to make a change in her life?"

We came forth with a few different theories, but the doctor finally answered.

"She didn't decide to change her life because she was scared of death. She didn't do it because I put forth some compelling arguments. She did it because she trusted me. She trusted that I have her best interests at heart.

"Most doctors wouldn't spend 30 minutes only on explaining to the patient what happens when you do not have a lifestyle that empowers you. Most doctors won't put time aside to explain how medicine works. That's a fair thing if you think about the amount of people that we have to see in a day, but it's not if you want that patient to go home better educated that when he came." I looked at my colleague and we both nodded.

"What we need to do is to show the patients the respect they deserve as human beings. We need to take the time to talk to them and more importantly listen. If they're going to change their life, they won't do it because some dude in a white coat told him so, or if he will, he won't do it in such a way as to become responsible for his own life. We need to understand the patient and help him understand that we're only trying to help him, but we cannot do that without his help. You can do a lot of things during your years here, and by all means do. You're young. You need to have fun, you need to travel, meet new people and dream about changing the world, but the most important thing that you can do is this. Learn to relate to your patients and do not think of a case as a disease that you can treat, but much rather of a fellow human being who you're trying to help."
Enroll your activities to IFMSA Programs now!

Have you ever wondered who can help you develop an activity for a topic of your interest?

• Are you working on a project and want to further develop it and improve it? Do you want to show the impact of your activity with the rest of IFMSA? If these questions are true for you, then IFMSA Programs is the way to go! The Programs Team of 2019/20, with 13 enthusiastic Program Coordinators, is ready to help you with anything you need to enroll, develop or evaluate your activity.

• IFMSA endorsement and certification, global promotion, impact assessment, sharing of innovative ideas, a chance to showcase your work in Activities Fairs or Rex Crossley Awards. These are just a few of the benefits of enrolling your activity under an IFMSA Program.

• Almost 250 activities have already been submitted for enrollment. Will you join our great Programs family?

For more information, check this link or contact our VPA at vpa@ifmsa.org
REX CROSSLEY AWARDS

Meet the Winners!

1st Place

STUDENTS FOR GLOBAL HEALTH U.K
VITAL SIGNS: OUR PLANET OUR HEALTH

2nd Place

IFMSA-MOROCCO
AMR PHOBIA

3rd Place

WAAW
WORLD ANTIBIOTIC AWARENESS WEEK
With UpToDate, you can easily access over 11,800 evidence-based topics covering more than 25 medical specialties that can help you stay ahead of your studies and practice with the latest, reliable content.

- Learn more about the resource that helps you prepare for exams, write papers, and thrive in your clinical practice.
- Explore more than 35,000 referenced graphics and charts that can be used in presentation slides.
- Access anytime, anywhere through your smartphone, tablet or computer.

UpToDate strives to ensure that current and future medical professionals all over the world have the most current medical information at their fingertips!

Scan the QR code or visit go.uptodate.com/ifmsa20 to access our special rates for students.
Universal Health Coverage (UHC) is the state of healthcare wherein all individuals and communities receive the health services they need, without facing financial difficulties or issues on reaching of reach. Primary Healthcare serves as an engine for UHC; providing the basic framework needed to achieve health for all. It is a system that allows individuals to avail basic health needs, and to move up further in the chain of health services if needed; such that they have access to treatment, preventive and palliative care while keeping with the principles of equity, evidence-based medicine, intersectoral collaboration, and overall basic human rights, etc.

Over the decades the concept of PHC has undergone repeated transformation and reformation. It is sometimes thought of as a point of contact care, or sometimes as basic health services for underprivileged populations. But fundamentally, PHC is a set of principles that focuses on wholesome human development and health maintenance, integrating physical, mental and social wellbeing.

PHC strays away from an individualized approach to a society-centric approach, thereby eliminating the We-They dichotomy. It aims to provide care that meets the needs of the people, rather than merely treating disease. And it does so, by integrating individuals of the community into the health system, allowing them to serve as decision-makers and caregivers, at varying tiers of healthcare delivery. The inclusive participation of community members in their own care empowers individuals and communities and allows health services to be in accordance with the cultural and biopsychosocial needs of the population. Ultimately, this proves useful in ensuring patient response and compliance, an issue that often plagues rural healthcare delivery. A noteworthy example of community participation is the role of Auxiliary Nurse-Midwives (ANMs) and Accredited Social Health Activists (ASHAs) in India’s National Health Mission. They are trained and given the responsibility of spreading health education, bringing primary care services to people’s homes, improving access to maternal and child health services, etc. Research studies have shown that the reproductive health services and awareness have also improved as ANMs have been able to build a better rapport with young girls from their communities in rural India. Adopting PHC as the guiding force for health services in a country serves as a step forward in reducing the reliance on vertical development models and adopting actions that are based on the broad foundation of primary healthcare. This horizontal integration is achieved by Intersectoral collaboration (ISC) between the health sector, policymakers, civil society organizations, the technological industry, non-profit organizations, and non-health sectors such as water and sanitation, and local communities. The benefits of ISC are that it allows the pooling of knowledge and resources to improve healthcare delivery, and decreases the overall costs. Born out of such collaboration is the example of the usage of digital modalities in providing healthcare in remote areas, thus reducing the reliance and need for human workforce. Another prime example is the partnership between the Rwandan government and with Babylon, a healthcare company that specializes in linking technology with medical care. The result was a network that connected doctors and nurses to 75 % of the Rwandan population, giving them access to a primary virtual consultation, online prescriptions and a system of referrals in case of more complex medical needs (1). The practice of evidence-based care, wherein there is a greater reliance by providers on research and literature-proven treatment options, may sometimes be overlooked in medical care, especially when faced with issues of coverage and cost to achieve UHC. However, evidence-based
medicine is an integral principle of Primary Healthcare and it is imperative to recognize its role in making healthcare sustainable and efficient. It compels doctors and nurses to use real-time data to dictate treatment, and also promotes a dialogue between patients and providers and increases transparency. In addition, it also encourages continued learning by providers and makes treatment outcomes optimal and consistent.

In the process of striving for financial protection and breadth of coverage, to meet the goal of Health for All, one might assume that quality of care might suffer. However, we find that PHC, by virtue of its emphasis on evidence-based medicine and intersectoral collaboration, can ensure quality, and thereby help achieve treatment success, disease prevention, palliation, etc.; whatever be the needs of the people. To put this into perspective, let us consider the Family Health Program (FHP), the largest Primary Healthcare program in the world, implemented in Brazil, from 2000 to 2009. As per a longitudinal ecological study conducted at the end of this time period, the FHP coverage increased to 227%. The rate-ratio for cerebrovascular disease mortality rate decreased from 1 to 0.69 (0.66 to 0.73, 95% CI), and the rate-ratio for heart disease mortality rate decreased from 1 to 0.64 (0.59 to 0.68, 95% CI). The percentage of people living in homes with inadequate sanitation decreased by 40.2%, and the per capita income increased by 36.5% (2).

Despite being a concept that has been known for decades, the idea of PHC is wrought with misconceptions. One common misunderstanding is that it is cheap care – since it focuses on communities rather than individuals, it can be misconstrued as being cheap care. But in reality, it is essential care. It lacks overspecialization, as it is need-based, but most often communities need basic care. Since it seeks to cater to a large population, there is a focus on quantity. But that is not to imply that quality is compromised. Through its application of evidence-based medicine, and the placement of check-systems for error-rectification, quality can be assessed and improved. Another common misconception is that PHC solely applies to basic treatment, or only maternal and child health – This is far from the truth. Rather, it is about disease prevention, health promotion, treatment, disability rehabilitation, and palliation.

PHC is an all-applicable scheme, the principles of which can be applied to any healthcare system, irrespective of health infrastructure and expenditures. The versatility of PHC as a skeleton of healthcare arises from the fact that it is grounded on basic human rights. However, despite its widespread acclaim, often PHC does not receive the traction and support that is its due. Some countries face a lack of adequate investment by non-government sectors, while others are failing to achieve adequate intersectoral collaboration and adequate advocacy. So, today, while we set out to meet the SDG agenda, we need to critically evaluate and revitalize the current status of Primary Healthcare Systems, and work towards empowering such a system, if we are to achieve Health for All.

References:
1. Measuring What Matters: Case Studies on Data Innovations for Strengthening Primary Healthcare, English, Allyson et al., 2018; Primary Healthcare Performance Initiative
2. Impact of Primary Health Care on mortality from heart and cerebrovascular diseases in Brazil: a nationwide analysis of longitudinal data; Davide, Rasella et al., BMJ 349, 2014: g4014
Waking up today Kainat, whose name roughly means the universe, had no idea that her universe will turn upside down in the most excruciating manner. It all began when she saw her father looking sick and asked him to get himself checked by a doctor to which he said, “the money is really tight and I can barely afford the ~400km journey to the city, let alone the treatment itself”. Hence, it was decided that they will wait till next month for their father to go to the hospital with properly functioning equipment, medicine and healthcare providers. Little did they know that the unfateful night would take their father away in terrible agony from chest pains and apnea on the scuddy, torn table of the Primary Health Care center and that the bitter feeling of helplessness will leave them wishing for a different life with at least better options for accessing the basic healthcare amenities. However, the lamentation is not only for the reason that a family lost a loved one who could have easily been saved if the proper help was available but also for the fact that this is not an uncommon tragedy in the remote districts. These unfortunate events will continue to happen in places like Balochistan and many other remote areas around the world, unless PHC is given the prime importance that it deserves on the journey for the achievement of health equity by 2030. "PHC is the foundation of UHC" (1). The 1978 declaration of Alma Ata (2) paved the way for all countries towards achieving the goal "Health for All" whilst setting sound PHC as the driving force.

"One of the defining characteristics of a highly functioning primary healthcare is the inclusivity of the community in active leadership role..."

Today, however, standing only 10 years away from 2030, the concept still seems like a dream rather than a reality. Astana 2018 has become the new advocate behind strengthening PHC for pursuing UHC which calls on the governments, policy makers and other stakeholders to strengthen the PHCs in
order to protect the right of everyone’s access to safe and effective healthcare (3).

PHC serves as a platform to provide remote communities with people-centered approach, addressing the determinants of health in a broader aspect (4). This approach provides a better and unique opportunity to integrate the conventional and digital methods of treatment which would provide quality, comprehensive, continuous and coordinated outcome based treatment. One of the successful examples is Senegal, where they adopted the use of digital medical records of patients, which ranged from the diagnostics to the long term monitoring and assessment of outcomes pertaining to the set goals and objectives for improvement in the quality of health (5).

One of the defining characteristics of a highly functioning primary healthcare is the inclusivity of the community in active leadership roles, which helps in identification of needs of that community as well as help in building better strategies for improvements in health coverage (6). Studies have shown that health systems based on PHC have better patient outcomes (7). Moreover, studies by WHO suggest that 80-90 % of health needs of patients can be efficiently dealt with at the first point of contact between the patient and the healthcare professional, provided that the PHC is well functioning (8).

In conclusion, the ambitious goals of UHC can be a reality if the world would realise that UHC is based on the pillars of PHC (quality, efficiency of healthcare workers and equity) and achievement of UHC by 2030 is only possible if we start the process from the most cardinal element, which is Primary Health Care.

References:
EVERYONE EVERYWHERE
The role of Primary Healthcare in Universal Health Coverage

Jonathan Knight
Oxford University

"Universal Health Coverage: Everyone, everywhere." These words, from the slogan of the 2019 World Health Day, elegantly sum up the principles of social inclusion and equity that underpin the objectives of Universal Health Coverage (UHC). The idea that all people should have access to healthcare, regardless of their location or ability to pay, is clearly a worthy one. It speaks to the capability approach to development pioneered by Amartya Sen, since it has the potential to release people from the "unfreedom" of poor health (1).

What exactly is UHC? Broadly speaking, it is the universal provision of a package of essential health services that address the most significant causes of death and disease. The measurement of this package was developed by the World Bank and the WHO, and includes 16 essential health services. UHC strives for quality, not just the most basic or emergency services. It can encompass reproductive health, infectious and noncommunicable diseases, as well as access to essential medicines. In addition, it avoids significant direct payments at the point of care, protecting the least well off in society from financial barriers and burdens. This last point is key as over 930 million people, or 12% of the world's population spends at least 10% of their household budgets to pay for health care (2).

What role would primary health care (PHC) play in achieving these goals? As Dr. Tedros put it in a 2019 editorial, PHC is the cornerstone of UHC, so much so that achieving UHC would be impossible without it (3). A PHC approach prioritises a long-term and community based model for providing for health needs throughout life. It emphasises the broader determinants of health, and aims to empower individuals and communities to improve their health. PHC is a cost-effective and equitable way of providing healthcare, particularly with its focus on preventative medicine. A case study of the primary care model has been Cuba, which places great emphasis on healthcare in the community. Specialisation in family medicine is a requirement for the majority of medical graduates, who are then allowed to go on to apply for a residency in another training. This means that almost all of the specialties are now taking in doctors with a previous background in family medicine. Structurally, the healthcare system is based on polyclinics linked to a set of community care offices, which are intended to be located in every neighbourhood and village, headed by physicians, who are responsible for approximately 2500 patients (4). Overall, this has led to strong healthcare outcomes in Cuba, which has a life expectancy equivalent to the United States at 78 years (5). While Cuba faces many challenges, including lack of equipment and supplies and scarce tertiary care, the strength of the PHC system is a model for achieving UHC objectives in low-income countries.
The efficacy and impact of PHC is notoriously hard to measure for a number of reasons (6). There is also the broader problem of quantification of the impact of a large shift in the approach of a health system, which will naturally affect many sectors of the economy and society. Despite these issues, a number of studies have indicated that investment into PHC is economically effective and achieves the goals of UHC better than any comparable system. For example, an analysis of 102 low- and middle-income countries’ health statistics found that PHC provision was significantly associated with improved population health (7). PHC was also found to have more equitable access (8) and reduced individual healthcare costs (9). As the WHO outlines, there is still a need for common measures and data requirements in order to produce a high quality study analysing the precise impact of PHC (10). Despite this, it seems logical that PHC, with its emphasis on prevention, holistic health and the social determinants of health, would be a more effective system than simply relying on specialist care.

Another example of the success of the primary care model can be seen in Ghana, where a number of initiatives have been put into place to improve PHC. Ghana has a Community-based Health Planning and Services programme which places community nurses in communities within their own region but not their home community. This is a good balance since it provides staff who speak the local language, but who also have the right social distance to be effective healthcare providers. Such a strategy also allows the lateral diffusion of knowledge and good practice between community practices. Ghana has also been a pioneer in providing a National Health Insurance Scheme that nearly every Ghanian can register for. It is specifically designed to promote equitable and affordable access for all Ghanaians by reducing the out-of-pocket and upfront payments, which can be catastrophic for those on low incomes. The scheme is a first among sub-Saharan countries. A 2018 systematic review indicated that while there is still progress to be made, the introduction of the NHIS in Ghana has reduced the impact of out-of-pocket payments on the poorest households (11). Ghana’s approach shows the power of multiple programmes focused on community level PHC to allow equitable access to healthcare to all, one of the key goals of UHC.

References:
Leveraging Artificial Intelligence in Primary Healthcare to Achieve Universal Health Coverage

Fatima Ali (1), Fizza Ali (2)
1. Imperial College London | SfGH-UK
2. Palacky University Olomouc | IFMSA CZ

The World Health Organisation agreed on the triple billion target at the 71st World Health Assembly, where one of the top objectives is Universal Health Coverage (UHC). To obtain equity in health services, it is essential that people are not exposed to financial hardship when trying to access healthcare. There are many methods that have been put forward as conduits to achieve UHC including the use of artificial intelligence (AI) (1,2).

AI is the principal term used to describe advanced intelligence in computational agents that are created to emulate human cognition and decision-making. There are arguable many characteristics that determine intelligence in these agents including the ability to adapt to altering environments, learning from experiences and making appropriate decisions with respect to the aims (3). AI is initially broadly categorised into two types, artificial narrow intelligence, which constitutes the vast majority of current AI research, and artificial general intelligence. While artificial narrow intelligence solely focuses on performing defined single tasks within a limited contextual situation, artificial general intelligence is more sophisticated as it can compute a variety of general tasks in different environments, like humans (4,5).

While AI is prevalent in developed countries and has many uses including telemedicine, early high-quality diagnosis, data analysis and prognosis assessment, there is uncertainty regarding its relevance in low-income countries where the inequalities shaped by the technology divide is common knowledge. It is evident that some developing countries currently lack the digital service infrastructure and resources needed to uphold a complex system such as AI. Despite this, it can be noted there is still 94% mobile phone penetration in developing countries, early developments of a digital economy and an indication of the digital-divide is narrowing (4). Although it is important to be mindful of the effect that AI can have on further exacerbating the socio-economic divide, it should not negate the potential positive effect such as an ICT infrastructure development and probable transformation of healthcare facilities (2).

In developed countries, health inequity is attributed to socio-economic determinants, whereas in developing countries, failure in accessing healthcare services is held accountable. There is considerable emphasis put on empowering self-reliance of communities using primary health care (PHC) as it allows assessment of the grassroot causes of health inequality (6). Despite the efforts of the government, society and even the private sector, the financial support for UHC in developing countries is unable to meet the minimum requirements. One contributor to this is the lack of health workforce. There will be an estimated shortage of 14 million health workers in 2030 and this, coupled with an increased demand for chronic care, manifests itself as incredible pressures on health workers (7-10).

AI has the potential to support Community Health Workers (CHWs) in providing more efficient and effective services. Although it cannot solve the root of the cause (the shortage of CHWs), it does ensure the system is effectively aligned so that CHWs are not overburdened. CHWs, often members of the community or patients, are very versatile and can assume a wide variety of healthcare roles. The most prevalent in this situation is being the first point of contact to the established healthcare system. They are also proficient in delivering standard medical and preventive care, overseeing treatment, educate in health issues and identify serious conditions and triaging these patients to doctors. The latter is where AI has the most potential to intervene in rural settings.
AI can help CHWs make more informed diagnostic decisions to prevent unnecessary referral to the primary or secondary care doctors, thereby improving the outcomes of interactions and reducing medical errors. An example of this being used in rural clinics is in India where they adopted the Early Detection and Prevention System (EDPS) for clinics without a doctor. This was highly successful in giving CHW treatment recommendations, achieving an overall 94% uniformity to physicians’ recommendations (11,12).

Access to care is another element which can be developed using AI in resource-poor settings, particularly using mobile health which is also known as mHealth. With increased mobile phone penetration at 80% in sub-Saharan Africa and increased service coverage, mHealth is an impending avenue for advocates of health equity (13,14). This can be an invaluable tool, especially in areas where there is no formal healthcare infrastructure set in place as it allows provision of personalised health information to both the health-care worker and patient. Uses of mHealth include diagnosis, disease monitoring, health literacy, public health surveillance, data collection and tailored self-management to name a few (11,12). However, these methods are not positively received by all stakeholders, particularly patients who place a high level of trust in personal connection and are apprehensive of using technology (15). Nevertheless, when face-to-face communication is not viable in remote areas, mHealth provides an accessible solution.

As AI in mHealth is a nascent concept, the effect on patient outcomes has not been fully assessed. However, there are numerous developing countries implementing mHealth into their healthcare infrastructure. Examples include Nigeria which established the ‘learning about living’ project which aims to distribute AIDS awareness information (16). Also, the use of clinical decision support (CDS) has transformed the use of smartphones, facilitating treatment and improving overall outcomes. An example of this is in Kenya, where CDS was used in 107 rural facilities to improve adherence to malaria treatment via timely texts containing advice for CHWs – this resulted in a 28.6 increase in drug adherence (16). Though there is considerable potential in mHealth, all of this relies on having reliable bandwidth to upload, data storage facilities, hardware affordability, CHW receptivity and an acceptance from all stakeholders (15).

It is worth noting that a shift toward AI is also often accompanied by a parallel adoption of electronic health records (EHR) and cloud data storage. Once an EHR system has been established, safe and reliable storage of patient data is an imperative prerequisite for sustainability. A dependable and cheap solution, which does not compromise data protection and security, is cloud computing. However, this does come with infrastructural criteria (17,18).

Indeed, one of the other significant identified methods of attaining UHC is being able to prevent, identify and effectively react to outbreaks of disease that threaten community health and possibly international public health too, such as in the case of a Public Health Emergency of International Concern (PHEIC) as defined under the International Health Regulation (IHR) (19,20). This is a very topical issue and requires extensive further analysis. Disease outbreaks have a substantial effect on global security and disproportionally affect the poorer more isolated communities; hence highlighting the pivotal role UHC has in the maintenance of social justice in the face of adversity (21).
Limitations of Artificial Intelligence in Achieving UHC

An initial concern of using AI as a conduit to eradicate health disparities is the cost of implementation and creation of an appropriate infrastructure. Hence, it is essential for local healthcare services to work collaboratively with national and international organisations to strengthen their financial resilience before implementation. In addition to preparing a suitable infrastructure, the key users of the AI will also have to be trained and prepared to use a new system.

Due to the numerous services that AI can provide in healthcare, whether through advice for doctors or health information analysis, there are also worries of skill erosion for some doctors or CHWs. As AI is only as good as the dataset used, it can emulate human biases relating to ethnicity or gender, for example. To prevent this occurring in the healthcare system, it is important to involve all key groups to be involved in the development and use representative datasets.

Using AI, EHR and cloud computing all highlight issues of data security, privacy and data confidentiality. Each of these elements will have to be fully integrated into the digital system as well as within the healthcare strategy. There is also a legal concern over who owns the data and ultimately, who controls this technology as there is considerable risk of malpractice. Protective mechanisms need to be put in place to protect patients and doctors. A potential additional technology which could resolve these issues is blockchain technology. In developing countries, a particular concern is collection of good quality secure data, this has a direct effect on scaling up AI.

Conclusion

Overall, the success of AI in achieving UHC depends on how well we integrate AI into an overall holistic approach to improving access to quality care. There is definite potential in the ability of AI to improve access to care through increasing efficiency and quality of care while also incorporating different facets of technology such as mHealth and cloud-computing. While there are still challenges that must be overcome including issues of governance, privacy, security and accountability, these factors will only be resolved with extensive interdisciplinary collaboration with all stakeholders. Ultimately, AI has tremendous promise for developing a healthcare system which narrows the current health disparities and is one step closer to achieving UHC.
The role of Primary Health Care in the inclusion and guarantee of Universal Health Coverage for transsexuals and transvestites in Brazil

Gustavo Augusto Silva, Irina Paiva Duarte
Universidade Federal do Rio Grande do Norte | IFMSA-Brazil

In 1978, during the International Conference on Primary Health Care, Alma-Ata Declaration appeared emphasizing to the world the importance of Primary Health Care (1). From that point on, health was established as a fundamental human right, as well as a new understanding of what it means to “be healthy”: physical, mental and social well-being (1). More than 30 years have passed, and what was proposed at the time is not yet fully implemented, that is, coupled with the growing social demands that have emerged, there is still no universal health coverage. A striking example of this is the LGBTQI+ population, which suffers from marginalization and faces impasses to access Primary Care. In view of this, the Ministry of Health created the National Policy for the Comprehensive Health of Lesbians, Gays, Bisexuals, Transvestites and Transsexuals in 2013 (2), an essential step in recognizing the needs of this vulnerable population, which, although very important, still doesn’t guarantee this coverage.

Although several advances have been achieved, there are still problems that plague this population. The range of prejudice and exclusion on the LGBTQI+ population in society is visible, and within that group, the population of transsexuals and transvestites deserves even more attention. Therefore, guaranteeing this access means promoting continuous, longitudinal and person-centered care, as well as human rights, in addition to promoting and protecting health. But what makes this access difficult? Pereira and Chazan report that the main factors are “low accessibility, fragmented, focused and non-integral system, absence of equity and reception, absence of decentralization and regionalization of care” (4).

Therefore, there needs to be a better territorial distribution. However, an essential point of improvement is the need to improve reception, since the lack of comprehensive care for this population is naturalized. But what would be calling this into question? According to Pereira and Chazan, it would be simple things like not observing the social name, the inability to handle issues specific to the LGBT universe, not talking about the therapeutic process, using technical terms excessively, symbolic barriers (such as culture and people’s beliefs) and other things that would end up causing trans people embarrassment and insecurity.
This non-reception or "cheap" reception, which is also influenced by the resistance of older health professionals (since they are reluctant to promote the inclusion of this community in the System) goes against the principle of equality of the famous, brilliant and Brazilian Unified Health System (SUS). All of this, in addition to damaging the doctor-patient relationship, weakens the relationship of this population with the health system, facilitating the chronicle of circumstances that threaten the well-being and health of these individuals. Although at a slow pace, some progress has already been made. In addition to the aforementioned National Policy, discussions on topics involving LGBTQI+ health are already being promoted, for example, at the Federal University of Rio Grande do Norte, in Brazil, the Academic League of Sexuality and Gender (LASEG) in the medical course that promotes this type of debate, in order to train doctors prepared to create bonds and guarantee the permanence of this population in the System (6). United in this same objective, they meet monthly to discuss increasingly relevant topics on the subject, participate and promote events in order to involve both the academic community and the population in general, creating a network of information, support and perspective for the future where health is truly universal.

Such thinking may seem utopian, but it is necessary to work for it and to feed the hope of improvement as a harvest of much dedication. In addition to this, there was the creation of the clinical protocol for trans health clinics in the city of São Paulo in 2010 and the creation of the Primary Health Care Outpatient Clinic for Trans People (AAPST) in Florianópolis (4). In this sense, also, the Government of Rio Grande do Norte (RN), through the Secretary of State for Women, Youth, Racial Equality and Human Rights (SEMJIDH) and the Secretary of State for Public Health (SESAP), held on the 20th January 2020 a meeting on the creation of the Transvestites and Transsexuals Clinic in the State of RN (5). The event counted with the participation of Civil Society Organizations interested in the theme, which, in this way, were willing to discuss the needs of this group and how health professionals can increasingly help in this process.

Therefore, the need to create these actions and this type of outpatient clinic aimed specifically at this population arises to meet the important specific demands that these individuals have, since possibly a large part of general practitioners (and many specialists) unfortunately are unable to act safely in this area (often due to the non-debate of these contents during the academic and professional environment). It is these types of attitudes that need to be stimulated. The education of LGBTQI+ patient care is extremely necessary, since it is an undeniably marginalized population, and it needs the support of the State and the SUS so that we can move towards a more inclusive society that fights for the health of all, without any distinction, in order to really achieve universal health coverage.

References:
Violence against women is recognized as a Public Health problem, according to the WHO, and is characterized by its physical, verbal, oppressive and psychological aspects, the results of a patriarchal society. Given this scenario, the victims of this type of violence, in addition to not denouncing their offender - usually their own spouse - are also reluctant to seek help from health services because they do not consider this as a public health issue. Thus facing this issue through Primary Health Care (PHC) is essential. However, some difficulties of this service prevent it from working fully in relation to victims of gender violence, something that maximizes this blemish in the Brazilian society, which has a history in its cultural formation of objectifying women, that reflect today on the high rate of femicide in the country.

Regarding the Unified Health System (SUS) that prevails in Brazil, it is worth highlighting among the principles and guidelines that make it up the hierarchy of health networks as an alternative to facilitate and streamline the service of users according to the increasing levels of complexity, being the same divided into three main levels of care: Primary, Secondary and Tertiary. Primary care, in turn, is characterized by low complexity and is defined by promoting health promotion, protection, and recovery activities. Care provided by the teams of the Community Health Agents and / or Family Health programs, as well as in Basic Health Units (UBS), are included at this level, as well as some care and follow-up carried out in outpatient clinics. At this level, the procedures are inexpensive and approximately 80% of the population’s total health problems can be included in it. From this perspective, women who are physically abused are still reluctant to seek medical care, but when this happens, most of them go to PHC to the detriment of specialized hospitals (secondary level), since the first is seen as the gateway to health services in Brazil, where problems that can not be completely resolved are referred to consultations with specialists, exams or care at the Emergency Care Units, hospitals, Psychosocial Care Centers, among others. Therefore, as it is installed close to the users’ lives, playing a central role in warranty access to quality health care due to the diversity of services provided by SUS, PHC creates a bond with the user of its services, as well as moving to the even when necessary through community health agents and policies such as the Family Health Strategy (FHS) services in Brazil, where problems that can not be completely resolved are referred to consultations with specialists, exams or care at the Emergency Care Units, hospitals, Psychosocial Care Centers, among others. Therefore, as it is installed close to the users’ lives, playing a central role in warranty access to quality health care due to the diversity of services provided by SUS, PHC creates a bond with the user of its services, as well as moving to the even when necessary through community health agents and policies such as the Family Health Strategy (FHS).

However, the unpreparedness of the medical team, the lack of welcoming to the victim, the lack of a protocol geared to care, low resolution, underreporting and limited treatment contribute to failures in the management of victims of aggression. It is important to emphasize that many of the prejudices experienced in the daily lives of women are reproduced in the doctor’s office, something that inhibits the victim from reporting the violence suffered...
to those who should minimize their pain. This also reveals that knowing how to deal with patients in situations of fragility, whether physical or emotional, shows a skill that is often neglected during academic training: caring for the patient. It is also worth noting that a multidisciplinary team makes a difference in PHC, since psychological assistance and the role of health agents are essential to guide women in vulnerable situations, both for the long-term treatment of victims through therapy, and for avoiding violence with the agents’ identification of the problem and possible guidance from women on how to report the aggressor.

In this way, the PHC is a strategic way to deal with gender violence, since it creates a bond between the user and the institution, due to the possibility of continuous care. In addition, the potential of Primary Care offers a means of health promotion for victims who receive primary care, such as preventing violence through a multidisciplinary team. However, the design of health professionals is one of the main bottlenecks affecting PHC to solve problems of approach. In addition, health services are not able to solve all the problems of violence against women, and the role of other public bodies, for example, legal power, is essential to minimize this evil in society.

It is therefore necessary to expand this network of care for women in situations of domestic violence, avoiding limiting the practice to isolated actions, which in themselves do not account for the complexity of the phenomenon. Besides that, it is important to highlight the training of health professionals in order to improve the way this topic is worked in primary care, prioritizing ethics over the victims judgment, as a fundamental tool to optimize the role of PHC in combating gender violence. Furthermore, as long as civil society sees women with the eyes of the last century and neglects basic principles of equality among all individuals, as advocated by article 5 of the Brazilian Federal Constitution, all this will be in vain to end this stain that persists in current days.

References:
The role of Primary Health care in achieving Universal Health Coverage

Sarah Ibershimi
Universiteti i Mjekësise Tirane | ACMS - Albania

According to the World Health Organization, Primary Health Care (PHC) is a whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families and communities (1). The Declaration of Astana openly states that the enjoyment of the highest attainable standard of health is a fundamental right of every human being without distinction of any kind (2). Actually, this is also one of the main purposes of Universal Health Coverage (UHC) together with the access to quality health services without suffering financial hardships (3). But, what is the role of Primary Health Care in achieving Universal Health Coverage?

Over the last decades, many European countries have taken steps forward in providing not only a public health system to their citizens, but providing a Universal Covered Healthcare System as well. The greatest challenges of UHC have been and continues to be the reduction of maternal and children mortality (4).

Unfortunately, UHC is not achievable all around the world. The data shows that more than 50 countries not only lack the basic elements to provide Universal Health coverage, but they are also extremely deprived of basic services such as: water, hygiene, medical and pharmaceutical products, etc. All the above make it difficult to achieve the goal and for this reason, UHC continues to be the main priority for both the World Health Organization and governments, because it is up to political solutions and priorities to provide health services (4).

Primary Health Care (PHC) is a "catalyst" between people and the health care system. PHC includes health promotion and health maintenance, disease prevention, education and rehabilitation (5).

According to the Declaration of Alma-Ata, PHC brings health care as close as possible to where people live and contributes to the formation of the first elements of a continuing health care process (6). It is important to underline that health systems based on PHC provide quality services that are well-coordinated and people-centred (4). The letter means that the main focus of PHC are the people, rather than the diseases. Primary health care has played and continues to play a significant role in achieving Universal Health Coverage.

Firstly, PHC is a forerunner of UHC, which means that it is crucial to building a solid health care system in order to achieve Universal Health Coverage. This step facilitates the impact of the low financial context on health. By enabling access to high-quality health services without paying out-of-pocket and by ensuring affordable medical services and products, Primary Health Care directly reduces mortality and increases average life expectancy.

Secondly, given that Primary Health Care is the most efficient method to address broader determinants of health and it has a significant impact on the protection of family finances, it is evident that the strengthening of PHC will lead to achievement of UHC (1). United Nations General Assembly sustains the idea that Primary Health Care is the route to Universal health Coverage, as well (7).
Thirdly, by weaving together the primary care services with public health, it will lead to the improvement of the performance of the health care system and it will ensure equitable access to everyone (5). Dr. Tedros Ghebreyesus, World Health Organization Director-General, once said: “If we are really serious about achieving Universal Health Coverage and improving people’s lives, we must get serious about primary health care” (8). But, to show the positive results of investments in strengthening the Primary Health Care, it is very important to continuously monitor the implementation of health system policies.

The role of Primary Health Care in achieving Universal Health Coverage is particularly important in countries with limited economic and social resources. Low-income countries often face higher health threats and therefore need more health services. According to the UN report for 2019, upper-middle and lower-middle income countries have achieved significant results on essential services, but they have not achieved high levels of financial protection (8). The benefits of Universal Health Coverage will depend on the qualitative health services provided.

A strong Primary Health Care is fundamental in achieving Universal Health Coverage. Moreover, when it is combined with financial protection, it seems to be the best option to ensure health for all. Strengthening PHC requires resources and infrastructure. For this reason, it needs to be supported by both governmental and health institutions. It is essential to make sure that no one is left behind, particularly the stigmatized and vulnerable groups.

References:
5. Chris Van Weel, M. R. (April, 2018). Why strengthening primary health care is essential to achieving universal health coverage. CMAJ.
Slow Medicine
A Card-Mediated Action Focused on Hospitalized Mental Health
Bárbara Okabaiasse Luizeti, Carlos Henrique de Lima
Unicesumar | IFMSA-Brazil

INTRODUCTION
Our support network helps to face health challenges (1) as it promotes resilience and enables the use of psychological resources to overcome emotional problems. Social support is associated with adherence to health treatments, a sense of stability and psychological well-being (2, 3), proving capable of reducing individual susceptibility to illnesses (4).

Interventions that strengthen the support network, provide better health conditions for the population. Comprehensive care by health agents favors the integration and strengthening of the bond between patient and family with the team that provides care, choosing a source of support necessary to intervene in crisis situations (5, 6).

Slow Medicine rescues the primacy of time in science and the art of caring. Time to listen, time to reflect, time to build solid and lasting relationships between doctors, patients, families and the community. Thus, Slow Medicine helps health professionals in getting closer to the patient’s reality, preventing anxiety during the allowed delay, assisted observation and non-urgent procedures, and so is an efficient strategy to strengthen the support network (7, 8).

There is a need to verify the following question: is it feasible to implement Slow Medicine in order to preserve the doctor-patient relationship and favor joint decisions in the curriculum of medical schools?

METHODS
Between 8 and 17 November 2019, medical students from the University Center of Maringá were invited to write letters, voluntarily and anonymously, of motivational content for hospitalized patients. These were delivered by members of Humanizart, a project that takes art to hospitals in inpatient health facilities in Maringá, Paraná, Brazil. They were evaluated on their perceptions of the effectiveness of this practice in the prognosis of patients.

RESULTS
When asked whether long periods of treatment could affect patients’ mental health in addition to the underlying disease, everyone said yes. 50% of respondents assessed that, on a scale of 0-10, 9 was the level of competence of the letters delivered to contribute positively to mental health and, consequently, to the physical health of patients. In the qualitative assessment, they were asked what hypotheses could be raised about the influence of

*On a scale from 0 to 10, how much do you believe these cards positively affect mental and physical health?*

- 8
- 9
- 10
correspondence in easing patients’ pain. There were anonymous responses such as: “They can generate a feeling of trust and faith in the patients, and consequently a strength so that they can remain firm and confident in the treatment” and “They can bring an extra joy to the patient, a good, loving feeling in that tiring time in the hospital … and whenever the patient wants, he will have it to be able to remember it all the time”.

**DISCUSSION**

Comprehensiveness in patient care has been distancing itself from medical practice. This statement is evident in the unanimity of the students interviewed in recognizing damage to the patient’s health in extensive treatments. That is, the resolution of patient care is compromised.

Slow Medicine, in this context, accumulates benefits for the doctor-patient relationship and reduction of damages and public spending towards improving public health (8, 9). Thus, there is a positive assessment of future doctors in affirming the high probability of the anonymous letters of motivation delivered, as a strategy of this ideology, contributing to the improvement of patients.

**CONCLUSION**

It is concluded that inserting Slow Medicine in medical education contributes to combating the continuous depreciation of medical sciences by hospital-centered thinking.
Spirituality is a particular characteristic of a person. It involves faith, link with the transcendent and life’s purpose, without necessarily being related to the manifestation of religiosity. The approach of this theme in the academic formation of health courses is important to help in the care from professional to patient and family along all of medical monitoring (1), because the use of this practice in clinic and surgery helps positively in prognosis (2). For many years, it was neglected. Today, many health professionals feel uncomfortable approaching this aspect with patients. So, the diffusion of the teaching of spirituality during graduation, as in 80% of the United States and Europe universities, helps in the development of this ability and in the reintroduction of spiritual context in health care, because of its influence on the life of the majority of the population (3).

A research was conducted to elucidate the importance and influence of spirituality in the doctor-patient relationship and in the health-disease process. In the first semester of 2019, the optional discipline of Medicine and Spirituality was organized by Amazonas State University professors. It was taught by doctors of different specialties, cardiologists, psychiatrists, orthopaedists, and surgeons. At first, they explained the difference between religiousness and spirituality. Besides, there was a discussion of many themes, with the presentation of scientific studies, which made possible a reflexion of the influence of faith in the health-disease process.

As a result, forty-one students whose average age was 22 years, with the prevalence of female sex (59%) and most of them from Medical school (93%) followed by Nursing (5%) and Odontology (3%) attended the class. From all these 41 students, the presence of those who are in the basic cycle was 49%; clinical cycle, 39%; and internship, 12%. Most of them declared to believe in God (93%) and to follow a religion (73%), predominantly Catholic religion (46%). At the end of the classes, all agreed about the importance of the approach of religiousness/spirituality matters with patients. However, only 22% would talk about it independently of the patient’s request, and 57% of them would only talk if the patient wanted to. Eighty-eight percent declared believe in miracles. When the index of evaluation of extrinsically religiosity developed at Duke University was applied, it was observed that habits of individual religious activities (83%) are more prevalent than the presence in cults/masses (39%). When the same index for evaluation of intrinsical religiosity was applied, it was observed that 66% was classified as carriers of intrinsic religiousness (spirituality).

In conclusion, the acceptance and dissemination of spirituality like an important way for the development of care strategies with the patient became evident, across better comprehensive care, respecting and valuing religiousity/spirituality in a patient’s life.

References:
Thanatology in the education of health professionals

Laura Reyes González, Faculdade de Medicina de Marília (FAMEMA) | IFMSA Brazil

Death is part of the routine of health professionals. However, these professionals don't have enough training to deal with the death, resulting in less humanization of care, unappropriated use of drugs or unnecessary treatments as well as the illness of health professionals. This is the result of a medical curriculum that does not provide adequate spaces for discussing the topic. Thus, it is necessary to promote discussions about Thanatology in undergraduate courses, in order to train professionals prepared for the demands of professional life.

In view of this scenario, the local committee of IFMSA Brazil at FAMEMA decided to hold an event, The Thanatology Course, to promote a debate on the topic and to learn more about what was the perception of Thanatology and the reality about Thanatology teaching. The Thanatology Course consisted of three lectures: "Everything healthcare professionals should know about palliative care", "Thanatology’s importance in the Medical Curriculum" and "Thanatology and Palliative Care from a perspective of urgency and emergency care pre-hospital". After the lectures, participants received a questionnaire to appraise their previous knowledge of Thanatology, the presence of the theme in undergraduate courses and the importance of the event.

There were 80 participants, mainly students and health professionals; 58.8% knew what thanatology was before the event, 33.3% were not sure and 7.8% did not have any knowledge about this specialty. Regarding the contact with thanatology during the medical studies, only 2% said it was satisfactory but limited to the SPIKES Protocol or extracurricular activities; as to the theme of the course, 100% said it was important.

Therefore, it was evident how Thanatology, although important, is neglected; this highlights the need to increase the promotion of spaces for the discussions of the topic, resulting in graduate doctors and other health professionals better prepared to deal with the death and, thus, make healthcare more humanized and improve the mental health of professionals. To this end, it is essential to reconstruct the medical curriculum, as teaching about death should not depend on extracurricular activities.

References

Ana Quintana, a famous palliative care physician in Brazil has rightfully said, "Unhappiness is a constant presence in the life of the doctor who has only learned about diseases" (1). This shows the value of teaching palliative care to medical students as it will help not only the doctors, but also the patients in coping with the dark realities of certain incurable diseases. WHO defines palliative care as a quality-of-life promoter for patients and families living with life-threatening diseases (2). A Brazilian study with 16 doctors reported that this subject is not addressed adequately in academic education and they feel that they are unable to communicate bad news to their patients (3). This important theme is overlooked in most medical schools not only in Brazil, but also worldwide. Today, our medical school teaching focuses on diseases and their treatments and not on empathy and resilience. Budding physicians should be taught that they have no control over this natural circle of life and death. This means that sometimes just giving support to patients and families in terms of being there for them or providing them with comfort care, without the crutch of disease-curing medicines is also a part of essential medical care and that the inability to cure patients should not be considered a failure and a cause for frustration (4). So how can medical schools help in teaching the concept of palliative care to their students? A palliative care education proposed by Caldas, Moreira and Vilar (2018) (5) can go a long way in this direction. It suggests teaching through these 5 basic modules: Basic Principles of Palliative Care, Symptom Management, Team Work, Ethical considerations and Legal Assistance in the Last Moments of Life. Communication is a fundamental item of this theme. This skill, considered as one of the pillars of palliative care, must be understood as a technique to be developed and improved throughout the professional’s experience with patients and their families (6). Viewing films such as 'Patch Adams' with subsequent debate, theatrics demonstrating the need of palliative care and simulations mediated between students and qualified teachers are some of the ways to enhance the knowledge regarding this sensitive topic. Institutions need to adopt a more understanding attitude towards the physician's dilemma in the end-of-life care of their patients and start at the medical student-level to inculcate the intricate concept of palliative care into their curriculum. In addition to that, we need to teach our future doctors to be good listeners and to adopt a new approach as professionals by being respectful towards their patients’ feelings. There are many ways to approach the subject of palliative care, one of them is talking more about it. So, let’s talk more!

References:
1. Arantes ACQ. Death is a day that is worth living. Rio de Janeiro: Sextante; 2019.

Palliative Care in medical school
We should talk more about it

Brenda Chayná do Nascimento Pereira
Universidade do Estado do Amazonas | IFMSA Brazil
Pre-departure Training National Guidelines

A step towards academic quality

Letícia Nunes Campos (1), Mariana Vitória dos Santos (2)
1. Universidade de Pernambuco (UPE), 2. Faculdade Integral Diferencial (FACID) / IFMSA Brazil

In the context which medical placements abroad has become an increasing reality, considered as a key component of global health education and medical schools curricula, it is vital to ensure that this experience has an academic gain for the student. On the other hand, it is also a high priority to guarantee that these placements do not negatively impact the hosting community, especially due to the intercultural differences which may take place.

On the purpose of avoiding such harm, it is essential that IFMSA’s exchange program starts to take these cautions into account, outlining objectives on the Standing Committee of Professional Exchange (SCOPE) and Research Exchange (SCORE) strategic plans. Nevertheless, this issue is ought to be discussed among the National Member Organizations (NMOs). Taking this into account, the principal objective of this article is to report how stabilising the National Guidelines for the Pre Departure Trainings (PDTs) improved the academic quality of IFMSA Brazil’s exchange program, contributing to a better preparation of our outgoings.

This initiative was carried on by a partnership between IFMSA Brazil’s SCOPE, SCORE and Capacity Building national officers, as well as members from the national exchange team. This team, composed of 6 members, elaborated the National Guidelines for PDTs, considering the logistics, content and all required support materials. In addition, national officers from other Standing Committees were consulted in order to elaborate the guidelines through an interdisciplinary approach. Besides releasing the guidelines in July of 2019, the team hosted an online meeting explaining the proposal, which would be available for any local officer from IFMSA Brazil. Through the guidelines, IFMSA Brazil established that each LC must organize the PDT to all of its outgoings within a certain deadline, with the aim to provide proper preparation to all students for traveling abroad. Analysing the fact that the NMO has now more than 90 active LCs on exchanges, this was an excellent measure to decentralize the PDTs, putting the responsibility on the local officers, so they could be actively involved in the training realisation.

Furthermore, it was possible to standard the PDTs’ logistics, adjusting details as submission, time schedule and feedback, a system which would enable the national officers to have a proper evaluation and quality assurance of the hosted PDTs.

Moreover, it is relevant to stress that the guidelines specify a series of mandatory topics that must be addressed during the PDT, but also of optional subjects, giving the LC the freedom to adjust the agenda accordingly to the target public. Among the topics, there are: communication guidelines; global health; travel precautions; bioethics; scientific production, as well as a list of soft skills trainings.

Based on the reported experience, it is evident that implementing the guidelines was a riveting alternative not only to assure that all outgoings receive appropriate preparation, but also to demonstrate that interdisciplinary approach is the required condition to guarantee a respectful and ethical medical placement abroad.

References:
Last, but certainly not least, for the third weekend, we suggest to take you away from the city’s hustle and bustle. So how about we go for a camping trip to the northern part of the country, to a virgin beach called “cap Serrart”? The highlight of this weekend is the NFDP, because what better way to celebrate it than on a sandy beach, under a starry sky, surrounded by the people that have been your family for the past month?

To sum up, this national social program is bound to be an adventure that the incoming can’t help but blabber about to whoever crosses their path.
The perception of a brazilian medical student about the professional exchange program (SCOPE) in Thailand

Melissa Gershon
Faculty of Medicine Siriraj Hospital | IFMSA Brazil

The clinical elective program in Siriraj Hospital is a short-term elective (under supervision, without hands-on activity) that is available for international medical students from all over the world. The exchange can be organized through direct contact with the hospital or through the IFMSA (International Federation of Medical Students’ Associations), which was the case in this process.

In December 2019, I participated in an internship program in the Pediatric Surgery department at Siriraj Hospital, which is a highlighted hospital not only in Bangkok, where it is located but in all over Thailand. In fact, the hospital’s structure is huge, with numerous buildings and operating rooms. In addition, the medical staff is very well-prepared to receive international students. I had several pieces of evidence of this especially when my task was to observe pre and postoperative consultations, surgeries and case discussions. Although the native language in the country is Thai, the language barrier that I imagined to face was certainly overcome: Thai students and doctors were very concerned about translating all activities carried out into English and solving doubts. Besides, the medical records were written in English whenever it was possible. This last fact, in particular, surprised me. It demonstrates that discussing and studying medicine in English are widespread customs in the country, allowing me to follow cases that I did not imagine seeing so soon as a student, such as tetralogy of Fallot, diaphragmatic hernia, gastroschisis, omphalocele, persistence of coacla, cystic adenomatoid malformation, hypospadias, hydrocele, portal hypertension, and neurofibromatosis.

As a bit of advice for making better these kinds of experiences, I strongly recommend paying attention to the country’s health system. From what I could understand by talking to some professionals, Thai citizens are entitled to health care in public hospitals. However, in order to undergo surgery, it is essential that they are referred by primary care - which seemed to be very similar to the Brazilian public health system. In contrast, whether there is a clear difference between Bangkok and Brazil hospitals, that is related to the dress code. It is curious that while here we recommend the use of white coat for students and surgical pajamas, with pants and shirts, for men and women, there, student attires must be a white shirt and black pants for men and a black skirt for women. In the operating room, a specific dress has to be worn.

I also emphasize that my excellent experience is also due to two other factors. First, the existence of an active international office at the hospital, which ensured the smooth running of the internship and guaranteed me an excellent accommodation in the dormitory inside the hospital campus. Second, it is important to note my interest in visiting and knowing a country with such a unique culture and incredible places. This exciting feeling, I think, is also a key factor for a great experience, and my experience was spectacular, full of welcoming people. Thailand really is the land of smiles.
The term empathy in medicine is related to “the physician’s awareness of the changes felt and reflected, moment by moment, by the patient” (1). In such a way, the medical practice goes far beyond physical and diagnostic exams, it is a daily exercise to raise awareness of the pain (not always physical) of the other person. And, taking into the field of pediatrics, this process involves two people, mother, and her child. This way, it was during a professional exchange in pediatrics at the Children’s and Adolescents Hospital (HCA) in Campina Grande, Paraíba, Brazil, that I was able to learn, in addition to techniques of pediatric practice, the ways of dealing daily with distressed children and mothers with the suffering of the hospitalization process. The professional exchange took place over 4 weeks in the months of December and January, in which I was able to evolve the patients admitted to the HCA with the medical interns of the UNIFACISA University Center. The routine consisted of evaluating the patients, doing the physical examination, adjusting the dose of medication and, if necessary, requesting control tests. For about two hours a day, the cases were discussed with a pediatrician who at the end signed the procedures established for each patient. It was in the middle of this routine that I took care of 2 patients made an impact on me and made my exchange not only theoretical learning but a life lesson. The first patient was MIH (fictitious name), 7 years old, with Down Syndrome,
admitted for an asthma attack and pneumonia. The second was NOS (fictitious name), 5 years old, with cerebral palsy, hospitalized for pneumonia. These two patients were in my care for 13 and 11 days, respectively.

Both patients had mothers of very similar characteristics since they had to learn to deal with their children’s differences so that they, as well as affirms Falkenbach et al.2, could have their potential valued in terms of the challenges of care. They showed me every day through quick conversations during evolution, the pain of seeing their children admitted to a hospital, but at the same time they said that “this was just another step and that all that would help them to mature as mothers”. This made me very sensitive and after that, I started going to the visits feeling more relaxed and less mechanized, always trying to play with the children (figure 2) since as stated by Junqueira3 playing helps the child to deal with his illness and with hospitalization.

Through this experience, I learned things that books don’t bring us: listening to the patient and adding his voice to the act of caring. These are things that are absorbed in medical practice, but for me, a 3rd-year medical student, that would be far from happening. Then, thanks to four weeks of professional exchange, I will be able to guide the rest of my graduation to learn empathic care with others.

References
SCORA
Sexual & Reproductive Health and Rights including HIV & AIDS
Abortion in Morocco is illegal ... we organised the first open national debate treating abortion in the presence of all the Heads of the political parties, ministers
Change does not come, it has to be brought

Yahya Lablad
IFMSA-Morocco - University Mohammed VI of Health Sciences

Abortion in Morocco is illegal. According to Article 453 of the Penal Code, abortion is only allowed if the mother's physical health is threatened. An amendment to Morocco's abortion law has recently been approved. The new amendment allows abortion in cases of rape, incest and foetal impairment.

Last september, our country has known a huge societal movement following the indictment of a journalist and her partner along with the medical team that practiced abortion. The movement teared apart the moroccan society, the conservatives and the liberals. The conservatives supported the decision of the justice and the liberals jumped on the occasion to plead for the respect of the individual freedoms and the abolition of all the laws that condemn the free will in term of SRHR including LGBTQIA + restrictions. The societal debate was launched.

IFMSA-Morocco as the representative of moroccan medical students and as a stakeholder in the SRHR moroccan landscape, organised the first open national debate treating abortion in the presence of all the Heads of the political parties, ministers, influencers and national celebrities. The debate was covered by dozens of national and international medias, counted more than one thousand participants and reached more than thirty five thousands through lives and broadcasts.

The event lasted for approximately four hours, and everyone was allowed to express their opinion and develop their arguments. The intensity of the debate made us all realise the uniqueness of the human being and it's diversity and made us feel something we don't usually get to experience in a country like ours: the freedom to speak, the freedom to disagree and the freedom to think. During the debate we received the most joyful and attended news, the journalist, her companion and the entire medical team were released under the orders of his majesty king Mohammed the sixth, and this was definitely far beyond the impacts we were aiming for.

Following the success of the debate, IFMSA-Morocco was approached by public figures and non governmental organisations to organise another national debate that will tackle LGBTQIA+ community rights and individual freedom and will take place in March 2020.
An indirect way to directly affect against homophobia

Pedro A. Ferreira Quirino, Alexandre dos Santos Lima
Universidade de Pernambuco Campus Serra Talhada | IFMSA Brazil

The LGBT agenda in Brazil has gained more importance and is getting more cited, by both politicians and civil society. It is estimated that there are around 20 million gays in the country (10% of the population), 12 million lesbians (6%) and 1 million trans people (0.5%).

However, talking about Homophobia in Brazil is difficult due to the lack of official statistics, having to resort to unofficial sources in search of those above (1). In 2018, 420 LGBT+ deaths from homophobia were recorded, of which 320 homicides (76%) and 100 suicides (24%). According to human rights agencies, more homosexuals and transsexuals are killed in Brazil than in the 13 countries in the East and Africa where there is a death penalty against LGBT people (2).

But the murders are just the tip of the iceberg. Based on the data obtained from the complaints received through Dial 100, an initiative of the Ministry of Human Rights, in 2017, it was identified that most of them relate to psychological violence - threat, humiliation and bullying (3,4).

In this sense, the IFMSA Brazil UPE-ST Committee carried out interactive activities to disseminate information about the homophobia’s current panorama in Brazil in the action “I see your colors”, in Serra Talhada/PE, with the participation of 23 people previously trained and supported by the University of Pernambuco, Course Student Center, General Population and City Hall.

The action took place on November 13, 2019, in a square with a high flow of people, and several activities occurred, with an estimated 200 people fected.

It started with the “color-stop” - arrangement of pairs with posters containing homophobic phrases and information about the LGBTQI+ community, distributed throughout the square and approaching people who were passing by -. Epidemiological data on homophobia in Brazil and in the world were reported, calling attention to the relevance of the topic.

Those approached were invited to participate in a conversation around the flag of the LGBTQI+ movement, surrounded by candles - an homage to the people who died victims of homophobia -. At that moment, homophobic phrases were read, commenting on their content and tearing them apart, as a gesture of fighting prejudice.

Among those approached, 45.1% reported having little/no prior knowledge on the subject and 48.4% reported having been homophobic at some point. 95.6% considered that the action was able to raise awareness and sensitize about homophobia, 97.8% evaluated as well their achievement and 93.4% believe that the acquired knowledge can be applied in the daily lives. 74.8% consider their municipality not safe for someone LGBTQI+ and 87.9% consider it necessary to hold more meetings that address the theme.

The initiative is concluded as positive, as it had the capacity to raise awareness about homophobia today, informing the population about homophobia victims across the country. The exchange of different experiences was favored, making the experience closer to reality, be it heterosexual or LGBTQI+.

Therefore, we believe that we achieved our objective, as Martin Luther King said, “What is done indirectly to an individual affects everyone directly”.

References:
More than a debate
Pro-life and pro-choice
Eunice Thambiraja
Weill Cornell Medicine | QMSA Qatar

A seventeen year old girl stands in a tiny room in front of five police officers. No one sits down. The air in the room hangs thick as the tiny, ineffective table fan whirs on. One of the officers asks her for identification. As she reaches into her wallet, she wonders if she has made the biggest mistake of her life by arriving at the address that the man on the phone had dictated to her. Their conversation had been short:

"Is this _____ ?"
“Yes, speaking."
“You have to come here to pick up your package from Amsterdam. We can not deliver it to you."
“Can I ask why?”
“It’s standard procedure."

In her haste to receive the contents of the package, she had forgotten about the legal ramifications of her secret being discovered. Now she stood trembling as the officer in front of her ripped open the package and dumped the contents out on the table. A strip of four misoprostol tabs, a tiny sealed mifepristone capsule and a home pregnancy test lay exposed. She braced herself for the worst. She knew that within the next few minutes she could be jailed, prosecuted and even deported. The room was silent for several minutes before another officer spoke loudly and rapidly in Arabic. She swallowed the lump in her throat and tried to explain that she could not understand him. He spoke louder, faster and placed a sheet of paper in front of her. The form, also in Arabic, was incomprehensible to her. Again, she tried to ask for a translation and was met with testy silence as a pen was shoved into her hand. The officer tapped impatiently on the little box marked for signatures and she hesitantly scribbled her name.

As she left the building, she was close to tears. Her only way to safely terminate the pregnancy in the country without legal repercussions had been just within her reach a few moments ago.

Many weeks later, she finally received the package she had been waiting for, through a friend who managed to bring it with him from Taiwan. She was 14-weeks pregnant when she had her abortion and just 2 months shy of her 18th birthday. She self-administered the misoprostol orally and carried out the abortion in the home of the man who had impregnated her while he slept. He had asked not to be disturbed. He had made it clear that the pregnancy was her problem.

“You are the one that’s pregnant. I can’t get pregnant. This is not my problem. Don’t blame me for the way it is and has always been between men and women.” The words swam around her head as she sat on the bathroom floor for hours after the abortion.

She knew she had gotten incredibly lucky. In case anything had gone wrong, she had no one to turn to for medical advice. A trip to the ER would have precipitated a police enquiry into the case of the recently pregnant minor who had seemingly miscarried. In a state where Zina law prohibits premarital sex and abortions are illegal, she had very few options. Yet she was able to find ways for the medication to be shipped to her through the internet. Luck. Privilege. God. She had a lot of names for the forces of the universe that had enabled her to find a way to have a safe and informed abortion where she lived.

She thought often of the women who were denied this basic right to choose. She thought of the women who would not be as lucky as she had been. The women who could barely report their assault for fear of violation of Zina, let alone seek safe abortion at a medical facility. Many pregnant women in the region had taken the same route that she had. Websites like WomenOnWeb and Safe2Choose not only ship the medication globally at a low cost, they also include a prescription to circumvent customs procedures and a detailed how-to written by a physician. The “Map” feature on the WomenOnWeb site shows reviews and stories from people all over the world who were able to have a safe abortion due to their services. Yet, for many women, even this service is inaccessible. The usual reasons are either minimal access to the internet, lack of information, fear or lack of mail delivery services in the region.
What should be a universal human right and a healthcare right has now been a subject of contention and debate for too long. Women die due to excessive bleeding from unsafe abortions. Women die because they are afraid of going to jail and hesitate to seek medical help. Women die because they are not allowed to choose a safe option to terminate unwanted or unsafe pregnancies. Women die because while people debate the morality and the ethics of an issue, the women who are actually being affected continue to find ways to terminate their pregnancies endangering their health and safety. And what of the women who live, unable to choose, unable to find a safe option to terminate their pregnancies? The women who are forced to carry unwanted pregnancies to term? The psychological, physical and financial strain could change their lives forever.

The death of Savita Halappanavar in Ireland is often cited as the case that sparked Ireland’s abortion reform. Doctors watched Savita develop septicemia following her miscarriage and refused to remove the fetus because it still had a heartbeat. A largely Catholic country, Ireland’s laws surrounding abortion were found to have caused significant confusion contributing to Savita’s death. A message by an advocate for safe abortions and women’s right to choose following Savita's death reads: "Sorry we were too late. We are here now. We didn’t forget you."

For the women in countries where they dare not to go near the hospital when they are pregnant, for the women in countries where their options are severely restricted, for the women who simply don't know what their options are because of misinformation and censorship, for all the women whose bodies are not fully in their control as they ought to be: we didn’t forget you.

One way or the other, when a pregnant woman no longer wants to be pregnant, she will find a way to no longer be pregnant. We owe it to Savita and all the other women like her to advocate for access to safe abortions around the world. The debate around women's bodies has cost too many lives as we wait for a consensus. There is no consensus. Regardless of perceived ‘morality’, we owe it to women around the world to restore their autonomy and respect their sexual and reproductive health and rights. The debate around abortions involves a lot of hypotheticals but women deserve concrete and unwavering support in this fight to gain full control of their bodies and their lives.

If we are ever to make progress towards a universal standard of healthcare that is both accessible and attainable, we must not shy away from contentious topics, the topics that are routinely featured in medical ethics classes and general debates.

**Pregnant women deserve more than debates. There is no room to waver: their sexual and reproductive health and rights simply must be respected and prioritized.**
I was walking down Hamra Street on December 1, 2019, wearing my red SCORA shirt raising awareness in celebration of World AIDS Day. To everyone on the street, it was just another red shirt, but to me, it was the voice of millions of global health advocates being echoed throughout the busiest streets in Beirut. I can still remember their chants, “Communities make the difference.” Today, around 2,500 Lebanese are living with HIV/AIDS. However, this number is a gross underestimation as many people do not get tested and thus, unaware of their HIV status.

I was speaking to one of the pedestrians on the street; he bravely admitted to the crowd that he is living with HIV. However, to him, the virus itself wasn’t the disease. It was the myths, the discrimination, the rumors, and several barriers that he faced that were truly affecting him. It is common for people in Lebanon to associate HIV with homosexuality, drug use, sex work, or infidelity; all behaviors which many disapprove of. Many believe that they can get infected by simply kissing a person living with HIV. For others, AIDS represents a death sentence.

In such circumstances, it becomes our mission as future healthcare providers to learn more about the topic and share that knowledge among the Lebanese community. Education is crucial in order to decrease misinformation around HIV and AIDS. It also constitutes an important step towards achieving a society where people living with HIV are treated with the level of respect and dignity deserved.

This is why, as LeMSIC, we annually work on a project entitled “WAD Walk”. The "WAD Walk" project focuses on spreading knowledge while decreasing stigma and discrimination around HIV and AIDS. To achieve that, a training was held to increase the knowledge of around 200 medical students regarding HIV and AIDS, as well as develop their communication and advocacy skills in order to deliver information properly. Booths were placed in different cities in Lebanon. Volunteers at the booths actively raised awareness on HIV and AIDS through flyers and awareness games while also selling bracelets. The money raised will be used to fund HIV viral load tests for people who can’t afford them, making LeMSIC a major stakeholder in the Sexual and Reproductive Health and Rights scene in Lebanon. Condoms and HIV self-test kits were also distributed to people in order to encourage safe sex and testing. Finally, performers also showed up to create a fun atmosphere and attract more people.

By the end of our night, that same man living with HIV came back and approached me. He thanked us for our work and told us more stories of solitude and of strength. He told us that for the first time after a long time, he felt hopeful. I left that night wanting to share this story because people should know communities can truly make a difference, and oh what a beautiful difference they make indeed.
The Abruzzo Adventure
A SCORE experience

Giulia Murillo Wollmann
Univille | IFMSA Brazil

As soon as I arrived in Chieti for my research exchange experience, I was surprised by the beauty of this south-centered city, Abruzzo (Italy). I chose this amazing place to participate in a project being held at the Università degli Studi "G. d'Annunzio". The research theme was "Analysis of the Functional Alterations Induced by Microgravity in Human Satellite Cells", a physiology study exploring the alterations in the astronauts' muscles cells in space, by Stephania Fulle, the head Professor.

During my stay, I was placed in a great apartment close to the University with six other medical students, where we all became very close during our four weeks in Chieti. As soon as we all arrived, we were well received by the local IFMSA committee, and were integrated into the most remarkable social program. Almost everyday they prepared a surprise for us, like taking us to amazing trips, parties, restaurants and tours around the city, and that made my trip unforgettable. In addition to that, on our first day, we all received a sum of money that allowed us to buy a monthly bus card and food at the university, which was great for me, as the euro is very expensive.

On my first day in the laboratory, I could not be more lost. Even though I studied a lot about the research theme before arriving, it was so different from what I was used to seeing in my own University that it took me an entire week just to understand what was going on. Of course, there was always a professor with me who explained the experiments and allowed me to ask any and all questions I wanted. At the end of the second week, they allowed and encouraged us to perform some routine laboratory experiments by ourselves, which helped me learn even more about the subject and gain valuable practical experience. At the end of the trip, I was surprised with an amazing letter of recommendation from the head tutor, which was icing on the cake.

At some point of the exchange, we all became so close to the local committee that they invited us to participate in their IFMSA reunions. They all arranged an "International Food and Drink Party" where all the exchange students, and the Italians of the local committee, would prepare a specific meal of their culture, and let's be honest, who would not love a dinner filled with Italian food! We were all able to connect with each other and learn so much about different cultures and customs, particularly Serbian, Nepalese, Chinese, Sudanese and Hungarian. In this one month trip, I was able to gain, not only laboratory knowledge, but also a rare insight into the different parts of the world.

I could not be more thankful to IFMSA, the local SISM team and my research professors for this unique opportunity, where I started to learn as soon as I arrived, and left not only with learning spoken Italian, but also with a tremendous knowledge baggage in various themes. I strongly recommend doing an exchange program with IFMSA as you will gain an outstanding life experience in addition to your enhanced curriculum.
Rese...
zil’s Scientific Team. Because of the OLM’s format of virtual “round table”, most of the participants stated that this enabled their engagement and interest in the session.

Due to the fact that the OC had a multiarea character, the team produced materials (Figure 2) which could facilitate the scientific production of the LCs on different areas.

CONCLUSION

Taking all into consideration, it is clear that the RW had a positive impact on raising research awareness on IFMSA Brazil’s LCs, approaching important issues and its possible solutions under an interdisciplinary basis, which can lead to meaningful changes in universities’ research education.

References:


<table>
<thead>
<tr>
<th>Day of the Research</th>
<th>Related Areas</th>
<th>Released Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>Exchanges; Publication and Research</td>
<td>Manual on Scientific Production on Exchanges; Manual on Submission of Research Projects</td>
</tr>
<tr>
<td>09/23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 2</td>
<td>Exchanges; Publication and Research</td>
<td>National Guidelines for Critical Appraisal Educational Activity</td>
</tr>
<tr>
<td>09/24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 3</td>
<td>Capacity Building; Medical Education; Publication &amp; Research</td>
<td>Manual on Scientific Abilities for Medical Students</td>
</tr>
<tr>
<td>09/25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 4</td>
<td>Publication &amp; Research</td>
<td>IFMSA Brazil’s Research Resource Center</td>
</tr>
<tr>
<td>09/26</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Standing Committee on Research Exchange (SCORE) supports the advancement in the world of research, especially in the field of medicine. Encouraging many different parties from various fields, SCORE carried out another research campaign in 2019. Partnered with Relawan Jurnal Indonesia (RJI), an NGO that focused on the importance of publication in Indonesia, together this year a campaign that took the “Open Access” movement as its theme was conducted.

Open Access (OA) provides a free, immediate, unrestricted availability of online high-quality, peer-reviewed scholarly research and literature with re-use rights. As a movement, OA has a long history starting from when it was first formulated in the 2000s. As the use of internet grows rapidly, OA provides the chance for any medical student, doctors, researcher, lecturer, public, and people working in other fields to widen their knowledge by unrestricted access to scientific or research resources (journals, articles, data, and etc.) without any barriers at issue, including economic barrier. This way, anyone at any time has the same chance of contributing to the development of knowledge, especially in the field of medicine, to the fullest extent.

Holding into the idea of Open Access, SCORE feels the need to support the implementation of OA, particularly in Indonesia. SCORE encourages every medical student to understand the importance of OA and to implement OA in their research practices. SCORE also encourages every lecturer, researcher, scientist, and related institutions to conduct Open Access to the fullest extent so that maximum improvement in the field of medicine could be reached. Therefore SCORE adopted Open Access as the theme for 2019’s Research Campaign.

The research campaign was held throughout November 5th until November 14th by publishing online infographics via social media platforms of SCORE. The infographics published via SCORE CIMSA’s Instagram® included contents such as the definition of OA, types of OA, the reason behind OA, challenges in conducting OA, some fun fact, the benefits of conducting OA, and accessible website sources providing OA. SCORE members (SCOREPUBLIC) also participated in this campaign by writing their opinion on OA in the comments section and chosen comments got to be published. Other than infographics, SCORE International Team, NOREs from other NMOs, and LOREs from our LCs made videos expressing their support for OA. These videos can be watched by going to SCORE YouTube® Channel and SCORE IGTV. Lastly, to encourage anyone to support Open Access, SCORE launched an Open Access Instagram® Filter.

SCORE hopes that this campaign would bring a greater awareness about Open Access to every medical student so that, in the future, the practice of Open Access could be done without any obstacles. Because we all know that #SharingIsGaining.
When I learned about IFMSA and all the medical students being unified, I knew this was meant for me.
The SCORE magic
A story of a new member of the exchange family

Ikshwaki Kaushik
David Tvioliani medical university | GMSA Georgia

It all started five years ago when I first came to Georgia. As an Indian girl who lived most of her life in Dubai, after moving between several countries, it wasn’t easy. I came to a country I knew very little about to pursue my dream of becoming a surgeon. I had to live alone, learn a new language, make new friends and work hard to make it in one of the most challenging medical faculties. I had my ups and downs, and in my second year, my life changed when my friend introduced me to our NMO GMSA.

When I learned about IFMSA and all the medical students being unified, I knew this was meant for me. I always loved to enact in my community and help others, and I finally found the perfect way to do so. That year I attended the GA in Tanzania and I remember being so excited about all the great work that members were doing all around the world. This inspired me when I came back home and I knew I must do something in my community as well. As I was a research lover myself, and as our NMO never had SCORE activated, I directly knew what to do.

The next year I dedicated myself to activating SCORE in GMSA. It was a long process, from contacting deans and professors, to motivating members, to talking with other NOREs and SCORE IT for advice and tips. It wasn’t easy, but with all new friendships I got from Georgia and all around the world, I always felt the warmth of the SCORE family pushing me forward.

That year, I did an exchange myself in Poland. I didn’t know what to expect: New professors, a new hospital and a completely different community. I was amazed to see how welcoming and inclusive it was, all the other incomings from different countries added another beautiful taste to its beauty. I got to learn new skills I wouldn’t find elsewhere, professors there were supportive and happy to help and include me all the time in their daily work. Poland as a country had a special place in my heart. The culture was unique, people were friendly, and the cities there were always enjoyable to discover.

That experience showed me how great being part of IFMSA can be, and helped me a lot to do better work in SCORE activation. Last year I attended SCORE sessions in both GAs, got SCORE active in GMSA and signed first SCORE contracts. These were some of the greatest moments of my life, feeling the results of long preparations come true, and I remember all the happy members during the GA for me and especially the SCORED and RA who were always there for me. They all felt the joy of having a new family member, and I also felt the same joy of joining that family. That was my SCORE story and I look forward to the next chapters of it.
Before studying medicine, what was your thought of a bipolar person? Or a psychotic patient? Movies and T.V. are responsible for most of our stigma about mental health. Most of us have watched the movie Joker by Todd Phillips. Leaving aside the major performance of Joaquin Phoenix, the movie gives a chance to understand, or at least empathize with people suffering from mental illnesses.

The Joker portrays a psychiatry patient with a pretty complex diagnosis, including the pseudobulbar affect that makes him laugh uncontrollably, a psychotic condition that makes him hallucinate, plus the narcissistic and psychopathic personality traits. His medical history shows his background, starting from child abuse and early life abandonment, head injury and family history of mental illness, which can together predispose to psychiatric conditions. In addition to all of the clinical aspects, the movie gives a context of how mentally ill people live: lonely, isolated, discriminated; the outcast. If you have had the opportunity of going through psychiatry rotation, I’m almost sure you can relate all these aspects to a real-life patient.

In a major scope, aside from the psychiatric approach, the movie gives a chance to analyze some serious public health issues occurring in our world today. There’s a scene where the therapist explains that the mental health program is no longer going to be funded by the government. Does it sound familiar to you? It’s not a secret that public health services are underfunded in most countries, and way often, mental health is the most neglected department.

Is this movie the perfect reflection of our society? Is there a real Joker living amongst us, untreated, mistreated, and forgotten? We all know, and some of us might have personally experienced the great prejudice held towards mental illnesses. And this movie is a perfect example of it. People with mental health issues are forgotten, disregarded, left aside from society. They’re vulnerable and unprivileged.

During the movie, there’s a quote the protagonist writes in his journey: “The worst part about having a mental illness is people expect you to behave as if you don’t”. I clearly remember one of the patients I interviewed during my psychiatry rotation who told me: “It’s really tiring to fake, you know? Like a clown, you have to fake a smile and pretend to be ok all the time, just for the people not to notice that you are struggling with yourself.”

The Joker movie is an urgent call for us to act towards mental health. We, as part of the future medical workforce, have to make a difference to these patients. Quality healthcare and an empathetic approach to mentally ill people can really make a difference in their lives. We are also responsible for raising awareness of the importance of mental health amongst all populations. From now on, every time you approach a psychiatry patient, take the time to fully understand the illness they’re struggling with, and most importantly, show them empathy and support. And never forget that mental health matters!

References:

1. Ahmed K. As a psychiatrist, I was blown away by the latest Joker. The Sydney Morning Herald. 2019. Available at: https://cutt.ly/YrzpMfd
Vaccination is the single most efficient and safe way to prevent several diseases. Through the usage of SUS (Sistema Único de Saúde), 1988, the PNI (Programa Nacional de Imunizações), 1973, Brazil is internationally a reference in promoting free access to vaccines by its population, while respecting the criteria of the World Health Organization (1). In August 1976, the decree number 78.231 made mandatory the vaccination for diseases that could offer quarantine and isolation measures in Brazil (2).

In the following decades, the Immunization process was getting consolidated. In 1991 the program gained strength with the new legislation that came with ECA (Estatuto da Criança e do Adolescente), that promoted the integral protection of kids and adolescents. The reduction of incidence and mortality from illness through the use of vaccines had notorious reflexes with the increase of life expectancy and the reduction of hospitalization (3).

The implementation of PNI in conjunction with lower instances of infections, of clinical signs and of deaths caused by said illnesses, had an affect that caused a lower adhesion to modern vaccines campaigns (4). Considering the lower rates of vaccination, measures are being taken to increase its range. Among the many forms, there is the identification of the child vaccination schedule as a part of the school registration. Even if the school cannot turn away the child based on his vaccination schedule, it can be used as evidence that there is a lack of respect to the public’s health, since the vaccines protects not only the individual child, but the rest of the children in a society.

This is an infringement against the ECA and can lead to a penalty translated in a fine and advertency, that will be allocated to orientation programs. If all this proves to be inefficient, parents could lose custody of their children (5).

In the current scenario, the role of a caretaker leaves some ambiguity when the subject at the hand is vaccination. Even if it’s a personal choice for a parent to vaccinate their children, this choice ends up affecting society as a whole: diseases that were considered eradicated came back to challenge the immune system of the population (6).

In this context, the antivax movement ends up placing the public health of the majority between a rock and a hard place, so that their world vision is validated. Certainly, as seen before (5), there are existing measures that intent to penalize parents that deliberately avoid having their children vaccinated. However, the impact of a parental figure on a minor could induce a future generation to turn its face on preventive medicine advancements (7).

This notion of cultural hegemony follows basic principles of anthropologic dialectics (8). In simple words, there is a familiar accommodation that will shape in an invisible way the world vision of a certain individual, in our context, antivax parents will raise antivax kids with similar insight.
In conclusion, stricter regulations on child vaccination is an extremely viable method of protecting public health in the present time. However, a change in the way people perceive this subject, a reform of the cultural hegemony, could guarantee the safety of the population for a more significant time period.

For starters, the vaccination campaigns must encapsulate, along with dates and places, the positive impact brought by vaccines until the present time, with the eradication of diseases (such as malaria and polio) (9), and elucidate the most frequent doubts: explain that virus being taken is not going to promote the illness when it is in an attenuated state, deny any false association of vaccines to autism, expose the safety measures faced by pregnant parents. (10)

A more informative vision could accomplish a much wider range of an audience, since is bringing a promotion of basic health with the reasoning that allows for individual understanding.

References


Groundbreaking non-uniform progress has been made in global and Public Health (PH) for the past 30 years. Mortality and morbidity from simple surgical conditions have grown in low-income and middle-income countries (LMICs), in real and relative terms. Simultaneously, the development of safe and life-saving surgical, anesthesia and obstetrics (SAO) care has stagnated or regressed (1).

Surgery in medical specialties has been described as the ‘neglected stepchild of global health’ and one of the ‘Cinderellas of the global health agenda’ (2,3). Anaesthesia has witnessed worse, as the ‘invisible friend’ of the neglected stepchild’ (4). Henceforth 1980, the WHO Director-General, Dr Halfdan Mahler, highlighted: ‘the vast majority of the world’s population has no access whatsoever to skilled surgical care and little is being done to find a solution’ (5).

The increasing global burden of non-communicable diseases comes with profound variations observed in highlighted journals, most notably, at Lancet Commission on Global Surgery, which set new priorities within healthcare policy (6).

Global surgery is the concept to describe this rapidly developing multidisciplinary field, concerning the interface between SAO, public and global health. It aims to improve and equalize surgical care across international health systems, often with an explicit need for public health and policy, quality safety and effectiveness, and access cost, capacity and culture.
focus on LMICs. This discussion perpetuates the future of global health, dialoging with IFMSA’s goals in achieving high-quality medical care worldwide, transformative medical education and meaningful youth participation.

Global surgery’s work involves three main backbones: Need, with policies and advocacy in LMICs; Access, in cost, capacity and culture of countries; and Quality, about safety and effectiveness in good surgical care (6).

Although primary health care is well established in preventive medicine and highly effective interventions, SAO also contributes largely to this matter (7). Addressing PH can enhance resoluteness in primary healthcare by targeting access to timely essential surgery, highlighting surgical volume, and workforce density. As a consequence, these factors are able to decrease mortality and morbidity (8).

Despite being a developing country, Brazil has a surprising large health system, even though the lack of access to health care remains a problem (9). SAO is essential to reduce children and maternal mortality. Promoting access to surgery timely decreases unnecessary expenses, therefore it is recommended that eight indispensable surgical procedures are available on first-level hospitals, confronting recurrent but highly lethal conditions, such as appendicitis, hernia, fractures, breast, and cervical cancer (10). Comparatively, access to sexual and reproductive care must include prevention strategies against vertical transmission diseases and comprehensive maternity care, extending this approach to the provision of safe anesthesia for cesarean section and safe PH abortion care.

Furthermore, along with other goals, government policies aid in reducing poverty are fundamental keys to the democratization of PH access. SAO plays an essential role in developing health care systems and recognizing those contributes on several levels for public health advances in primary health care (11).

Therefore, global surgery advocates, as medical students, are playing important young leadership roles in improving global health worldwide, focusing on thinking globally and acting locally to make the difference.

References
A controversial popular series, 13 Reasons Why, has recently released its 3rd season, and it was being strongly urged to be the last following the recorded increase in the number of teenage suicides. Some people say it’s overrated, that it exaggerates depression and bullying in American schools. And although that may have an element of truth to it... the show has created a starting point for so many controversial topics. Conversations about mental health in relation to sexual abuse, parents triggering depression, and most importantly, how can parents and guardians get involved and make a difference.

There’s no doubt that we’ve come a long way in raising awareness regarding mental health and the best ways to deal with it. However, there is something we don’t like talking about or we’ve avoided for far too long, and I believe it’s because it’s something we’re afraid may awaken emotions that we have to confront. We’ll be forced to come to terms with things we’ve ignored for a very long time. So here it goes... Brace yourselves.

Just like 13 Reasons Why I’m about to get a little controversial by starting a conversation nobody wants to open...

Let’s talk about it... How the people closest to us are the primary triggers of our mental health issues, particularly parents. I’ve been in quite a number of spaces where people talk about depression and very few of them dive into the concept of depression amongst youth that is triggered by parents. More than half of the people who have trusted me with their depression survival stories highlighted the active role of their parents in triggering it. For some, they were talking about it for the first time and showed a significant level of discomfort and unease. Some would say they wouldn’t even tell their therapist about the parts where their parents were involved. I pondered on it for a while and it was shocking to me how we just never talk about it. Why? Why don’t we want to talk about it? We can talk about depression and avoid this issue with ease and intention... Maybe because talking about it in itself is a trigger, but not talking about it is even worst. Depression is equally boring and difficult to talk about. Everyone is always like ‘reach out’ and ‘you can talk to me anytime’ but let me tell you from the wealth of my experience that 96% of people don’t want to hear you rehash your unstable self-image for the 371st time but we know that conversations of us talking about our depression are like ‘hi yeah I hate myself, same as yesterday. I feel I’m very incompetent at everything’. We add a few fresh details to the catechism of why we’re so unhappy but never really talk about what or who triggered it. People love hearing about the dramatic bits stories about hospitalizations and surefire as long as you can maintain the balance of seeming like a credible narrator but never the root of the problem that is so often normalized in the African society that it seems almost silly to say it triggers your depression. The things that parents and relatives say and do push people to the door
of their mental illness. Sometimes it even opens the door and pushes us right in. The high expectation of perfection in the rest of your life stemming from your intelligence in primary school and that one prize you got way back then. As if you aren't allowed to make a mistake all because of that one prize. The fear of talking about how something has been really hard for you because you're lucky you're even in that space in the first place. The constant reminder that you are not expected to have any problems because you don’t work, your school fee is covered and there’s food in the fridge. So what on earth would make you unhappy? The comparison with cousins, siblings and peers and having bars set for you that you have to reach or you just haven’t succeeded. The pressure of picking a certain career path because your parents know best and just have your best interests at heart. These pressures dance on the surface of emotional abuse at a tender age and extend into one’s adulthood where you’re a failure to your parents and guardians because you’re not yet married, you don’t have kids or your salary just isn’t good enough for them to brag about to their workmates and church friends. The normalization of these daily pressures and reminders in the African society has led to consistent emotional breakdowns thus mental instability to anyone who just doesn’t meet the set standards. We don't talk about it though because talking about it makes it real. Talking about it means we have to confront it. Deal with it. It brings me joy to see people getting rid of people who disrupt their mental health. It’s easy to avoid a classmate or cut off some people we spend time with voluntarily. But now how do you avoid your parent and how do you explain that as a solution to anyone? How do you sit down with a person you respect so much and address how their behavior triggers your depression... Sometimes, they may not even know what depression actually is. Then there are just further layers of thinking "Is talking about this a brave disclosure or am I just doing it for attention?", "Am I wallowing or working with my trauma?", "Is this person going to overreact if I tell them I can't stand my parents or does everyone think I’m such an ungrateful child who doesn’t see the sacrifices that are made for my wellbeing?"

Essentially, so many young people are afraid of the judgment that will come from people that insist that parents are to be respected, loved and allowed to share their energy no matter what it is they’ve done or do. In an African society, it is more important to maintain the image and integrity of parents than address their toxic nature. It is time to address it. It is time to confront those feelings because we'll become the African parents we complain about. We will trigger our children's depression and let the cycle continue because if you really look at it, guardians and parents have mental health issues of their own that they do not understand and fail to address. The pressures of being an adult leave no room for them to breathe or get into spaces where they can talk about things. This can often cause them to act out and trigger us. The solution is not to point fingers. It is essential to involve adults and parents in mental health issues that their children may face but do not tell them about. It is important to start the conversations with friends, siblings, and mentors and move up to our guardians with sensitivity and understanding that they too haven’t dealt with their childhood traumas and are unaware of how they become generational. The next time we are talking about mental health, let us bring it up and share solutions on how to best tackle this issue. Only then can we tackle mental health in its complete and bare state so as to move forward and face our problems head-on. Perhaps some people may not be ready for this conversation and that’s okay, but to those who are ready let’s talk about it, let’s make it easier for them.
Formation of health leaders using health promotion and equity - an experience report

André Augusto Guerra Gomes, Murilo Rodrigues da Silva
Instituto de Educação Superior do Vale do Parnaíba (IESVAP) | IFMSA Brazil

Equity is one of the doctrinal principles of the Brazilian National System of Public Health, in Portuguese known as Sistema Único de Saúde (SUS). This Principle is sustained by the philosophy that although everyone has access to the SUS, there are different people with different needs. In practice, SUS equity serves to correct the injustice and inequality, seeking to establish a link between marginalized social groups and the Health System. With the desire to sensitize medical graduates about this theme, the National Workshop of Health Promotion and Equity was organized.

The I National Workshop of Health Promotion and Equity, performed in Porto Alegre-RS, in a partnership between the International Federation of Medical Students Associations of Brazil (IFMSA Brazil) and the Ministry of Health, was a formative seminar in which methods of inclusion in the Public Health System of vulnerable populations were discussed during July 10, 11 and 12, 2019. The workshop was attended by twenty-three medical students, affiliated to IFMSA Brazil and was held in a theoretical-practical manner. Initially, dialogue tables were held, in which we discussed various topics that brought us to the reality in which academics would be inserted in the future professional, among them, the social determinants of health, important tools in the reduction of inequities, study on race/color and ethnicity, sex, gender identity, sexual orientation, in addition to addressing social markers from the perspective of intersectionality. After that, academics participated in a debate table on the implementation of public policies and the allocation of resources from the perspective of equity, in which it was discussed the lack of government policies that insert vulnerable populations in the Health System. A technical visit was made to a Specialty Center aimed at serving the LGBTQI+ community, with qualified professionals prepared to welcome this population. Finally, the students paid a visit to the women’s prison in Canoas-RS, in which we saw the marginalization of health that affects this population. Thus, it is seen that activities like these form future leaders in Health, with knowledge and preparation to act and manage Health in the places that are inserted.

The health situation of the population found during the Workshop served as an overview to understand what happens or should happen in the rest of the country. The knowledge generated by this practice not only served to consolidate theoretical concepts and even hypothetical situations, but also showed mechanisms and means to establish true equity in the face of different inequalities and countless injustices.

References

“...Activities like these form future leaders in Health, with knowledge and preparation to act and manage Health in the places that are inserted...."
Regarding psychological violence, we saw progress to 100%, which shows that the examples discussed were well assimilated.
Participation of future health professionals in the prevention of violence

Amanda Raquel Zanini Castanho da Silva, Gabriella de Almeida Emerim
Fundação Universidade Regional de Blumenau (FURB) | IFMSA Brazil

INTRODUCTION
Brazil ranks 5th in the world ranking of Feminicide (1), reflecting a national demand, mainly in the scope of education. Based on that, an action was planned by medical students from the Fundação Universidade Regional de Blumenau to bring the knowledge of the types of violence to school; concepts that despite being recurrent are silenced by patriarchal culture (2).

OBJECTIVES
The purpose of this intervention was to show students how to identify the different types of violence and to encourage them to report it if they experience it. Their knowledge was evaluated through a pre and post-questionnaire.

REPORT ON THE EXPERIENCE
According to the Maria da Penha (3) law, the government has an obligation to curb domestic violence. However, their measures are often ineffective. Thus, it is necessary to debate the topic mainly with children and young people so that they do not reproduce similar behaviors. For this, the theme was developed with newspaper articles, so that students could talk about a certain crime. Psychological violence was discussed in two hypothetical cases. Students would have to identify the signs that indicate violence. According to the Panorama of Violence against women in Brazil, in 2015, 30.33% of the complaints were related to psychological violence (4).

As for sexual violence, academics exposed comments made on social networks to learn a little more about the students’ opinions on the topic. In addition, consent in sexual intercourse was also discussed, a concept that still raises many eyebrows. According to the Ministry of Women, Family and Human Rights, 17,093 children suffered from sexual violence in 2018 (5).

Finally, patrimonial violence was exhibited under different circumstances, so that the students could identify if it was happening to them. As much as it is a type of low-incidence violence (6), academics decided to address this issue since that community is vulnerable to this type of hostility.
RESULTS

From the analysis of the questionnaires, the greatest difficulty (improvement of only 4%) observed regarding sexual violence was in the question of the right to give up a sexual relationship in the middle without the partner forcing the continuity of the act.

Regarding physical violence, the challenge was the normality of exchanging aggression in marriage. This question may not have been clarified, as “normal” might have been confused with “common”.

Regarding the situation that addressed this issue, there was an increase of 8%. Regarding patrimonial violence, we could see that it was not easy to associate the right to divide assets within a marriage equally between men and women, with an improvement from 70% to 92%. Regarding psychological violence, we saw progress to 100%, which shows that the examples discussed were well assimilated.

CONCLUSION

Unfortunately, the misconceptions in the questionnaires are the result of a very conservative society. Probably the students experience violence within the home that is admitted as common. The right over the body of women and participation in financial matters, as well as gender-based violence, need to be addressed in all possible areas, especially in the classroom.

References:
3. BRASIL, Lei 11340/06 de 07 de Agosto de 2006. Art. 1 da Lei Maria da Penha.
The National Politics for Integral Health of the Black Population (PNSIPN) is a committee affiliated with the Ministry of Health, that stands against inequalities in the Unified Health System (SUS) and in promoting the health of the black population in an integral way, considering that health inequities are a result of unfair socioeconomic and cultural processes - in particular, the current racism - that corroborates the morbidity and mortality of black Brazilian population (1). Through the publication of this Policy, the Ministry of Health recognized and assumed the need to establish mechanisms to promote the integral health of the black population and to confront institutional racism in the SUS, with a view to overcome the structural and daily barriers that negatively affect health indicators of this population - early deaths, high rates of maternal and child mortality, higher prevalence of chronic and infectious diseases and high rates of violence (2). Such recognition is extremely important because according to a survey by the Institute of Applied Economic Research (IPEA) carried out in 2008, it was pointed out that the black population represented 67% of the total public served by SUS (3,4). In this perspective, talking about this subject should be a routine, whether in universities, schools, health units or any other place of social interaction. However, it is well-known that the topic is still neglected. As medical students at the Federal University of Amazonas, we noticed the need to bring this debate to our reality, through the I Multicentric Call for Health of the Black Population of IFMSA Brazil, the objective of which was to foster discussions during the Black November. As activities were published in the social network Instagram about PNSIPN, emphasizing the existence of this policy, its main characteristics, objectives, and goals will help in the promotion of the health of black people. Another publication was about the 20th of November, which in Brazil is celebrated as the National Day of Black Consciousness. The date refers to the death of Zumbi dos Palmares, leader of Quilombo dos Palmares (one of the main and most important leaders that existed in the country) and symbol of the black resistance against slavery. These two disclosures were well received by users of the social network who made positive comments regarding the initiative. In addition, we held a thematic meeting on the health of the black population on 11/27/2019 for 18 affiliated members, facilitated by the Standing Committee on Human Rights and Peace (SCORP), focusing on national politics, health indicators and the national panorama of conditions of life of the black population. Racism and its consequences were also raised and the participants promoted interesting debates about the subjects and the relevance for the training of doctors. We believe that academics were made aware of the need to address these issues in undergraduate courses, as well as recognize the relevance to professional practice and the impact of racist actions and prejudices that still affect the black population in Brazil.

References:
Machismo: Brazilian word that means the belief that men are superior to women. Fighting violence against women is a difficult and long-term task. For this reason, achieving gender equality is one of the UN goals for 2030. Understanding violence against women as a criminal phenomenon composed of complex cultural and social elements and guided by relative social acceptance is essential to understand why this crime is so difficult to identify and extinguish, especially in a patriarchal and continental-sized country like Brazil. Present in more than 150 Brazilian medical schools, IFMSA Brazil has always positioned itself as an advocate for gender equality. For this reason, in 2019, our local IFMSA Brazil committee, present at UNIOESTE FB decided to promote an event that articulated an academic debate on abuse and violence in its various forms, with a practical part, aimed at teaching basic self-defense techniques, in order to minimize risks in the face of a possible aggressive approach. During the theoretical part of the event, the participation of lawyer Jessica Brum Barancelli, member of a support network for women called NUMAPE, was essential. During the speech, themes related to the care of women victims of domestic and sexual violence were addressed, promoting awareness about the multiple faces that violence against women has. In addition, a discussion about abusive relationships was conducted by the psychologist Raoany de Souza Ribeiro, through a conversation circle with anonymous reports from the event participants themselves, in order to make people aware of behaviors that indicate the beginning and progression of an abusive relationship.

The second part of the event included a practical self-defense class, given by the instructor and professional Álvaro Alexandre Francescon, to teach the participating women how to respond to an intimidating attitude, seeking to offer a feeling of empowerment and self-protection through the use of simple and effective techniques, in a morning that resulted in an improvement in autonomy and self-confidence of the women present there.

In this sense, the objective of the action was concluded, since the two moments of the event promoted the empowerment of women through awareness of their conditions and rights and through the learning of self-defense. In addition, in a country that still has very high numbers of violence against women, it is essential that medical students are prepared not only to treat the patients they will contact in the future, but also to empathize and offer alternatives, ensuring that they know there is a support network and they are not alone. Teaching future doctors how to create a comfortable and safe environment for victims of violence is fundamental. Thinking globally and acting locally is one of the IFMSA’s goals and building a more humanized medicine is a job that starts in each university, therefore, would result in future doctors who know the importance of 
defending what really matters.

De die in diem,
Vices are going up against her,
Rape, prostitution and feminism,
Poised with fangs,
Ready to devour.

Listen! O girl child,
Rise and take up the gauntlet,
Be of good courage and take up arms,
To cut the gordian knot,
And forever be free,
For the game is in your hand.
A stitch in time...saves nine!
Fiery darts from every direction hurled,
Assaults spike and crimes grow,
All against the fairer sex,
For she’s vincible,
A gender more vulnerable...

Rise up to her aid,
She deserves to be protected,
Stand to answer her call for help,
For she has a right,
To quality education,
She possesses an entitlement,
To be salvaged from genital mutilation,
For she is vincible,
A gender more vulnerable...
IT CAN BE ABOUT HEALTHCARE

South America, nature’s beauty
Feijoada and fandango
Yet, Zika too.
This can be different.

Middle East, Asian culture
Falafel, sandwich and fidjeri
Yet, MERS
This can be overcome.

West Africa, a lot of ethnicities
Joy of rice and gumbé
Yet, Ebola too.
This can be better.

Central America, caribbean beaches
Tortillas and reggaeton
Yet, kidney insufficiency.
This can be solved.

The world’s healthcare needs to be discussed
It needs you to achieve a change.
And it can be a great reality.
Meet the Officials

Executive Board

Saniya Sahasrabudhe (India)
Vice-President for Activities
vpa@ifmsa.org

Nebojša Nikolić (Serbia)
President
president@ifmsa.org

Gabriela Cipriano Flores (Peru)
Vice-President for Finance
vpf@ifmsa.org

Tarek Ezzine (Tunisia)
Vice-President for External Affairs
vpe@ifmsa.org

Hayder Noori (Iraq)
Vice-President for Capacity Building
vpcb@ifmsa.org

Paulina Birula (Poland)
Vice-President for Members
vpm@ifmsa.org

Saad Chaibi (Morocco)
Vice-President for Public Relations & Communication
vpprc@ifmsa.org

Regional Directors

Alistair S. Mukondiwa (Zimbabwe)
Africa
rdafrica@ifmsa.org

Maria José Jaramillo Cartwright (Ecuador)
Americas
rdamericas@ifmsa.org

Po-Chin Li (Taiwan)
Asia-Pacific
rdaasiapacific@ifmsa.org

Gita Mihelčič (Slovenia)
Europe
rdeurope@ifmsa.org

Aamr Hammani (Morocco)
Eastern Mediterranean
rdemr@ifmsa.org
Meet the Officials

Standing Committee Directors

Marouane Amzil (Morocco)
Medical Education
scomed@ifmsa.org

Gabriela Dias Silva Dutra Macedo (Brazil)
Professional Exchange
scoped@ifmsa.org

Mahmood Al-Hamody (Egypt)
Human Rights & Peace
scorpd@ifmsa.org

Matthieu Pierre (Belgium)
Research Exchange
scored@ifmsa.org

Sarah Maitho (Kenya)
Public Health
scophd@ifmsa.org

Laura Lalucat (Spain)
Sexual & Reproductive Health and Rights Incl. HIV/AIDS
scorad@ifmsa.org

Liaison Officers

Alaa Abusufian E. Dafallah (Sudan)
Medical Education Issues
lme@ifmsa.org

Omnia Elomrani (Egypt)
Public Health Issues
lph@ifmsa.org

Egle Janusonyte (Lithuania)
Sexual & Reproductive Health and Rights Incl. HIV/AIDS
lra@ifmsa.org

Tammy Yu (Taiwan)
Human Rights & Peace Issues
lhp@ifmsa.org

Saad Uakkas (Morocco)
Student Organizations
loso@ifmsa.org

Katja Cic (Slovenia)
World Health Organization
lwho@ifmsa.org
<table>
<thead>
<tr>
<th>Country</th>
<th>IFMSA Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan (RMSA)</td>
<td></td>
</tr>
<tr>
<td>Albania (ACMS Albania)</td>
<td></td>
</tr>
<tr>
<td>Algeria (Le Souk)</td>
<td></td>
</tr>
<tr>
<td>Argentina (IFMSA-Argentina)</td>
<td></td>
</tr>
<tr>
<td>Armenia (AMSP)</td>
<td></td>
</tr>
<tr>
<td>Aruba (IFMSA-Aruba)</td>
<td></td>
</tr>
<tr>
<td>Australia (AMSA)</td>
<td></td>
</tr>
<tr>
<td>Austria (AMSA)</td>
<td></td>
</tr>
<tr>
<td>Azerbaijan (AzerMDS)</td>
<td></td>
</tr>
<tr>
<td>Bangladesh (BMSS)</td>
<td></td>
</tr>
<tr>
<td>Belgium (BeMSA)</td>
<td></td>
</tr>
<tr>
<td>Bolivia (IFMSA-Bolivia)</td>
<td></td>
</tr>
<tr>
<td>Bosnia &amp; Herzegovina</td>
<td></td>
</tr>
<tr>
<td>Bosnia &amp; Herzegovina – Republic of Srpska (SaMSIC)</td>
<td></td>
</tr>
<tr>
<td>Brazil (DENEM)</td>
<td></td>
</tr>
<tr>
<td>Brazil (IFMSA-Brazil)</td>
<td></td>
</tr>
<tr>
<td>Bulgaria (AMSBI)</td>
<td></td>
</tr>
<tr>
<td>Burkina Faso (AEM)</td>
<td></td>
</tr>
<tr>
<td>Burundi (ABEM)</td>
<td></td>
</tr>
<tr>
<td>Cameroon (CAMSA)</td>
<td></td>
</tr>
<tr>
<td>Canada (CFMS)</td>
<td></td>
</tr>
<tr>
<td>Canada – Québec (IFMSA-Québec)</td>
<td></td>
</tr>
<tr>
<td>Catalonia - Spain (AECS)</td>
<td></td>
</tr>
<tr>
<td>Chile (IFMSA-Chile)</td>
<td></td>
</tr>
<tr>
<td>China (IFMSA-China)</td>
<td></td>
</tr>
<tr>
<td>China – Hong Kong (AMSAHK)</td>
<td></td>
</tr>
<tr>
<td>Colombia (ASCEMCOL)</td>
<td></td>
</tr>
<tr>
<td>Costa Rica (ACEM)</td>
<td></td>
</tr>
<tr>
<td>Croatia (CroMSCIC)</td>
<td></td>
</tr>
<tr>
<td>Cyprus (CyMSA)</td>
<td></td>
</tr>
<tr>
<td>Czech Republic (IFMSA-CZ)</td>
<td></td>
</tr>
<tr>
<td>Democratic Republic of the Congo (MSA-DRC)</td>
<td></td>
</tr>
<tr>
<td>Denmark (IMCC)</td>
<td></td>
</tr>
<tr>
<td>Dominica (IFMSA)</td>
<td></td>
</tr>
<tr>
<td>Commonwealth of Dominica</td>
<td></td>
</tr>
<tr>
<td>Dominican Republic (ODEM)</td>
<td></td>
</tr>
<tr>
<td>Ecuador (AEMPPPI)</td>
<td></td>
</tr>
<tr>
<td>Egypt (IFMSA-Egypt)</td>
<td></td>
</tr>
<tr>
<td>El Salvador (IFMSA-El Salvador)</td>
<td></td>
</tr>
<tr>
<td>Estonia (EstMSA)</td>
<td></td>
</tr>
<tr>
<td>Ethiopia (EMSAA)</td>
<td></td>
</tr>
<tr>
<td>Finland (FiMSIC)</td>
<td></td>
</tr>
<tr>
<td>France (ANEMF)</td>
<td></td>
</tr>
<tr>
<td>Gambia (GaMSA)</td>
<td></td>
</tr>
<tr>
<td>Germany (bvmdMSA)</td>
<td></td>
</tr>
<tr>
<td>Ghana (FGMSA)</td>
<td></td>
</tr>
<tr>
<td>Greece (HelMSIC)</td>
<td></td>
</tr>
<tr>
<td>Grenada (IFMSA-Grenada)</td>
<td></td>
</tr>
<tr>
<td>Guatemala (IFMSA-Guatemala)</td>
<td></td>
</tr>
<tr>
<td>Guinea (AEM)</td>
<td></td>
</tr>
<tr>
<td>Haiti (AHMSA)</td>
<td></td>
</tr>
<tr>
<td>Honduras (IFMSA-Honduras)</td>
<td></td>
</tr>
<tr>
<td>Hungary (HuMSIRC)</td>
<td></td>
</tr>
<tr>
<td>Iceland (IMSAA)</td>
<td></td>
</tr>
<tr>
<td>India (MSIA)</td>
<td></td>
</tr>
<tr>
<td>Indonesia (CIMSA-ISMKI)</td>
<td></td>
</tr>
<tr>
<td>Iran (IMSA)</td>
<td></td>
</tr>
<tr>
<td>Iraq (IFMSA-Iraq)</td>
<td></td>
</tr>
<tr>
<td>Iraq – Kurdistan (IFMSA-Kurdistan)</td>
<td></td>
</tr>
<tr>
<td>Ireland (AMSIA)</td>
<td></td>
</tr>
<tr>
<td>Israel (FIMIS)</td>
<td></td>
</tr>
<tr>
<td>Italy (SISM)</td>
<td></td>
</tr>
<tr>
<td>Ivory Coast (NOHSS)</td>
<td></td>
</tr>
<tr>
<td>Jamaica (JAMSIA)</td>
<td></td>
</tr>
<tr>
<td>Japan (IFMSA-Japan)</td>
<td></td>
</tr>
<tr>
<td>Jordan (IFMSA-Jo)</td>
<td></td>
</tr>
<tr>
<td>Kazakhstan (KazMSA)</td>
<td></td>
</tr>
<tr>
<td>Kenya (MSAKE)</td>
<td></td>
</tr>
<tr>
<td>Korea (KMSA)</td>
<td></td>
</tr>
<tr>
<td>Kosovo - Serbia (KOMS)</td>
<td></td>
</tr>
<tr>
<td>Kuwait (KuMSA)</td>
<td></td>
</tr>
<tr>
<td>Kyrgyz Republic (AMSA-KG)</td>
<td></td>
</tr>
<tr>
<td>Latvia (LaMSA)</td>
<td></td>
</tr>
<tr>
<td>Lebanon (LeMSIC)</td>
<td></td>
</tr>
<tr>
<td>Lithuania (LiMSA)</td>
<td></td>
</tr>
<tr>
<td>Luxembourg (ALEM)</td>
<td></td>
</tr>
<tr>
<td>Malawi (MISA)</td>
<td></td>
</tr>
<tr>
<td>Malaysia (SMMAMS)</td>
<td></td>
</tr>
<tr>
<td>Mali (APS)</td>
<td></td>
</tr>
<tr>
<td>Malta (MMSA)</td>
<td></td>
</tr>
<tr>
<td>Mauritania (AFMM)</td>
<td></td>
</tr>
<tr>
<td>Mexico (AMMEF-Mexico)</td>
<td></td>
</tr>
<tr>
<td>Montenegro (MoMSIC)</td>
<td></td>
</tr>
<tr>
<td>Morocco (IFMSA-Morocco)</td>
<td></td>
</tr>
<tr>
<td>Namibia (AMSA)</td>
<td></td>
</tr>
<tr>
<td>Nepal (NMSS)</td>
<td></td>
</tr>
<tr>
<td>The Netherlands (IFMSA NL)</td>
<td></td>
</tr>
<tr>
<td>Niger (AESS)</td>
<td></td>
</tr>
<tr>
<td>Nigeria (NIMSA)</td>
<td></td>
</tr>
<tr>
<td>Northern Cyprus, Cyprus (MSANC)</td>
<td></td>
</tr>
<tr>
<td>Norway (NMSA)</td>
<td></td>
</tr>
<tr>
<td>Oman (MedSCo)</td>
<td></td>
</tr>
<tr>
<td>Palestine (PMSA)</td>
<td></td>
</tr>
<tr>
<td>Pakistan (IFMSA-Pakistan)</td>
<td></td>
</tr>
<tr>
<td>Panama (IFMSA-Panama)</td>
<td></td>
</tr>
<tr>
<td>Paraguay (IFMSA-Paraguay)</td>
<td></td>
</tr>
<tr>
<td>Peru (IFMSA-Peru)</td>
<td></td>
</tr>
<tr>
<td>Peru (AEMP)</td>
<td></td>
</tr>
<tr>
<td>Philippines (AMSA-Philippines)</td>
<td></td>
</tr>
<tr>
<td>Poland (IFMSA-Poland)</td>
<td></td>
</tr>
<tr>
<td>Portugal (ANEM)</td>
<td></td>
</tr>
<tr>
<td>Qatar (QMSA)</td>
<td></td>
</tr>
<tr>
<td>Republic of Moldova (ASRM)</td>
<td></td>
</tr>
<tr>
<td>Republic of North Macedonia (MMSA)</td>
<td></td>
</tr>
<tr>
<td>Republic of North Macedonia (FAMSIR)</td>
<td></td>
</tr>
<tr>
<td>Russian Federation (HCCM)</td>
<td></td>
</tr>
<tr>
<td>Russian Federation – Republic of Tatarstan</td>
<td></td>
</tr>
<tr>
<td>Rwanda (MEDSAR)</td>
<td></td>
</tr>
<tr>
<td>Senegal (FNESS)</td>
<td></td>
</tr>
<tr>
<td>Serbia (IFMSA-Serbia)</td>
<td></td>
</tr>
<tr>
<td>Sierra Leone (SLEMSA)</td>
<td></td>
</tr>
<tr>
<td>Singapore (SiMSA)</td>
<td></td>
</tr>
<tr>
<td>Slovakia (SloMSA)</td>
<td></td>
</tr>
<tr>
<td>Slovenia (SloMSIC)</td>
<td></td>
</tr>
<tr>
<td>South Africa (IFMSA-SA)</td>
<td></td>
</tr>
<tr>
<td>Spain (IFMSA-Spain)</td>
<td></td>
</tr>
<tr>
<td>Sudan (MedSiN)</td>
<td></td>
</tr>
<tr>
<td>Sweden (IFMSA-Sweden)</td>
<td></td>
</tr>
<tr>
<td>Switzerland (swimsa)</td>
<td></td>
</tr>
<tr>
<td>Syrian Arab Republic (MSA)</td>
<td></td>
</tr>
<tr>
<td>Taiwan - China (FMSA)</td>
<td></td>
</tr>
<tr>
<td>Tajikistan (TJMSA)</td>
<td></td>
</tr>
<tr>
<td>Thailand (IFMSA-Thailand)</td>
<td></td>
</tr>
<tr>
<td>Tanzania (TaMSA)</td>
<td></td>
</tr>
<tr>
<td>Togo (AEMP)</td>
<td></td>
</tr>
<tr>
<td>Trinidad and Tobago (TTMSA)</td>
<td></td>
</tr>
<tr>
<td>Tunisia (Associa-Med)</td>
<td></td>
</tr>
<tr>
<td>Turkey (TurkMSIC)</td>
<td></td>
</tr>
<tr>
<td>Turkey – Northern Cyprus (MSANC)</td>
<td></td>
</tr>
<tr>
<td>Uganda (FUMSA)</td>
<td></td>
</tr>
<tr>
<td>Ukraine (UMSA)</td>
<td></td>
</tr>
<tr>
<td>United Arab Emirates (EMSS)</td>
<td></td>
</tr>
<tr>
<td>United Kingdom of Great Britain and Northern Ireland (SFoG)</td>
<td></td>
</tr>
<tr>
<td>United States of America (AMSA-USA)</td>
<td></td>
</tr>
<tr>
<td>Uruguay (IFMSA-Uruguay)</td>
<td></td>
</tr>
<tr>
<td>Uzbekistan (Phenomenon)</td>
<td></td>
</tr>
<tr>
<td>Venezuela (FEVESOCOM)</td>
<td></td>
</tr>
<tr>
<td>Yemen (NAMS)</td>
<td></td>
</tr>
<tr>
<td>Zambia (ZaMSA)</td>
<td></td>
</tr>
<tr>
<td>Zimbabwe (ZIMSA)</td>
<td></td>
</tr>
</tbody>
</table>

www.ifmsa.org

medical students worldwide