MSI 42
Youth & Health Emergencies
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 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.
From the Editor-In-Chief

Saad CHAIBI
Vice-President for Public Relations and Communication

Dear IFMSA members around the world,

A worldwide emergency has surprised the world. It has led to a terrible number of lives lost, drastic changes in our lifestyles, devastating impact on our education, and subverting our economies, hence drifting us to the brink of a global recession. During this time, students worldwide suffered numerous consequences due to the impact of the pandemic on their medical education, their environments, and their communities. Nevertheless, this didn’t stop them from leading local actions, raising awareness, sharing ideas, and awe-inspiring stories on platforms such as our magazine.

It’s my utmost pleasure to welcome all our beloved readers to the 42nd Issue of the Medical Students International (MSI) Magazine. This issue focuses on Youth and Health Emergencies, and dives into the diverse aspects of current health emergencies, and widens our perspective, from the current infectious diseases preparedness to climate resilience and other planetary health crises.

The next pages will uncover invaluable students’ reflections and visions about the imperative roles, impacts, and actions that youth around the world are leading to empower and serve their communities, while relentlessly fighting these unfortunate global phenomena. Moreover, this magazine serves as another consecration of our tag-line “Think Globally, Act Locally”, and a meaningful tribute to our 1.3 Million Medical Students Worldwide, a statement that our members are acting now more than ever to minimize the effect of the pandemic and to ensure that our impact will never stop.

Finally, I would like to extend my thanks and gratitude to the Executive Editor, the Editors, and the Designers. This tireless team of empowered individuals worked around the clock during the past months to review, distill, edit and design stories, poems, articles from all around the world, all driven by one objective “Showcasing the proudest stories and reflections of our Members.” I would also like to thank my fellow IFMSA Officials for their contributions and I wish you all an undeniably exciting reading to come!

Regards.
Blank not Blank
(A tale about mental health)

Tasnia Noor Salim
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Books before beds
I throw the black hat in the air and jump, rejoicing, with an empty scroll in my hands. I join my peers and smile for the camera. When we’re back home, my parents ask me, “So, now that your big day has arrived, have you decided on your speciality?” I don’t answer them. I am blank.

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All beds new
I walk from bed to bed in my new crisp white apron; ready to begin day one, with the shiny stethoscope around my neck. I can’t seem to figure out what’s more overwhelming - the illness reflected from these bodies, or the sadness resonating from their souls. I’m blank.

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Bed number: Some road crash
He’s amputated from the waist down. I sit next to him and ask him how he’s doing. “I wanted to die. I told these doctors to kill me, but they cut my legs instead” he says in a daze. “What do I do now without them? How do I work? With what do I feed my kids?” He’s not crying, but I feel the anguish within him. I hold his hand and his breathing seems to calm down. I want to know what to say... But I’m blank.

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Bed number: Bad ankle
A kind looking old man this time - seems safe enough, I think. I decide to go speak to him and brush up my history-taking skills. I ask, “What trouble brings you to the hospital, baba?” “I tried to hang myself from the fan, but somehow I landed on the floor and twisted my ankle”, he says, “but don’t tell the big doctors that... I told them I fell down”.

The tears come, his wife’s before his. I don’t know what to say. I don’t have the heart to ask why he did it. Yet again, I’m blank.

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Bed number: Best friends
He smiles wide, showing all his teeth at once. Beside him is his best friend, his mother. Suddenly, the schizophrenic goes into a trance. He’s talking to someone, bragging about the wife he doesn’t have and the money he could never make. His best friend turns to me saying, “He does this sometimes. Sometimes it’s worse... he loses control of himself and hits me. Again, and again. But he is a good boy.” The depression in her eyes is of a mother who can’t leave her son but doesn’t know how to live with him either. I’m so blank.

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Bed number: Innocent souls
This kid is here for a follow-up - a three-year-old who had his bladder carcinoma removed. He’s playing with his teddy. His mum is staring into nothingness. I can’t help but ask: “Is everything okay?” “No,” she screams, “I can’t do this anymore. I can’t stay awake all
night, day after day to make him urinate through a pipe. I am so tired.” Her face fills with guilt immediately, for complaining about her child. She kisses her son and starts sobbing. I understand. But again, I’m so, so blank.

... Blank no more
I sit down to read my journal. 100 entries as an intern doctor. Tales of 463 patients. And I’m no longer blank. I can feel my words and their needs resonating:
Psychological support.
Regards to mental health.
Counselling.
Motivation.
Positivity.
Hope.

...... A triumph
I walk into my parents’ room and look straight at them. I’ve never felt more ambitious, before this day. “I know what I want, I want to be a psychiatrist” I tell them. I am in my zone, no longer blank, and continue to speak, “More people are sick in the head than in their bodies, ma” I tell my mother, “Everyone who has to come to a hospital is in one way or the other experiencing trauma... there’s a mandatory follow-up with the physician but no scheduling of a psychological follow-up, unless the person wants one. I’m telling you though, everyone needs it. People are so depressed there, baba. I’ve seen it. For 100 days, I’ve seen it.” I go on and on, my heart feeling whole from finally knowing and accepting what it truly wants.

...... And a fall
I turn to look at them. Their faces are grim. My dad takes a deep, disappointed breath. Is that anger in his eyes? “Is this your BIG dream?” He asks with brutal sarcasm, shaking his head. I see my big dream being crushed into pieces and falling to the floor.
My mom opens her sullen mouth and asks me “Tui pagol der doctor hobî?” or, to translate, “So you will be the doctor for crazy people?”. They’re disgusted with me - because being crazy, is that even an illness?

“In Bangladesh, mental health remains to still be a topic of taboo amongst many. From the small number of patients who do visit psychiatrists, most do it secretly, for fear of being called “crazy”.
We are trying to raise awareness about mental health through our events, time and again, making it a topic of focus through open discussions with psychiatrists. We believe that hearts are changing, and will continue to change, if we resiliently keep working towards our goal. The entire world must know - mental health matters.”
These are some facts.

Amane is twenty-one years old to Victor’s twenty-five.

Amane is in between high school and university. Still not sure what I’d like to do. I dislike making hushed decisions. He works at a local public library, and mostly reads all day. It’s a rather comforting job. I don’t have to do much.

Amane is 1.65m tall, and just slightly under the weight he should be. His right ear is 30% less efficient than his left one. White-grey hair - was born with it. No one knows why light blue eyes. Wrists so thin they fit on the span between Victor’s thumb and forefinger. A tendency to let his head loll back and to stare at the ceiling for no particular reason.


Blood type: AB negative.

“The rarest blood type in the world,” Victor commented idly as he wrote it down in his notepad.

Amane hums. Yes, and that’s a problem. I’m a hemophiliac, you see. So if anything happens, it’s hard to find blood for me.

Hemophilia, Victor thinks. Genetic disorder. Makes a body unable to coagulate blood, unable to stop a wound from bleeding. The cruelest illness - blood pouring out of someone, constant. He looks at Amane - slight and thin and graceful.

This is a fact: Amane isn’t Victor’s first patient as a doctor, far from it. But he’s the first one that sticks to Victor’s head when he goes to sleep.

There’s something comforting in listening to someone’s breathing.

He was taught the proper technique for searching for respiratory issues during his first year of medical school, and again with more depth during his fourth - but it’s something else when it’s like this. When it’s Amane sitting on the stretcher, half-naked with his clothes pooling on his lap, his back turned to Victor, with his delicate features framed by the sunset streaming in through the window.

Victor grabs the stethoscope, runs through the motions made natural by now. Puts on the eartips, checks if they’re in the right position, takes hold of the stem, presses his finger to the bell and the cold surface of the diaphragm to Amane’s back, just over the ribs almost visible through his milky-white skin.

“Breathe,” he says, softly, but he can’t listen to his own voice - like this, Amane’s heartbeat and the soothing, rhythmic depth of his breathing take over his entire hearing, filling up his mind.

Back when he was a student, one of his teachers said that examining someone’s breathing was like hearing the ocean. He finds himself staring at the soft silver hair on the back of Amane’s neck, but he’s not seeing - he’s hearing the ocean of his respiration, the slight stutter-stop and the hiss in the corner of the sound that tells him something is wrong. Has been wrong.

He slides the diaphragm to a different spot, closer to his heart. “Breathe, please,” he instructs again.
Amane does, deeply. Victor focuses on listening. He knows what he’s looking for; the same thing he’s heard and seen and diagnosed multiple times before, knows precisely how Amane’s bronchi don’t work, knows what pain and discomfort look like on his face, how they drag a frown between his eyebrows and grit his teeth together. He took Amane from his mother’s arms, placed him on a bed, watched over him as he suffocated in his lack of oxygen, held his shaking hand and shushed him until he fell asleep.

When his crises don’t take over him (and something else Victor has learned, the ability that pain and illness have of making tangible vulnerability out of the coldest characters), Amane is an interesting patient, elegant and curious and composed. Victor has never heard him complain, or even so much as felt him flinch away from a needle or an IV. Even when his face is pale with pain, his forehead damp with cold sweat, he presses his lips together and handles it beautifully. Victor can’t see his eyes, but he can imagine them - big and cold and gorgeous staring out of the window with all the grace of a prince.

“Once more, please,” he breathing out. Amane breathes in.

“Good evening, doctor,” Amane greets when he sees Victor enter the library. “Wasn’t expecting to see you outside of a hospital.”

Victor shrugs. He’s not exactly sure what he’s doing here either - he’s just finished moving into his new apartment. He divorced his powerful wildfire of a wife, walked out on her after one argument too many. Besides, Victor is a doctor now, and has been a real doctor for a year or so. He has an obsessive-compulsive personality, a tendency to save up money for future catastrophes even if there’s no reason for it. So he got a place for himself, a nice-looking apartment close to the hospital he’s been working at lately, and today he finished moving in. It felt lonely, and silent, and strange - so he left, locked the door, wandered around town.

And now he’s facing Amane and his blue eyes.

“Evening,” he answers, belatedly, mind glitching slightly at the peculiarities of human interactions. “I was just walking around.”

Amane hums, straightens on his chair behind the front desk. “Well,” he says, “since we have found ourselves in a strange twist of roles here, I can ask now - how can I help you?”

Victor isn’t sure how to respond to that. He didn’t come here looking for anything in particular. Amane props his chin up on his entwined fingers. “You can browse around if you want to.” His voice is airy, distant, and that is reassuring to Victor, as if he’s entered a different, easier, less than real dimension. “I do that sometimes. Just walk between the shelves, touch the books. It might do you some good.”

Victor makes a vague questioning sound.

Amane smiles, not particularly kind but not dismissive either. Just an afterthought of movement. “You look rather lost, doctor.”
#BLM
Through an African Lens

Sarah Njeri Maitho
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I did not grow up aware of my “blackness”. I was born and bred in Kenya and have spent my entire life in an environment where almost everyone is African. Even now, it feels odd to describe myself as black since in my context, it is mainly used in reference to African Americans. The first time I became conscious of my racial otherness was when I joined the IFMSA, a multinational organisation. It was the awareness that as an African, your otherness transcends the category of minorities, because in reality, you are perceived as the minority of all minorities.

We are all familiar with the #BlackLivesMatter (BLM) movement. In the last couple of weeks, the gut-wrenching murder of George Floyd has fanned the flames of this movement, causing its impact to reverberate across continents. Ordinarily, I would have paused briefly to lament this issue with little attachment. After all, I am not ‘black’, I am African. It would not have disturbed me in the same way it did the African Americans. This time, however, I was gutted by the senseless killing. Four years of working in the IFMSA have heightened the awareness of my racial identity and consequently, my sense of responsibility to the race. This newfound awareness got me thinking, how often do we talk about race and racism in the IFMSA? It is easy to assume that racism is the practice of ‘those’ barbaric people, but if we are honest, it is a common practice by ‘us’ all. Ask yourself, ‘have I never had a racist thought?’ Most likely, you will find that you have not only practised, but also perpetuated covert racism.

Covert racism often takes the form of common stereotypes. For one, the belief that Africans are illiterate at best and unintelligent at worst. This is typically indicated by the surprise on people’s faces when an African expresses themselves articulately and further surprise that their expressions are smart and well elaborated. Secondly, the suspicion that they are criminals and you have to be extra-cautious around Africans, lest you get robbed and/or physically attacked. Other stereotypes are so comical that some Africans are more likely to laugh than take offense. For instance, that we cohabit with wildlife and live on top of trees. Even the ignorance that ‘Africa is a country’ stems from a dismissive disinterest in this ‘inferior-thus-insignificant’ population.

“Covert racism, just like its twin overt racism, is neither innocent nor harmless.” -Rodney D. Coates
In multi-national organizations and a significant chunk of modern society, overt racism has been subdued under policy reforms that protect minority races. Unfortunately, covert racism is more widespread and difficult to legislate against since it is not obvious and is essentially hard to define. Nonetheless, covert racism is just as damaging because it still maintains the social gap between Africans and other racial groups.

Is this a call for affirmative action? For diversity and inclusion of Africans? No! I am calling for more than that. I hope to appeal to individuals rather than societal structures. Beyond advocating for inclusive societies, I am advocating for inclusive people. Institutional changes have proved ineffective in curbing covert racism. We must start with the individuals who make up these institutions. Instead of reflecting on the kind of society we want to create to accommodate the ‘minority of racial minorities’, let us explore what kind of selves we need to be so as to embrace each other with a genuine sense of equality.

One way would be to encourage relationships between people of different races. Admittedly, close relationships between people of different races might be uncomfortable at first. However, the call to embrace each other is not a call to ignore our differences. Rather than tiptoe around the landmine conversations on race, such relationships should openly explore the difference between colours, in order to debunk the stereotypes. In a bid to be politically correct and cautious not to offend anyone, we have avoided this important discussion altogether. It is possible to be curious without being disrespectful. Hopefully, one day the conversations in the relationship will cease to be mainly about race and become solely about being human!

“It may not be too much to claim that the future of our world will depend on how we deal with identity and difference. The issue is urgent.”
-Miroslav Volf
(Croatian theologian in his book Exclusion and Embrace: A Theological Exploration of Identity, Otherness and Reconciliation)
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YOUTH & Health Emergencies
O CAPITALISMO NÃO É VERDE
The imperative for international medical student action against the planetary health emergency of climate change

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Over the past months, unprecedented public health measures have been implemented in many countries; however, health systems globally continue to struggle with the ongoing COVID-19 pandemic. As a result of a zoonotic virus spilling over from a non-human reservoir, it serves as a critical example of the deteriorating interface between human populations and the natural environment ¹. In this article, we will discuss connections between the current pandemic and the ongoing health emergency of climate change. We will focus on the health impacts on youth as a result of our degraded relationship with the natural environment. We frame this discussion through a planetary health lens, acknowledging that our health as humans is integrally linked to the health of the natural environment within which we live and upon which we depend. We believe that medical students must understand the health impacts associated with the degradation of our natural environment to be competent future physicians. To this end, we will present brief updates from ongoing efforts to integrate planetary health teaching into medical curricula globally and other medical students-led climate action efforts.

Studied have shown that increasing global urbanisation and biodiversity loss exacerbates the likelihood of an infectious pandemic occurring as animals come into closer contact with humans through deforestation, ecosystem loss and habitat encroachment. Higher population densities ensure easier interpersonal transmission²⁻⁴. Biodiversity has also been found to moderate human immune system responses⁵⁻⁶. When considering the transmission of new pathogens like COVID-19 and their health impacts, we must look at the characteristics of the human host and its environment. The vulnerability of individuals to infections is intrinsically linked to the presence of comorbidities like heart diseases, obesity and respiratory diseases. The environment itself plays a significant role in the risk of these comorbidities as a determinant of health, illustrating again the interconnectedness of human health and the health of the environment⁷. In light of the recent COVID-19 pandemic, it is clear that humankind and the natural world are connected more than ever before, and in more ways that we thought. The coronavirus outbreak illustrates just how little we know about the repercussions of our disruption of environmental systems.

Climate change has been called the greatest threat to global health in the 21st century, and also the greatest opportunity to improve health worldwide⁸⁻⁹. These diverging viewpoints recognize both the significant health burden that climate change and the at
tendant destruction of our environment has on us all, and also the co-benefits to health that could come from taking climate action. For example, the burning of fossil fuels contributes to the accumulating greenhouse gas emissions and air pollution. The use of personal motorized vehicles that have combustion engines is an example of how we individually contribute to these emissions. Public policies to limit coal-power generation and promote public or active transport will reduce air pollution and slow the rise in greenhouse gases. In this way, those policies can be said to have health co-benefits.

The impacts of climate change are being felt globally but not equally. Differences can be found between regions, income levels, genders and generations. Those who have contributed the least may bear the greatest burden. Youth and future generations are at increased risk in the climate emergency, as many health consequences including flood associated illnesses such as water borne viral diarrhoea outbreaks, malnutrition from extreme weather events, and vulnerability to heatwaves, will increase in frequency in the coming decades. Furthermore youth may experience significant mental health impacts such as “ecological grief” referring to the grief felt in relation to experienced or anticipated ecological loss. Recognizing the urgent threat of climate change and imperative to act, young people around the world have rallied behind youth leaders such as Greta Thunberg, Autumn Peltier, Helena Gualinga and Tekanang to develop broad youth-led movements such as Fridays for Future to demand action.

As the future health workforce, medical students will be at the frontline of the health impacts of the climate crisis. We must be adequately equipped to practice in future clinical settings that will be affected by climate change and engage in evidence-based public health and eco-health advocacy. Surveys and evaluations conducted around the world have shown that there is a global gap in medical curricula when it comes to planetary health. Despite the immense threat posed by the climate emergency for health, when surveying 118 countries, IFMSA found that only 15.9% have it included in their medical curricula. This shows that the importance of the environment as a determinant of health is insufficiently reflected in the training of future physicians.

In 2018, IFMSA adopted its Climate Change in the Medical Curriculum 2020 Vision to guide the advocacy for integrating climate change education, with the goal to have an element of climate change teaching included in every medical school by 2020, with full integration by 2025. The IFMSA has worked to empower medical students with knowledge and tools through international workshops, sessions, and consultations for medical students on planetary health leadership and advocacy. A Climate Change Medical Education Framework has also been developed and will soon be shared with all NMOs. It includes core competencies that cover the complexity of climate change as a health crisis and an assessment scorecard that will enable members worldwide to practice evidence-based and informed advocacy on a country-level. NMOs have also been working towards 2020 Vision on national levels as well. For instance, CFMS HEART has developed a set of planetary health learning objectives that was finalized in 2018 to equip medical students across Canada who then approached their medical faculties and successfully started integrating them into their medical curricula. They also conducted a National Curriculum Evaluation to assess the current state of climate-health teachings in Canadian medical curricula and opportunities for student engagement, which was then used to produce a set of recommendations for students and faculties. Another example is AMSA-Australia Code Green who is working on a multi-faceted approach to improving the health literacy of medical students, both through the integration of evidence-based climate health competency recommendations into the existing curricula, and synthesizing information about climate change and health into an engaging set of educational resources.
been adopted by IFMSA to inform external advocacy efforts. Local NMO efforts are also an essential component to support both the internal and external work of IFMSA and answer the local needs of the population. The climate emergency has led NMOs to push for ambitious climate action and implement measures to instigate a culture of environmental accountability. After a successful carbon-neutral August Meeting 2018, IFMSA-Québec implemented a Green Coordinator position within its team to ensure the application of strict eco-friendly measures in all its national events. CFMS HEART launched “Project Green Healthcare” to promote meaningful youth engagement in creating a more sustainable healthcare system. AMSA Code Green is also collaborating with local health workforces and the Global Green and Healthy Hospitals international network to improve the sustainability of their healthcare sector, which currently contributes 7% of their nation’s total emissions. IFMSA-Honduras created a Standing Committee on Climate Change and the Environment to ensure a bold commitment to climate action. They have engaged in climate advocacy by posting infographics, webinars, some outgoing investigations, and photography contests in their official social pages. Actions, such as these examples from medical students worldwide, start gradually with an understanding of the connection between Climate Change and Health.

In May 2020, the IFMSA joined 40 million health professionals and signed onto a letter addressed to the leaders of the G20 countries calling for a #HealthyRecovery from COVID-19. We, as medical students, have a responsibility to advocate for the protection of the health and wellbeing of our future patients and communities in a changing climate and prevent possible future health crises. We must ensure the health sector youth voice is heard in climate change discussions. This must be done not only through robust health and population-centered climate advocacy, but also through a commitment to lead by example with concrete local actions to reduce our environmental footprint. We must walk the talk and implement initiatives and measures that match the ambition of our tasks related to climate action. The climate crisis requires a unified and ambitious response from the health sector and grassroot activism is paramount to this global response. We encourage every medical student to work collectively in protecting and promoting health in the face of the impending climate crisis, and contribute to building back better through a healthy, green recovery.

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References:
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Youth involvement during health emergencies

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The evolution in the world is forever going, and we are in a daily race to keep up with this change. This phenomenon could be noticed in many fields, but one common thing among those events is: the increased demand of youth involvement in many aspects of life, and medicine is no exception. The emergence of pandemics have been known throughout history. Some of them appeared as early as 165 AD, while others are as modern as the current coronavirus disease. All of those health emergencies require an immediate response, and the stakeholders couldn’t deny their need for the population’s help. For instance, the first initiative to involve an important part of the population was during the 1955 winter anti-typhus campaign in Afghanistan, when women took a role in the dusting team; but involving the youth community was seen later. Nowadays, many medical schools around the globe have allowed their students to graduate early so as to join the frontline forces to combat the COVID-19 pandemic. However, the role of young people isn’t limited to fighting the disease, it actually goes beyond that.

In Public Health, we believe that raising awareness is one of the most important assets to control the spread of any disease; hence, the youth in many countries made it their obligation to fulfill this mission. The biggest witness for such action was the International Federation of Medical Students’ Associations (IFMSA) itself, as this youth-based organization responded to the spread of coronavirus disease by creating an “Activities Map” to visualize the efforts made by its members to fight and raise awareness about this disease. But medical students were not the only ones who worked to fight this emergency. Pharmacology students and youth from different fields in Sudan produced hand sanitizers and distributed them amongst the citizens. Also, social media influencers around the world used their voices to stress upon the danger of this disease in many creative ways. But, of course, raising awareness wasn’t the only way to prevent a health contingency form happening.

As a person who lives in a country where the Neglected Tropical Diseases are prevalent, and are threatening to put the health systems into jeopardy, young people are constantly putting an effort to stop the spread of those diseases by various activities other than awareness campaigns, such as: environmental campaigns to eradicate the breeding area of the vectors, and vaccination campaigns for the populations who are at high risk of catching these diseases.

Triage is also another way in which the youth community is continuously engaged in cases of health emergencies throughout history. At first, the idea started as field ambulances when the 26-years-old Baron Dominique-Jean Larrey insisted on a rapid evacuation and response by putting his special surgical teams near the frontlines in the battles of the War of the First Coalition in 1792. This action serves as a basic department of the medical services in the army till this day. Then, the description of the modern triage goes back to the time he started treating the wounded soldiers according to the severity of the wounds rather than their ranks in the army.

Until this day, triage is used in many disastrous situations, and the stakeholders around the world have acknowledged their need for youth power during such events. For example, the department of Radiology in Dartmouth Geisel School of Medicine in the United States established a Medical Student Triage Program in 2010. This program was designed for the students who completed their pre-clinical years and students in the third year and above. We cannot deny the ability of the youth to adapt to the unexpected changes. Studies from Concordia University in Canada showed that younger adults are faster at responding when a routine task is interrupted by a sudden event. This study could be seen in reality as many youth-based initiatives over the globe tried to ease the lockdown by many means. Some of them in many countries started to provide groceries to the doorsteps of elderly in their communities. Another youth-based initiative...
started giving financial support with a dose of knowledge to the families with low daily wages, and the list of similar actions goes on\textsuperscript{12}.

Young people’s support during similar health emergencies is not only limited to materialistic goods only. We have all witnessed the creativity in the global emotional support which was provided for the class of 2020 as they have been deprived from the joy of a physical graduation. Young celebrities and social media influencers all stood up to those students by sharing their graduation photos, giving motivational speeches, and a memorable lesson to those freshly graduated students. Social media platforms like Facebook\textsuperscript{®} and YouTube\textsuperscript{®}, which globally gathers a huge number of young people, supported those actions as well by offering a “Graduation 2020” event and a “Dear Class of 2020” celebration respectively.

Nowadays, with Beijing activating the “wartime mode” to contain the new emerging cases of the COVID-19 disease, and South Korean officials threatening a second wave of the virus, social-distancing should be our new normal \textsuperscript{13,14}. Creating this norm would be greatly facilitated by the delivery services which employ a large number of young people. Moreover, governments could also use the help of the youth to distribute the necessities to the residents of their own neighborhood, which will help the ministries of health to contain the disease.

All in all, voluntary global youth actions proves to be vital in all the health emergencies. Recruiting the youth and preparing them for such events should be put into action, and this pandemic has proven to the world the importance of involving the young workforce; not only to cover up the shortage of manpower in such contingencies, but also to correct the improper and false information which are widely spread among the population. The governments could also use the vigorous manpower of this age group in the manufacturing lines of the Personal Protective Equipment. Furthermore, the stakeholders should also involve the youth in decision making as they will benefit from the creative ideas of the younger generation.

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HIV: A New Wave Emerges

Thaíssa Ramim Reis Belgo, Sergio Felix Dos Santos Júnior, Clara Couto e Silva de Oliveira Prates, Pedro Henrique Cordeiro Flores, Katlan José Rodrigues, Pedro Henrique Melo Sípoli Marques, Maria Eduarda Garcia de Andrade

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Human Immunodeficiency Virus (HIV) detection firstly occurred in the 1980s. Albeit forty years have passed since then, a new wave of cases seems to approach the young population of numerous countries around the world. In the United States, in 2010, approximately 12,200 people from ages 13 to 24 were infected, an average of more than 1,000 infections per month¹. In this scenario, Acquired Immunodeficiency Syndrome (AIDS) should be recognized as an impending health emergency. Notwithstanding the advances in antiretroviral therapy (ART), HIV was the second major cause of mortality among youngsters around the world in 2015². The presumable reasons for this number center on the insufficient funding for HIV testing and AIDS counseling services, the shortage of medical and psychological support for adolescents tested positive and requiring ART, and, finally, the lack of prioritizing the health of the young population in national health programs in most countries³. Therefore, this review intends to ascertain, theoretically, the motives behind the rise of HIV among youngsters, a massive health risk.

The methodology adopted in this research was elaborated based on seven articles published until June 2020 and deemed satisfactory to our purpose. The databases searched were Pubmed and Scielo, and the following keywords were used: “adolescent,” “HIV,” “increase,” “LGBT,” “transmission,” “youth,” and “young.”

Data acquired showed that according to the Centers for Disease Control and Prevention (CDC), while annual HIV infections have decreased. In general, an 87% increase in cases among 13-to-24-year-olds was documented throughout the last decade, and 81% of them occurred among gay or bisexual men. 51% of the cases, from 2011 to 2015, were left undiagnosed. Meanwhile, the youth composes the age group with the lowest rate of viral suppression, 27%⁴.

Depression was more prevalent in 21%-50% of the HIV+ young population⁵; and associated with unprotected sex and alcohol use⁶, evidencing the relevance of prevention and treatment retention projects as “Text Me, Girl!”⁶. Altogether, inconsistent condom use among the HIV+ is 34% from the ages of 21 to 35, with men tending to be more adherent to prevention than women, regardless of age (79.3% against 60.7%)⁵.

As stated by Marinho et al.⁷, in Northeast Brazil, knowledge about HIV/AIDS transmission was satisfactory (>70%) in female and male youngsters, regardless of age. 100% of the subjects declared intercourse without a condom as a form of contamination. Among the 410 youths, 85 had had prior sexual experiences, and 57 had used condoms in the last intercourse. Major determinants associated with condom use were the initiation of sexual activity less than a year before, the age gap between partners, and the nature of the relationship.

Davids and van Wick² showed several barriers and one facilitator of adolescents’ ART adherence. Participants often declared feeling conflicted between school commitments and the obligation to attend clinic appointments. Furthermore, as aggravators were the scarcity of financial assistance, leading to transportation costs and long waiting times at the health facility. Additionally, participants feared that the flow of patients could lead to unintended disclosure of their HIV status, rejection, stigma, and discrimination. Some respondents reported feeling like outcasts among their families, as they were the only HIV+ members. Despite that, receiving social support from family members, particularly siblings and friends, encouraged participants to remain adherent to ART.
That being said, it is possible to affirm that in some countries, juvenility is the only age group in which there was not a reduction in AIDS-related deaths in the last few years. As AIDS is a preventable disease, with condom use and ART restraining HIV republication and its complications, this data complies with a pressing health emergency. The fact that this portion of society is vulnerable, considering the dependency on family support and government help as the majority is still engaged in the educational system and has yet to achieve financial independence confirms their position as even further worrisome. Moreover, considering that HIV+ individuals are more likely to present with mental illness diagnosis than the general population, the youth’s situation is additionally aggravated as they are still developing mentally and physically.

The disorganization of the health systems points to an relevant reason for adolescents to abandon ART, as they strive to balance studying, social life, and caring for their health. Also, as Davids and van Wick asserted, individuals subject themselves to prolonged waiting room periods, becoming fearful of being exposed as HIV+. A burden that would not be necessary, however, if the general population was less discriminating and more informed about AIDS, ART, and transmission.

Regarding information about HIV and AIDS, although distributed in multiple means of communication, such as the Internet and television networks, some researchers reckon adolescents do not take satisfying advantage of it. For instance, high school students of Northeast Brazil showed that although a significant portion of them knows how the virus is transmitted, safe intercourse is not practiced by all yet. A possible explanation for it is the belief that the non-use of protection during intercourse poses as a way of demonstrating trust in a partner. Besides, there were broadly established false ideas of non-vulnerability to getting STDs, making youth the most arduous population to participate massively in prevention.

As the educational system has not fulfilled its role correctly, sexual education is still a taboo. Commonly it consists of counseling, and the theme is approached through a heteronormative vision, neglecting men who have sex with men (MSM), the population most likely to be contaminated with HIV. Consequently, the system contributes to the rising rates of HIV among youngsters. Transgender women are also another minority overlooked and subjected to numerous risk factors for HIV transmission, as several of them experience discrimination, substance abuse, and sex work. Therefore, specific practical interventions must occur towards these groups and any other minorities, aiming primarily on providing psychological support and maintaining ART adherence.

This way, HIV transmission tendencies would be diminished, and quality of life would improve. Furthermore, factors related to the mental well-being and quality of life of the juvenile infected by HIV, like depression, contribute to the nonadherence to ART and unsafe sex practices, creating a cycle. It was indicated by HIV+ interviewees who were dealing with depressive symptoms that they had already thought about abandoning treatment, besides an expressive number reporting past intentions of ending their lives. In the same study, van Wick and Davids stated that those who revealed their diagnosis for someone trustworthy, like a friend or a relative, were more likely to maintain treatment and to accept their condition considerably, confirming the pertinence of the demand for psychological support by governments and health systems.

In conclusion, HIV has a notable impact on young people, among whom there is an increasing rate of new diagnoses and a more pronounced tendency of health disparities. Thus, a new wave of infection poses, indeed, as a threat to this population. The reasons for such derive from several simultaneous factors that affect society structurally and culturally. The disorganization of the health system and the conception that neglecting safe intercourse is a way of trusting partners are both valid examples. As a result, a new alert about AIDS, and how it is an impending health emergency among young people, must be widely spread.

References:
Medical Schools in South Asia have failed to train us for the Communities we will serve

Sheharyar Zameer
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In my last years of medical school, there's a statement told and retold to us time and again; A doctor has no gender. It’s supposed to indicate that a medical professional shouldn't be shy to examine a patient of the opposite gender. Not only does it pertain to the gender of an individual but also their sexuality. Furthermore, the statement is a very strong reflection of the struggles medical professionals undergo within South Asia.

South Asia is an area of the world where society is strongly influenced by a set of cultural, traditional and religious values, so much so that concepts are taboo to the westernworld, like arranged marriages, parda* and patriarchy are the norm here. These concepts are based on the acceptance of the two binary genders, male and female, within the basis of the society. Yet, it’s worthwhile to mention that hermaphrodites, transgenders, transsexuals, transvestites, homosexuals, etc are part of the same communities and their numbers only continue to grow.

Recognizing the social status of these communities within the society maybe a different issue but unfortunately and admittedly, ignorance about the transgender, intersex, and gender expansive communities appears to be widespread among medical students and physicians1–3. We have an adequate curricular content on the health of men and women however, our education on transgenders and gender non-conforming people is lacking. And it is the responsibility of medical schools to include this content within the curricula3.

Currently, the majority of the curriculum pertaining to sexual health is learnt through topics of endocrinology and sexually transmitted diseases1. Topics specific to transgender and non-binary person health, such as gender affirmative care, are rarely addressed2. It further needs to be mentioned here that in South Asia practices like estrogen injections, prostitution, unauthorized and illegal plastic surgeries are also found within the transvestite communities, who’s health concerns ultimately fall onto the healthcare system.

The lack of relevant knowledge and skills is dangerous because it limits our ability to provide comprehensive care and exacerbates existing health disparities. Improved education is also needed to help combat stigma as intersex people are routinely subject to ignorance and harassment in healthcare settings4.

It is worrying that medical students are graduating with little or no knowledge of the communities we will be serving. We took an oath to help every individual in our community that needs it irrespective of any prejudice. We now need to show that we have no prejudice against anyone’s gender, sexuality or belief. We must equip ourselves with the knowledge and skills needed to honour our vows and be effective healers and advocates.

* A screen intended to conceal women and men either in the form of a burka, hijab, niqab, etc.

References:
A journal club is a space where people interested in analyzing and commenting on different recently published scientific advances meet, in addition to updating their knowledge, necessary for evidence-based practice. This learning dynamic promotes the search for relevant contributions, critical interpretation of articles, the opening of spaces for opinion and the development of reading habits in attendees.

Despite being an academic activity that is frequently carried out in medical schools, generally in a fully scientific field, it can be used in approaches beyond this, allowing students to understand the contents of their curriculum from different scenarios and developing multiple competencies to perform adequately in their professional future. Here is where the Standing Committee of Medical Education takes a fundamental role.

In addition to establishing an academic space in which an educational process focused on exhaustive analysis and understanding of articles is promoted, the main objective of the set up journal club is to provide a multidisciplinary approach, in which the subject matter to be studied is contextualized from different points of view such as public health, human rights and educational strategies that have emerged or could take a fundamental part in the area of knowledge exposed.

Methodology proposed for this activity is simple and easy to replicate. For each session, an approach is selected from those mentioned previously, towards which the contextualization of the topic to be reviewed is oriented, and a discussion space is opened where personal ideas and opinions are shared.

Subsequently, the review of articles begins (two per meeting) in which academic content is deepened, allowing a dynamic of peer education. After this, the structure of the article is analyzed according to the type of study selected, and finally a debate arises based on questions asked by the speaker, which seeks to promote critical thinking.
The COVID-19 pandemic has been a favorable factor for the creation and implementation of new methods that allow different activities to be carried out while maintaining the necessary biosecurity measures required by the situation. Through virtuality, numerous initiatives such as this have emerged, which promote learning while strengthening the critical attitude of students around current situations that must raise awareness in society.

Likewise, it contributes to the improvement of mental health during the pandemic by generating spaces for interaction with peers, not limiting itself to individual work. The activity is projected for six months; when the first month finished, a feedback was made in which a positive perception of the members was observed in aspects such as the methodology of the strategy and its impact on their education.

The main tool for the positive transformation of society is education. The importance of carrying out this type of complementary learning activities is that by providing a broad vision of current events, students acquire the ability to create new strategies to face problems from different key points, in order to adequately solve different situations and generate a greater impact that benefits the community, thus becoming true agents of change.

References:
As Moroccans, we pride ourselves on the cultural and linguistic diversity of our community but as healthcare professionals, it can sometimes be challenging. Furthermore, we welcome on a yearly basis a number of foreign students that struggle with their clinical rotations because they can neither speak nor understand our languages and dialects. It was the need to adapt and break the language barrier that birthed the “Amazigh and Darija guidebook” Project.

Darija and Amazigh are the two mainly spoken dialects in the region of Souss. A group of SCOMEdians from Agadir LC (IFMSA-Morocco) came together to elaborate a guide that will help their colleagues overcome the issue aforementioned above. With the help of their teachers, families and other parties who fluently speak both languages, this group managed to conceive a practical tool that provides students with a translation of terms and expressions needed in taking a patient’s history.

These expressions and terms are organized according to the order of a typical patient history questionnaire, starting with personal information, then medical history, and on to symptoms, which were divided into their respective categories. This categorization facilitated the task of history taking for the students and made the use of the guidebook easier and more practical.

The main difficulty encountered during this project was the multitude of dialects and thus expressions in the region of Souss. The choice of the right expression out of many was challenging at times, but the guidebook offers the most widely used expression (sometimes two to three expressions) in the region as to not confuse the user of this tool with a multitude of options.

Addressing the same issue, a group of students instated the concept of “Darija-logy” which consists of communication lessons in Darija provided by fluent speakers. The project targets mainly, but not strictly, foreign students interested in improving their Darija by learning the basics and practicing simulated conversations and situations with their fellow colleagues.

By working on their language, foreign students gain not only the tools to thrive in their medical practice but also in their everyday life, thus making their social integration within the Moroccan community smoother and easier and further improving their relationship with their patients.
As of today, the medical practice is leaning more and more towards patient-centered care, which makes it mandatory for us, health workers, to maintain a good doctor-patient relationship; for which good communication is the pillar.

IFMSA Morocco has been interested in this theme for a long time and has been working on it in other LCs. Today, we are planning on making the current form, developed by MSA-Agadir, prosper and spread it even more by encouraging all the LCs of our NMO to follow through these footsteps; organize Darija and Amazigh communication sessions and make guidebooks adapted to each region’s dialect.

We believe that bridging the language gap, in order to provide information to our patients in a way they fully understand, is a necessary step in forming and preparing socially accountable and culturally sensitive future physicians.

“If you talk to a man in a language he understands, that goes to his head. If you talk to him in his own language, that goes to his heart.”

_Nelson Mandela_
“Curricular Conference” (CC) is a student promoted and led event of Medicine course at Universidade Federal Fluminense (UFF), in Brazil. It brings together students and teachers to collectively build responses to flaws experienced when applying the curriculum to university practice. Student’s representative entity, Diretório Acadêmico Barros Terra, is in charge of coordinating the event organization, composed of any interested student. They structure CC into five phases: four for the eight initial semesters; one for mandatory internship period.

CC adopted different methodologies over its nine editions. Currently, organizing students obtain, through a questionnaire, other students’ quantitative and qualitative assessment about their practical curriculum experiences. Then, they group the most frequent flaws of each phase into axes for the entire graduate student’s body to propose solutions, specifying to whom they must demand. On the last day, students bring proposals together in a document, to send to University superior instances.

This event was born in 2010 after a students’ mobilization against poor institutional answer to a lack of practice scenarios. To analyze documents built by different editions is also to understand how students’ priorities have changed over time. In 2020, although pointing to different flaws, phases still point to practical education as an unsolved issue, jointly with the need of pedagogical support for teachers.

However, after no mention in five documents, psychological health appears in the sixth edition as one of the most cited issues, being present in all following documents and demanding a considerable part of available time to debate. Other frequent demands include interdisciplinarity, ethical issues, and teaching staff organization.

This student protagonism experience managed to solve many curriculum issues; therefore, many changes were made: we achieved new practice scenarios, especially in emergency medicine for fifth phase; extensive subjects were reformulated after superior instances’ reviews; and the theoretical content considered deeply specific and disconnected of the general practitioner formation was excluded.

These gains were possible due to the students’ voice and participation and the dialogue between them and the teachers, which highlight distinct aspects of the learning process and engender more viable solutions.

UFF’s medical school current curriculum brings a lot of the discussion about the health reform in Brazil and the creation of the current Brazilian health system. After 10 years, the strength of academic mobilization moreover the pioneering of this debate from the students’ perspective, highlights the importance of this discussion in Brazilian universities.

Medical education is a great challenge worldwide. In the context of the different trajectories of medical education in Brazil, CC seeks to bring debates aimed at implementing improvements in graduation, from its structuring to the teaching-learning process. It also aims to guarantee and expand student participation in the faculty instances where teachers discuss curriculum issues.

Thus, we can conclude that, despite the cyclical problems, CC achievements and the experience of a democratic construction of Medical course justify and strengthen events like this not only in UFF, but in other universities around the globe.
SCOPE
Professional Exchange
Medical student exchange in the middle of SARS-COVID-2 outbreak in Italy

How was it to be on exchange in the middle of the pandemic outbreak?

Luisa Barbosa Soares
Escola Superior de Ciências da Santa Casa de Misericórdia de Vitória | DENEM-Brazil

Exchanging was always in my plans. In November 2018 the dream started, I was selected for the IFMSA SCOPE exchange program in Italy in March 2020. I started planning everything: which city I would choose, the places I could visit and even started Italian classes. On February 24th, 2020 I started living my dream: I took a plane from Brazil to Italy. At that moment, the COVID-19 had already arrived in the country, but everything still seemed normal.

On March 1st I arrived in Parma, the city of my exchange. Then I went to the place I would live for the next month, a building only for students and really close to the hospital. My contact person explained to me the current situation in the city and showed me the places I could go nearby, like supermarkets and restaurants. Later another incoming also from Brazil arrived in Parma, but all others incomings had canceled their exchange due to the COVID-19 situation.

Luckily I was selected for my first desired department, pediatrics, at the Ospedale Maggiore di Parma. They had an entire building dedicated only for pediatrics. The structure of the building was impressive, there were a lot of toys, drawings, and colors. I was welcomed by the interns and my tutor, Susanna Sposito. They introduced me to the hospital, explained how it works, and answered all my questions.

Sadly, because of the COVID19 pandemic, the hospital didn’t have that many patients and I couldn’t see many different cases. Despite that, I could learn about the health system of another country and how they deal with patients, but mainly with their children. Furthermore, I was able to live in the middle of the outbreak and I learned a lot about the real situation and how they were managing patients there. In the hospital, most of the patients had some respiratory symptoms, but fortunately, very few were confirmed with SARS-COVID-2.

As time went by, people started to seem more afraid of the disease. The streets were empty most of the time, supermarkets had more rules and social distancing had started. My second week in Parma started with the lockdown and the only things that were open were supermarkets and pharmacies. However, until that time I was still able to keep doing my exchange at the hospital. The only problem was that I couldn’t get out of the house without a good reason.

Unfortunately, the disease started to spread fast all over the world during my exchange. Then, I started to be afraid that I wouldn’t be able to go back to Brazil because most countries were closing their borders. For that reason and also advised by my college coordinator and family, I decided to go back home in the middle of my exchange. Despite the bad experiences because of the outbreak, the experience at the hospital, the acquired knowledge, the people I’ve met and the warm reception made my exchange really worth it. If someone asks me if I would do everything again, I would!
When Contrasts Collide

Fabiola Alexandra Gallucci Di Filippo,
Marcelle Rodrigues Carneiro de Souza Reis
1. Universidad Central de Venezuela | IFEVESOCM Venezuela
2. UNICEPLAC | IFMSA Brazil

To begin with, it is hard to believe that in an age where we have so much access to the Internet and different resources, we still have such a poor idea of the reality that is lived in other countries, even in neighboring countries. When traveling to Brazil as an incoming, I gradually discovered the differences we had, in all aspects.

Brazil and Venezuela are neighboring countries, with a charismatic, kind, and warm population. Their climate, soils, latitude, and longitude make them have similar flora and fauna, so we usually eat similar things. However, the dishes we put together are totally different, each with a unique touch. While there, I had the opportunity to show my host family some typical dishes from Venezuela, and they showed me the wonders of Brazilian cuisine from the moment I arrived at their house (literally).

Sharing with my host, I discovered the music, movies, series, and artists that were popular in Brazil, and showed her some of the pop culture that was popular in Venezuela. It could be said then that transculturalization for us started from the moment we met at the airport.

A few days after arriving in Brasilia, I first attended the service where I would do my clinical internship: neurology. There, I discovered that the infrastructure of their hospitals is similar to ours and that the conditions in which they are found vary only a little (Yes, Venezuela is a little worse). However, over the days I learned that their health system works in a very different and much more organized way. Also, I learned that undergraduate students don’t participate too much in the patient examination. While in Venezuela we are in charge of fully examining the patients and writing both their medical history and their evolution, I observed that in Brazil it is not customary to be as autonomous with patients when you are an undergraduate student.

For one month two cultures met, and they were fortunate to learn from each other. For a month I made new friends, tried new food, learned a new language, and fell in love with another country.

When deciding to make an exchange, you must keep in mind that, no matter where you go, cultures are different. The ideal is to learn from them, respect them, and also show a little of your culture. Among all the benefits of belonging to IFMSA, the cross-culturalization that occurs thanks to exchanges is one of the best. It allows us, without a doubt, to broaden our horizons, to become better people, better professionals, and above all, make new friends, who will last a lifetime.
Exchanges’ Crisis Committee: Increasing Global Health Learning while coping with a public health collapse

Sara Farias Costa¹, Caique Fernandes²
¹ UFC Sobral, ² UFPEL | IFMSA Brazil
Nahiman Saleh, Pedro Henrique Garcia Parreira, João Marcelo Gomes Botelho, Marcelle Rodrigues Carneiro de Souza Reis | IFMSA Brazil

Since February, when the first case of the new Coronavirus was confirmed in Brazil, the country has reached 1 million confirmed cases and 50,000 deaths, which unleashed a public health crisis within the country’s Unified National Health System (SUS)¹². Also, due to its continental dimensions and diverse local realities, the disease has singular behavior in each region³⁴, the contrasting infectious and death rates in different populations⁵. It becomes evident how Global Health⁶ concepts, such as social determinants of health, play an evident roll on this topic and have been presenting itself as an indispensable competence for medical students to act as health advocates.

Faced with this alarming scenario, IFMSA Brazil took a step forward to make these obstacles into learning experiences creating strategies to approach the new challenges we found ourselves facing: our NMO created the Crisis Committee, electing its priorities in a remote setting, such as events and social media management, activities and exchange’s remodeling. This way, the Exchange Crisis Committee integrated SCOPE, SCORE, and our National Exchange Program to promote initiatives to help our students be better advocates about the main aspects of a pandemic scenario.

Seeking to acquaint our students about the social and economic aspects that set the pandemic outcomes and their impacts on Exchanges, we developed materials and training meetings able to synthesize and address issues related to exchanges and Global Health, from the most basics to more advanced topics. On a first encounter, we met with exchange officers from other NMOs to discuss the different backgrounds, strategies adopted by foreign health leaders, and the impacts on coping with the pandemic. We greeted ANEM-Portugal and bvmd-Germany on our “Open Talk About Exchanges”, who enriched our discussions by providing data information and their national approach, an activity extremely well received by the participants.

On our next step, we provided information and capacity building focused on how our local committees could efficiently apply their knowledge to improve their local initiatives. Partnered with IFMSA Brazil National Exchange, we developed our first “Global Health on Exchanges Manual” alongside with a meeting when our local coordinators shared experiences about those topics on Exchanges, including the definition of global, international and public health; health care systems; universal health coverage; global health education; social accountability as an international federation of medical students; intercultural learning; health leadership careers and the applicability of this knowledge on Pre Departure and Upon Arrival Trainings, Educational Activities and every other initiative for sending and receiving foreign students and improve medical education.

With that being said, in a remote scenario that impacts on both health care access and medical education around the world, it has become crucial to recognize exchanges as a tool to educate ourselves about the global priorities of our society and make us social accountable as medical students in a pandemic framework. To bring awareness about social determinants of health in as many contexts as we can create a chain of events that begins with understanding how our actions can change our local realities by having the knowledge to advocate for more vulnerable populations, so we can fight the inequities around the globe.
References:
A South Brazilian College Experience on Exchanging Cultures: The Perception of Medical Students

Bruna Tiemi Onishi Ogliari, André Biegelmeyer Florian, Étila Dellai Campos, Rafaela Furian El Ammar, Sabrina Fialho Pinotti, Vinicius Victorazzi Lain
University of Caxias do Sul | IFMSA Brazil

It was in consequence of the arrival of a Thai medical student to the IFMSA Brazil UCS’s local committee (LC), at University of Caxias do Sul (UCS), that a South Brazilian city, more industrial than touristic\(^1\), opened its doors for cultural exchanges to become reality. However, it took a little while before the local medical students became more opened and engaged with the idea of receiving exchange students and also becoming travellers. Only a year later, the first outgoing student adventurers himself into an unknown country. Despite those baby’s footsteps, the LC achieved its visibility in the face of exchanges and many were the cultural interchanges that took place: 19 incoming students (Table 1) and 7 outgoing students (Table 2) in 3 years.

Brazil has the reputation of being a welcoming country with hospitable people. Therefore, to properly welcome the exchange students, we threw national food and drink parties with all the variety that our country can offer, considering its continental size and plurality\(^2\). In addition, we showed them our night parties and also took them to small trips, during the weekends, to show them the many beauties of our region. On the other hand, besides the cultural exchanges offered at these meetings\(^3\), the quality of the internships was also a positive difference. In Brazil, but mainly at our university, we have practical classes since the beginning of the medical course, thus we also offer this opportunity to our exchange students. Despite the language barrier, everyone is well tutored and assisted by the local tutors, who are always willing to help.

The exchange activities of the LC began in 2017, the year in which UCS received its first exchange students. The inter-student contact, the integrative activities and the advertisement by the LC itself, fostered the search for cultural exchanges and medical learning opportunities in other National Member Organizations. A progressive increase was observed not only in the demand for international student exchanges, but also in their effective conclusion. The students in our university are now more interested in exchanging knowledge, knowing different countries, their health systems and how medicine works in other places.

Nowadays, the LC has five departments for SCOPE, including General Surgery, Vascular Surgery, Gynecology and Obstetrics, Emergency Medicine and Sports Medicine. Here, foreign students have the opportunity of working within different scenarios, including in our own teaching-hospital, an ambulatory and a specialty lab. The incoming students are usually placed near the campus, sharing home with medical students from the University itself.

Since the beginning of SCOPE at UCS, there has been an increase in the students’ and tutors’ engagement with the exchanges. The knowledge that can be improved and the opportunities to practice medicine as part of the team, inside the hospital, makes a change in the medical student: it gives them a different view of global health. Medicine is all about the patient and a different culture changes the way we act with them, even if we are dealing with the same disease. As the main phrase of IFMSA says: “Think globally, act locally”.

References:
### Table 1: Incomings of IFMSA Brazil UCS

<table>
<thead>
<tr>
<th>Origin NMO</th>
<th>Department</th>
<th>Month/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thailand (IFMSA Thailand)</td>
<td>Cardiovascular Surgery</td>
<td>March, 2017</td>
</tr>
<tr>
<td>Uruguay (IFMSA Uruguay)</td>
<td>Emergency Medicine</td>
<td>March, 2017</td>
</tr>
<tr>
<td>Mexico (AMMEF)</td>
<td>Vascular Surgery</td>
<td>July, 2017</td>
</tr>
<tr>
<td>Mexico (AMMEF)</td>
<td>Gastroenterology</td>
<td>July, 2017</td>
</tr>
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<td>Mexico (AMMEF)</td>
<td>Internal Medicine - General</td>
<td>January, 2018</td>
</tr>
<tr>
<td>Mexico (AMMEF)</td>
<td>Internal Medicine - General</td>
<td>January, 2018</td>
</tr>
<tr>
<td>Switzerland (SWIMSA)</td>
<td>Emergency Medicine</td>
<td>April, 2018</td>
</tr>
<tr>
<td>Peru (IFMSA Peru)</td>
<td>Gastroenterology</td>
<td>July, 2018</td>
</tr>
<tr>
<td>Czech Republic (IFMSA CZ)</td>
<td>Gastroenterology</td>
<td>July, 2018</td>
</tr>
<tr>
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<td>July, 2018</td>
</tr>
<tr>
<td>Russian Federation (HCCM)</td>
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<td>Mexico (AMMEF)</td>
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<td>Emergency Medicine</td>
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<td>Slovenia (SloMSIC)</td>
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<td>January, 2020</td>
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<td>Chile (IFMSA Chile)</td>
<td>Gynaecology/Obstetrics</td>
<td>February, 2020</td>
</tr>
</tbody>
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### Table 2: Outgoings of IFMSA Brazil UCS

<table>
<thead>
<tr>
<th>Hosting NMO</th>
<th>Department</th>
<th>Month/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portugal (ANEM)</td>
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<td>Germany (BVMD)</td>
<td>Transplantation Surgery</td>
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Since the creation of IFMSA Exchanges, 2020 is probably the year in which SCOPE and SCORE have faced more challenges. With the outbreak of COVID-19, most countries had to cancel all exchange programmes for at least 4 months and the truth is that the next few months are still very uncertain. The cancellation of exchanges brought a big gap into the work of National Officers. So my question is: what can NOREs be doing at this moment?

What we understood in Portugal is that there have been several hidden challenges in SCORE since the beginning of the program. But due to logistics of the organization of exchanges, the time left to put some thought into these long-term difficulties was scarce. In ANEM-Portugal, we ended up finding 3 main challenges in SCORE, which we aim to tackle: the relationship with tutors, the lack of interest in research and the outgoing selection process. I will try to clarify our aim for the next months!

Regarding tutors, we mainly noticed that their perception of IFMSA and their involvement with ANEM was low. Hence, this year we aim to develop a leaflet adequate to the Portuguese reality explaining the project and engaging the older tutors with it. Moreover, it is being encouraged for LOREs to look at tutors as their stakeholders and contact them to receive feedback and share the latest news on SCORE.

We believe it is important, that even without receiving incomings, tutors can still remember our project.

Increasing interest in research among Portuguese medical students is also perceived as a priority for ANEM and the IFMSA Research Campaign appeared as a great opportunity for us to achieve our national goals. We aim to actively participate in this campaign!

Lastly, ANEM started to use a system of points for outgoing selection in 2006. Every year, this system is revised and adapted. Nevertheless, the increasing interest of Portuguese students in IFMSA Exchange Programs has shed some light on the fact that we need to do a deeper revision of this process, through comparison with other NMOs, input from students and brainstorming with LOs, so that we are able to achieve a more efficient and fair system.

COVID-19 brought us a lot of problems, but it also brought us time to think and reflect on old challenges. In times like this, we must keep working and understand challenges as a window of opportunity to grow. Therefore, although there was a break in exchanges, I hope after the pandemic, we have just grown stronger and brought new solutions to SCORE.

Letícia Nunes Campos¹ & Lucas Loiola Ponte Albuquerque Ribeiro²

1. Universidade de Pernambuco - 2. Universidade de Fortaleza | IFMSA Brazil

INTRODUCTION

Along with a disrupted global health crisis, the Coronavirus disease 2019 (COVID-19) has provoked an infodemic, which is an excessive amount of information towards an issue, leading to misinformation, disinformation, and cybercrime.¹²³. Inaccurate data promotion can not only be harmful to the community, with rampant consequences on subjects’ mental and physical health, but also to the stakeholders’ decision-making process.⁴

Furthermore, organizations and networks are essential to provide relevant and timely evidence, bridging the gap between science, policy, and politics.⁴ Hence, acquaintance and proper use of evidence-based medicine (EBM) should be stimulated among student-led national member organizations.

In IFMSA, access to research and research education has been prioritized and currently, attaining it is mandatory to promote significant differences. Therefore, the main objective of this article is to report an experience regarding the delivery of a research exchange session entitled “EBM VS Fake News in Times of Pandemics”, analyzing its outcomes towards scientific competences development.

EXPERIENCE REPORT

The online meeting (OLM) was held during the Al-Rufasa Local Committee Festival, on April 11th of 2020, using the Zoom platform. The OLM lasted 2 hours and was organized by 3 members of IFMSA Brazil National Scientific Team.

Initially, the facilitators addressed the concept of EBM and the differences between study designs. Afterwards, an article analysis dynamic was performed in which the participants needed to comment on the paper’s:

• Research question formulation using PICOT-D approach
• Selection, information, and analysis bias
• Internal and external validity
• Outcome description
• Protocols obedience

To evaluate the session impact, a summative and quantitative method was adopted, in pre and posttest format with Google Forms. For this paperwork, no personal data was collected or used during analysis, therefore, dispensing ethical approval.

The participants had to reply to 8 multiple choice questions. The primary outcome was the attendees’ individual knowledge, by the comparison of correct answers on the exercises on both tests, after the end of the session.

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Which Study Type has the highest Level of Scientific Evidence?

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<tr>
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<tr>
<td>Case Report</td>
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Which of the Following is Not a Component of a Well-Defined Outcome?

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<td>5.9%</td>
</tr>
<tr>
<td>Timepoint for Analysis</td>
<td>35%</td>
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</table>

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Figure 1. First question showing a growth of 35.59% in the correct assessment

Figure 2. Second question showing a growth of 29.71% in the correct assessment between the Pre-Test and Post-Test
RESULTS

20 and 17 answers were obtained, respectively, in the pretest and posttest. A notorious growth on the scores can be visualized on the figures, with a difference of:

- 35.09% (Fig. 1);
- 29.7% (Fig. 2);
- 49.7%, which had the biggest growth (Fig. 3);
- 25% (Fig. 4).

For the other questions, the growths were of:

- 28.2% - "What does ‘external validity’ of a study mean?"
- 24.7% - "In which of the following situations, it is UNLIKELY to have selection bias?"
- 70.6% - "Which of the following is NOT a component of a well-defined outcome?"
- 13% - Selection boxes with acceptable options

CONFLICTS OF INTEREST

None.

CONCLUSIONS

The results show an effective impact in the education of EBM, increasing participants’ critical appraisal, methodological skills, and awareness of fake news and misinformation. The principal aim of the session was achieved, which was enabling the attendees to apply EBM skills in a practical situation. Therefore, promoting such activities in IFMSA is vital to pursue meaningful youth participation and to develop health leaderships, whereas increasing research awareness.

REFERENCES:

1. King, A. (2020). Fast news or fake news?: The advantages and the pitfalls of rapid publication through pre-print servers during a pandemic. EMBO Reports, 21(6), e50817. Retrieved from https://doi.org/10.15252/embr.202050817
The increase in waterborne disease prevalence has raised concerns about the basics of water hygiene. The national health assessment reported an increase in diarrhea disease cases in 2018, cementing waterborne disease as one of the top health challenges in the nation, especially in Yogyakarta.

The second basis of this project is the lack of active researchers in Indonesia as mentioned by the Ministry of Research and Technology in their statement about the number of active researchers in our country that is far behind the number of researchers-per-population in other countries in Asia. This raises concerns about whether students are no longer interested in conducting research or there is a lack of research education among students.

Two tackle these 2 problems at once, EMPOWER strives to raise awareness about water hygiene while empowering our members in research by conducting a water hygiene and waterborne disease research project. The project was supervised and facilitated by the Microbiology Department of Gadjah Mada University. The examination results were used to educate students and villagers about water hygiene and its importance.

The first intervention was held on December 13th 2019, in which basic research and sampling techniques training were held in front of 35 students from the local junior high school, SMPN 4 Sleman (Fig. 1). The training was conveyed by our members with their prior knowledge from a pre-project training by Dr. Luthvia Annisa from the Microbiology Department.
After the training, samples were taken from the designated points and surveys regarding water hygiene were handed out to the villagers. Laboratory examinations, assisted by Dr. Luthvia, were conducted on the same day as the sample extraction with the Most Probable Number method and concluded within a week.

The second intervention was set to be held on March 28th 2020 to educate approximately 120 students about basic water research aspects and to showcase the examination result. Furthermore, we ought to educate the villagers of Jogokerten about the result and clean water management. Unfortunately, the event was cancelled due to the COVID-19 pandemic.

Therefore, we adapted to the situation and changed our intervention concept into an educational infographic which was given to the residents of the village and the head of SMPN 4 Sleman via instant messaging.

The first intervention has given us some understanding of how much coliform bacteria were present on Jogokerten water sources, 3 out of 11 water samples taken did not meet the sanitary standards set by the government, and only 2 out of 11 samples proved to be fecal Coliform negative (Fig. 2). The questionnaire also gave us an insight into the residents’ knowledge of water hygiene and its management which was actually quite well.

In conclusion, although intercepted with several obstacles, we’ve managed to adapt and adjust our concepts and executions as best as we could. We’ve provided our targets with knowledge regarding basic clean water standards and waterborne diseases.
The research exchange program at The University Medical Center Groningen (UMCG) in the The European Research Institute for the Biology of Ageing (ERIBA) was in my case organized by the International Federation of Medical Students’ Association (IFMSA) in a partnership with the University of Groningen. However, the research exchange could also be organized through direct contact with the institute. They always have many students from all over the world, but mostly from the Netherlands, working on their main areas.

In January of 2018, I started an internship at ERIBA institute on the “Testing compounds that can selectively kill aneuploid cells” project. It was only for a month, but it was also my first-time contact with science. At the time, I was in my 3rd year of medical school in Brazil, so I had just started the clinical year at my university.

However, in Brazil sciences are not well-rewarded, and even though we are encouraged to work with it, there is not much support to start a research project. Therefore, I had never had contact with any kind of lab before, only in biochemistry classes at the beginning of medical school, when I learned the basic principles of science. Therefore, I decided to apply for a research project in the IFMSA program.

At first, I was very excited to go, start doing research, and contributing to global scientific knowledge. However, the days before my internship, I started to question myself if I would really be able to help there since I had no previous knowledge in the area. Now, looking back at that time, I can see it was one of the greatest opportunities I had in my medical education.

On my first day, when I arrived at ERIBAS I was really shocked; it was a huge 5-floor building, entirely designed for science. Each floor had one lab coordinated by the main researcher with many research students working on their own projects.

I had never seen any lab that big, not even in the movies, and I got really impressed. After the introductions, my tutor, Dr. Floris Foijer, left me under Ms. Bakker’s supervision - she taught me all the karyotyping processes and cell harvest in the first week so I could do it by myself in the following weeks.

In my opinion, the only negative side of my experience was that I didn’t have a designed project for me, so all my work with the karyotyping and cells was worthless, I had no actual goal on doing it every day; which was kind of frustrating. However, I do think my time was worth it because I could experience and learn basic science techniques that I would have never had in my home country. This experience helped me to grow as a student and made me realize I do like research, but I also love the clinic.

In conclusion, it was a once-in-a-lifetime experience and I would strongly recommend all my friends to do it in their first years of medical university, so they can practice all we learned in the pre-clinical years.
Is prejudice as deadly as a nuclear weapon?

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¹Universidad de Ciencias Aplicadas y Ambientales U.D.C.A | ASCEMCOL Colombia
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Knowing about sexual and emotional development in the youth population is considered a fundamental part of comprehensive clinical evaluation¹, however, affective sexual, body and gender diversity is not entirely accepted. Daily newscasts report violent events against the adolescent population, specifically those with differences in their sexual orientation, which not only confers an internal conflict on youth, but also generates controversy and public health problems.

Violent attacks against adolescents therefore vested in courts that have different perspectives about the problem. Some of the judges are in favour of parenting under “traditional conditions” and some others are in favor of human rights and equality. Every human being at birth has not only a personal opinion, but also free will and human rights. That is why they have the rights of free expression, considering their age and what it means to be legal. Now, the impact that society attributes to sexual diversity translated into the increase on the violence data and global mortality.

According to reported figures, “about 1500 people from the LGBTTQAP+ community were killed between 2014 and 2019, and of this population, 30% were killed because of prejudice”², Is prejudice more violent than a nuclear weapon? These alarming data shows that 4 deaths occurring daily, which translates into the suffering of entire families, not to mention the difficult position: being part of the LGBTTQAP+ community in a society that is not ready to accept changes and individual realities in the XXI century.

This phenomenon triggers major problems and politicians, despite the alarming facts, do not define adequate sanctions against people that prompt this type of violence, and ignore, claims of civil society about this problem; the historical invisibility of this population in its maximum context of discrimination, leaves us a strong message: The LGBTTQAP+ community must hide their sexuality and what identifies them, in order to stay safe.

One of the most recent events that occurred in the city of Bogotá was the case of the death of Alejandra Monocuco, a 39-year-old transgender woman; This event became so famous that caused a social media movement “#JUSTICIAPARAALEJANDRA”- The colombian justice currently is investigating the case without any clear explanation of what happened that day, and whose impact only reached social networks.

Sexual diversity is not a condition, it is a way of identifying within a society and ourselves; it is not a movement in social networks, it is a lifestyle. Their safety is our safety.

We need more than a movement, we need to be accepted, not tolerated. Without equality, will we continue to be a developing power?

References:
Is LGBT+’s blood compatible with citizenship?

Fernanda Clara da Silva, Sadi Bruno Freitas Santin, Danielle Correia Furtado, Eliany Gurgel Cosme do Nascimento
Rio Grande do Norte State University (UERN) | IFMSA Brazil

In a historical context, it’s important to notice that during the 1980s, the epidemic outbreak of Human Immunodeficiency Virus (HIV) occurred. Due to the high prevalence of the disease in men who have sex with men (MSM), blood banks have banned donations from MSM.

However, this implementation has come to suffer harsh criticism in the current context for passing the prejudiced image of the Lesbians, Gays, Bisexuals, Transvestites, Transsexuals and Transgender (LGBT+) community. With that, in 2015, the World Health Organization established new guidelines, introducing the term "sexual risk behavior" without any reference to the sexual orientation of the potential donor.

Still, it’s known today that screening methods have advanced and the possibility of a transfusion-related HIV infection is extremely low. However, most countries are still hesitant to review the ban of LGBT+ blood donations¹.

In the Brazilian panorama, the discussion about blood donation by MSM was taken to the courts and the public policies raised questions about the fundamental rights of these marginalized populations, in addition to emphasizing that the restrictions are based on the gender and sexual orientation of individuals, and not on behavior risk².

In 2020, the Federal Supreme Court and the Ministry of Health ended the blood donation restriction by MSM, a celebrated fact in the country and recognized worldwide. However, the most important part is seeing this measure coming out of the papers and becoming reality, an important and necessary step towards the citizenship of all. We have examples, as Ceará, the 1st state to comply with the recommendation of the Justice of MSM blood donation, in public or private blood centers.

Based on the above, the practice of many countries to ban the LGBT+ blood, and define it as a risk, causes marginalization of this community, minimizing the sense of belonging and citizenship of this population, since blood donation is an expression of solidarity³.

Therefore, the medical community has a duty to guarantee safe blood for all people who needs it, not wasting potential safe donors, culturally stigmatized by outdated policies that lacked clinical and epidemiological analyses.

So, seeing Brazil moving forward on this theme, previously excluding with LGBT+ community, is not only relevant in the national context, but encourages many countries to also review their own policies.

References:
Abortion in the context of COVID-19: how can we make it more accessible?

Anastasia Kalantarova
Poznan University of Medical Sciences | IFMSA-Poland

On March 11th, 2020, the new strain of coronavirus (COVID-19) was declared as pandemic by the World Health Organization (WHO). Reference? Dealing with COVID-19 has introduced imbalances in healthcare provision, disruption of routine essential services and required redeployment of healthcare personnel across the healthcare field. This adjustment has inevitably impacted sexual and reproductive health care and rights at individual, systemic and societal levels.

A recent joint report based on surveys carried out by the European Parliamentary Forum for Sexual & Reproductive Rights (EPF) and the International Planned Parenthood Federation European Network (IPPF EN) concluded the increase of existing barriers to abortion, especially in countries with already existing legal limitations. Currently, Italian National Health System requires hospitals to suspend the services of voluntary termination of pregnancy or counselling for family planning 1. In addition, various restrictions regarding abortions have been introduced in other countries of E.U. including Poland, Germany, Netherlands, Romania. Marie Stopes International (MSI) has estimated that up to 9.5 million women and men in 37 countries worldwide risk losing access to its contraceptive and safe abortion services in 2020 due to the pandemic.

One of the possible solutions that has been even more extensively investigated during the current pandemic is incorporation of telehealth in medication abortion procedure. There is strong evidence that use of abortifacients at home rather than at the hospital is not only safe, but is also preferred by women and does not result in increased abortion rates 2,3. However, many providers have limited ability to eliminate some of the unnecessary, but traditionally used steps in evaluating eligibility to receive medication abortion due to legislative and institutional policies. Medication abortions often require evaluation via ultrasound to estimate gestational age and exclude diagnosis of ectopic pregnancy and a blood type for determining Rh status. In fact, many leaders in family planning research and clinical guidance, such as National Abortion Federation (NAF), Society of Family Planning (SFP), and American College of Obstetricians and gynecologists (ACOG), have published guidelines that demonstrate administration of medication abortion limiting the need for beforementioned testing. For example, evaluation of gestational age can be accurately done by dating the patient’s last menstrual period and risk of ectopic pregnancy can be evaluated based on clinical history and physical exam 4,5. Due to low volume of fetal blood cells in maternal circulation and low risk of sensitization, anti-D immune globulin administration may not be necessary in early pregnancy. In fact, NAF recommends against Rh testing for all abortions less than 8 weeks of gestation.

Newly suggested guidelines for medical abortions significantly reduce the need for extensive clinic visit, while ensuring timely and easy access to abortion care especially during the current pandemic. Although more research is required to assess the success of telehealth for medical abortion, this option is a great opportunity for physicians to offer the required care, while reducing the risks of exposure.

References:
A taboo among convicts: Experience of chatting about STIs with the prison population in a Brazilian penitentiary

Angélica Dettoni Modzinski, Bruna Cristina Parlow Hefle, Leticia Yabushita Rigoti
Universidade Estadual do Oeste do Paraná - UNIOESTE, campus Francisco Beltrão, IFMSA Brazil

Every day, more than one million sexually transmitted infections (STIs) are acquired worldwide, according to WHO data. In Brazil only, an average of 39,000 new cases of AIDS is reported annually. At this juncture, recent advances in research and prevention programs do not equitably reach the entire population, including the imprisoned, who lacks access to information and means of prevention to combat STIs.

In this scenario, in order to modify the local reality, the objective was to provide information about the transmission and prevention of STIs to the convicted population of Francisco Beltrão State Penitentiary. Thus, through an interactive presentation, with simple language, the aim was to minimize taboos and prejudices, as well as clarify doubts about STIs.

The event was developed by the local SCOPH coordinator, on August 9th, 2019, supported by 9 academics who participated in the action. Including theoretical basis on infection and prevention of HIV, HPV, viral hepatitis, syphilis and gonorrhea, there was also guidance on the use of condoms to the inmates, with a serious, free of prejudice approach. Furthermore, the academics involved were duly guided, by the prison guards responsible, about basic safety guidelines of the site, thus avoiding intercurrences during the visit.

The event lasted two days and took place at the Francisco Beltrão State Penitentiary, Paraná. On the scene, the academics worked in pairs, not only explaining about contagion and prevention of STIs, but also discussing access to health services in the penitentiary and giving general knowledge lectures to the inmates. After the action, there was a time to answer questions and clarify doubts, but it was not possible to apply questionnaires to the convicts, once they do not have access to pens and couldn’t be isolated to answer individually.

Prejudice and lack of information about AIDS and other STIs create obstacles that make it even more difficult to seek health care, accentuating the importance of the action. During the event, we observed heterogeneous behavior: part of the inmates knew some STIs, but were ashamed to seek health services for treatment or prevention, while others were unaware of the gravity or the real need to use condoms. Fortunately, in our action, many inmates were comfortable in questioning the topic and, at the end, thanked for the open conversation.

The positive impact of the action was clear, not only for the high number of doubts clarified, but also for the great interest shown by the convicts. It is clear that local difficulties are similar to national ones, where minorities suffer from a lack of quality information and access to health care. In addition, it is noticeable that there is a social barrier of taboos and prejudices involving the issue of STIs, which is even bigger dealing with imprisoned population. In this action, we succeeded in minimizing this inequality, providing imprisoned population information, respect and care.

References:
Intersectionality to better understand health inequities

Mohamed Elzemety
Mansoura University | IFMSA-Egypt

Leaving no one behind - a cornerstone of the Sustainable Development Goals agenda - is a paradigm shift in solving global health challenges. Recently, a pandemic hit the world pointing out a lot of health inequities that need to be solved. While it is true that the entire globe is being affected by the virus, health risks, experiences and outcomes are not the same for everyone. That urges us to find new ways to understand the complicated nature of health inequities, especially among the most vulnerable populations around the world.

Kimberlé Crenshaw - an American law professor - was the first to familiarise the world with the term “Intersectionality” in her article “Mapping the Margins,” in 1991, describing the different contributing factors to the marginalization of people who are “both women and people of colour”. Recently, it has become an essential concept in understanding and responding to health inequities, and experts see it as a promising approach to explain the multiple power structures and manners that generate and sustain unequal health outcomes.

Intersectionality: An approach that goes beyond determinants of health such as race, ethnicity, gender, class, religion and sexuality, and explores the relationship and intercommunication between all of them. These social categories intersect in dynamic and powerful ways to privilege or disadvantage different people depending on their characteristics and circumstances.

This approach hits two important aims. First, it considers differences within population groups that are usually portrayed as relatively similar such as women, men, migrants, Indigenous peoples, and some minorities. For instance, a white woman from a lower socioeconomic group might have some issues when accessing healthcare because of her social class but she has the relative advantage of being white over a black woman. This makes us understand that each one of them did not experience these two determinants separately. Second, the inequities are usually shaped by interactions between many levels of power including families, governments, laws, and policies; structures of discrimination including but not limited to sexism and racism.

Intersectionality helps us deepen our understanding of inequities as it sees problems as complex structures and explores its different aspects; It draws attention to the drivers of inequity as it contributes to generalisable knowledge, linking social circumstances of marginalised groups to discrimination and the structural factors underpinning them; It leads to more targeted and effective interventions and policies as it supports a rights-based approach to healthcare and can get an accurate insight about who is being affected. It is not just who is being left behind but it also cares about why and how.

Intersectionality is fundamental to create and implement new practical strategies at national and global levels and its application and mainstreaming in global health policies and programs requires more attention. I hope that we can discuss this concept more in our activities as students and spread the knowledge about it. As Audre Lorde said, “There’s no such a thing as a single-issue struggle, because we don’t live single-issue lives”.

References:
5. Bauer, G. (2014). Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity. Social Science & Medicine, 110, 10-17. https://doi.org/10.1016/j.socscimed.2014.03.022
Domestic violence through the eyes of high school students: an experience report

Beatriz Camargo Gazzi, Laura Mestriner Tavares de Carvalho, Yuri Brandão de Oliveira, Giovanna Coutinho Bettoni
Universidade de Taubaté | IFMSA Brazil

Introduction
According to the World Health Organization (WHO), intrafamily violence is characterized as any type of action that affects the well-being, physical, psychological, freedom of family member\textsuperscript{1,2}. This scenario entails high costs of health services, as violent young people tend to suffer from committing infractions, abuse substances and neglected sexual health\textsuperscript{1–4}. Thus, the need to break the cycle of domestic violence is evident, in addition to guiding our youth about forms of reporting\textsuperscript{2}. Therefore, the local committee of IFMSA Brazil FMT, on November 14, 2019, ran a campaign for teenagers that aims to fill the lack of actions about this theme in high school.

Experience report
The event consists of a play about domestic violence, approaching its physical, psychological, moral, gender and patrimonial aspects\textsuperscript{2}. Subsequently, a questionnaire was applied, so the students could identify each violence, and answer if they knew how to report it, followed by a debate. We ended the campaign highlighting the National Law Rights dial. The play portrayed everyday scenes, such as: harassment, property violence, physical, moral and psychological violation between mother and children and between coworkers. Then, the questionnaire was applied. Subsequently, the area was divided: the side "violence" and «not violence». Each scene was debated between the members of the committee and the students, stimulating them to take a position on one side, with the change of opinion at any time. In the end, it was reiterated that all acts were violence, surprising those who maintained the «not violence» side, highlighting the difficulty of identifying these situations.

After collecting the questionnaire data, the following results were recorded:

**Forms of violence**
- Physical
- Physical and Moral
- Moral / Psychological
- None
- Patrimonial and Physical
- Patrimonial / Moral
- Patrimonial / economical
- All

**Know how to report**
- Yes 20%
- No 80%

Fig. 1: High school students watching theater.
Fig. 2: Dynamics of discussion about violence.
Fig. 3: Illustrate the forms of violence identified by the teenagers.
Fig. 4: Illustrate if the teenagers know how to report violence.
In the first graph, all types of violence are clearly identified. However, the debate held afterwards did not reflect the same, as many students had doubts about where to stand and were easily influenced by academics.

In the second graph, the majority (80%) of the students knew how to report domestic violence on disc 100. However, it is more frightening that many students (47%) still do not know how to identify all kinds of violations and 5% do not know how to identify any.

Furthermore, during the event, we noticed embarrassment between the students. This may evidence the lack of approaches about violence, which reinforce the need of more actions like this.

**Conclusion**

This action was taken to educate high school students about various forms of domestic violence, seeking to train them to recognize and report it. This objective was achieved since students thought about the play and participated in the debate. Yet, the event shows us that the variants of violence are deeply rooted in social practices, as some of the representations were noticed as normal by the students, highlighting the need of more frequent approaches on this theme as it remains controversial.2-4

**References:**

The Vulnerability of Amazonian Indigenous Communities in front of the COVID-19 Pandemic: An Integrative Review

Bárbara Fernandes de Meneses Brito¹, Andrea Carla Soares Vieira Souza¹, Anne Barbosa Gonçalves Mesquita¹, Danielle Sotero Fortes Carvalho¹, Lucas Palha Dias Parente¹, Diego Sousa Campelo²
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².Uninovafapi University Center

The impact of Covid-19's on the indigenous population can reach dimensions that are difficult to monitor and control, due to social vulnerability and medical care limitations, directly impacting on the transmissibility of the disease.¹ The protection that isolation provides is a positive factor considering that the virus would not affect distant communities; however, once they are achieved, the result is catastrophic.² Thus, it is necessary to protect native communities, preventing access by invaders.

With that, the challenges in serving the indigenous Amazonian population in the Covid-19 pandemic were discussed. A qualitative, exploratory and descriptive research was carried out, through an integrative review. Among the databases used, we can point out SciELO, PubMed and VHL with the following descriptors: “indigenous AND health” and “Covid-19”. Six materials were included, among which are articles and electronic manuals published between 2019 to 2020, written in English or Portuguese, texts not available in full, and literature reviews were excluded.

The Covid-19 epidemic carries the risk of a new genocide, in a scenario already characterized by systematic violations of rights and intense violence against indigenous people. In addition to the evidence that younger age groups may be severely affected, the increased vulnerability of the elderly to this particular disease can have severe impacts on the identity of the population, since the intergenerational transmission of culture is interrupted with the loss of these members.³ According to the survey led by Marta Azevedo, a demographer at the State University of Campinas [UNICAMP], more than 81,000 indigenous people are in a situation of critical vulnerability because of the coronavirus. In addition, there is a great difficulty in accessing items that help prevent disease, such as soap, masks and alcohol gel.⁴ The study shows the Brazilian indigenous health system with its 34 districts and highlights the 6 main ones in degree of fragility, all from the Amazon region, as described in Table 1.⁴

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Table 1: Special Indigenous Health Districts most susceptible to mortality in the event of infection by Covid-19.
Vulnerability is intensified by factors linked to lack of sanitation, households with a higher than average number of residents, greater distance between municipalities, limitations in medical assistance and logistics for transporting the sick. In addition, deforestation and illegal mining are a great challenge for health professionals who seek to avoid the contact of these communities with the virus, since these workers are the main vectors of disease spread within the Amazon. In addition to population mortality, the decrease in socioeconomic integrity can further reduce the capacity of indigenous peoples to deal with the growing fragility of public health and territorial protection policies. In the face of the unknown and with precarious health conditions, indigenous peoples are vulnerable to the infection of the new coronavirus; therefore, it is important to implement rapid measures to contain the advance of the pandemic in these communities and meet the demand for health care in the villages. In addition, it is important to have inspection bodies in the fight against invasions, otherwise there will be a risk of decimation, as has occurred in other epidemics in the past.

References:
Beyond the Pandemic: A Fight for Our Fundamentals Is a Fight to Health

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With its first COVID-19 patient being officially recorded on January 20, 2020¹, the Philippines’ cases continue to rise despite its government’s response and implementation of months-long region-wide lockdowns. Compared to its neighboring countries, the Philippines has not been successful in flattening its curve nor is it close to even doing so². Aside from the distress due to this current public health crisis, other concerns continue to emerge over the recent controversial government actions that pose threats to its citizens’ human rights, such as the right to information, freedom of speech and expression, and to dissent.

Roughly two months into the quarantine, the government decided to shut down the country’s largest broadcasting media network³. Being an archipelagic country, where the internet does not reach the far-flung islands and mountains, cable and satellite media play a vital role in health information dissemination amidst the pandemic. While the issue explicitly shows a threat to press freedom and right to information, in hindsight, it aggravates the social exclusion and health inequality experienced by many Filipinos. In response to this, numerous student organizations expressed disagreement with the decision through statements and social media movements. Asian Medical Students’ Association-Philippines (AMSA-Philippines) was no exception, acting through an official statement addressing the threat to press freedom, and reminding the medical community about its relevance to the social determinants of health.

As the government continues to fight the pandemic, it also equally tries to address the criticisms that come along with it. Hence, the sudden urgency to pass the controversial Anti-Terrorism Bill - a bill that vaguely categorizes terrorists and puts the risk of arrest under the authority of law enforcers known to have history of abuse and selective justice - puts a
questionable line between dissent and terrorism⁴. This elicited another stirring of action from the youth, with rounds of awareness campaigns and protests online. Amongst these, AMSA-Philippines also published an official statement emphasizing the importance of our voice as citizens. The timeliness of these movements cannot be any more relevant, with a peaceful protest (practicing strict social distancing) done during the Philippine's Independence Day⁵, and incidentally with the global movement being done for Black Lives Matter.

Indeed, these threats magnify the multisectoral nature of health. As the World Health Organization defines it, the social determinants of health are roots for health inequities which are reflected in the intersectionality of the said present issues⁶. The pandemic reminds us that health is a right. If such fundamental rights are being trampled on, how can we even be assured that the right to health will be upheld?

With this question in mind, we, the youth, are called to educate ourselves on these rights and fight against indifference and repression. The Philippine's national hero, a young doctor who fought inequality through his writing, Dr. Jose Rizal famously taught us: “The youth is the hope of our nation's future.” Like him, may we embody the spirit of a physician healing not only the ailments of the human body, but also the society.

Fig. 2. Protestors practicing physical distancing during a rally on June 12, 2020. (Photo by Cathrine Gonzales/INQUIRER.net)

Fig. 3. Publication Material for the AMSA-Philippines Statement on Anti-Terrorism Bill

References:
Human beings are beings capable of surviving and natural selection has been a clear example of the constant struggle in which man finds himself in order to adapt to each situation. On December 31st, 2019, a health commission of Wuhan, Hubei Province reported to the World Health Organization (WHO) a cluster of cases of pneumonia caused by a novel coronavirus\(^1\). At that time the world did not know what it awaited, a new year was beginning and with it - new goals and purposes, for both the individuals and entire communities.

January 20th, 2020 was the date when the world began to glimpse what was to come as the WHO declared a global public-health emergency when COVID-19 cases began to be reported outside of China and more than 800 deaths were already attributable to this disease. Until that moment, people started realizing what was yet to come and feelings like fear, uncertainty, expectation, insecurity and to some extent a perspective of surrealism invades us.

Our plans were suddenly totally changed. We were anxious of our own health, hoping we were not going to get ill at any time or concerned of the wellbeing of our beloved ones. News and social media informing us about the situation around the world are not reassuring. Sudden worsening of our own reality, uncertainty of what would happen next, quarantine or some sort of isolation... mixed feelings that could lead to anxiety and depression, delirium and substance abuse.\(^2\)

But we human beings have a great capacity for resilience. History has shown that long-term resilience is the most common outcome after adversity. And resilience doesn’t mean you have to be happy or well all the time, but it gives you the capacity to move forward despite adversity. For sure you will have some bad days, we all have those, but resilience makes you capable of moving forward even when you’re at your lowest.\(^3\)

As you can find in science, history or biology books we all have been prepared to develop resilience as we have a long heritage in our species of individual and collective adaptation and evolution, and that has given us an enormous potential for resilience. However, we all must nourish this competence, in the sense that resilience is a combination of the capacity that people have as part of their history, but also what they learn through life experiences.

There’s no doubt that we are social beings, therefore resilience is strongest with social support. Communities can work together to cultivate resilience by building a sense of purpose to survive the crisis. Simple acts of support, tolerance and kindness can strongly fight against negative effects of this situation. We hear a lot about herd immunity against COVID-19, but what if we build a herd immunity to foster resilience and protect one another?\(^2\)
Burnout Syndrome in the face of the COVID-19 Pandemic

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INTRODUCTION
In recent years, viral epidemics have gained relevance globally - such as the Severe Acute Respiratory Syndrome (SARS) and the Middle East Respiratory Syndrome (MERS) - and harmed the mental sphere of health professionals. These individuals experienced severe emotional and psychiatric problems during and after SARS, in 2003, and suffered from stress and dysphoria throughout the MERS epidemic. Similarly, the COVID-19 pandemic promoted high levels of stress for the health professionals, providing conditions that may be linked to Burnout Syndrome (BS), which is a work-related syndrome that involves emotional exhaustion, depersonalization, and a reduced sense of self-accomplishment - great examples are sleep deprivation, feeling of insufficient time, excessive hours of work, and low autonomy, in addition to anxiety and depression.

OBJECTIVE
Analyze the existing literature that relates the COVID-19 pandemic to the mental health of health professionals, with an emphasis on BS.

METHODS
We conducted a literature review of Pubmed, Google Scholar, and Scielo databases without restrictions on location or writing language. The keywords “Burnout Syndrome”, “Covid-19”, and “Mental health” were used. Articles that did not directly mention BS, but its symptoms and characteristics, were also considered.
RESULTS AND DISCUSSION

The search resulted in the collection of nine scientific articles. The factors that induce the appearance of BS in the studied population are recurrent in the studies analyzed. Two articles demonstrate the reality observed in China regarding the psychological effects, and two other articles delve deeper into the relationship between health professionals with work overload and the emergence of BS. The highest prevalence of cases of BS was in nurses, women, and professionals with advanced age, which was intensified by the fear of self-contamination and transmission to relatives. It was also observed that the expectations created by society about the work of professionals, accompanied by uncertainties about the proper management of COVID-19, cause insecurity in them and increase their chance of developing BS.

Some professionals have a lower predisposition due to certain protective factors, such as family support, favorable work environment and team, breaks during long work shifts, and belief in recommended preventive measures. Some hospitals have already adopted measures to reduce the number of BS cases, offering continuous and quality psychological monitoring, and creating spaces for rest and meals for professionals. We had limitations in the database because it is a recent phenomenon and few articles were published in full.

CONCLUSION

There is a close relationship between the progress of the COVID-19 pandemic and the damage to the mental health of health professionals. The increase in sleep deprivation, fear of exposure, anxiety, and depression during the current stage of the pandemic favors the augmentation in BS levels. However, detailing the impacts of the COVID-19 pandemic on mental health will take months or years to become wholly evident and requires more specific studies, including a more significant number of professionals and countries.
The Impact of COVID-19 upon Climate Change and Health

Carragh Rabbitte
University of Glasgow | Students for Global Health UK (Glasgow)

Impacts of climate change on COVID-19 response

Currently there are no direct associations between climate and COVID-19 transmission.\(^1\) However, climate change indirectly impacts upon the global pandemic response through exploiting environmental health determinants.\(^1\) A false economy exists by ignoring environmental topics, emergency provisions, health systems, and social safety nets; this should be addressed to prevent further global crises.\(^2\)

Climate change creates challenges for health systems.\(^1\) It impacts availability of safe drinking water, food manufacturing, sanitation, and healthcare.\(^1\) These are paramount to reducing COVID-19 transmission.\(^1\) Climate change causes warmer/drier weather and increases heatwave incidences.\(^1\) Consequences of heatwaves, e.g. heat exhaustion/stroke, cardiopulmonary disease exacerbations, can place a strain on healthcare systems, thus increasing heat-related burden of COVID-19.\(^3\) Climate change may propagate infectious disease emergence from animals, with evidence suggesting that this occurred in COVID-19.\(^1,2\)

Effects of COVID-19 on climate change

Measures to decrease COVID-19 transmission have temporarily reduced air pollution due to declining economic productivity.\(^1,4\) The approximate decrease in daily carbon dioxide (CO\(_2\)) emissions was -17% at its lowest, while the annual decrease is estimated to be -4.2 to -7.5% (similar to decreases required to prevent a 1.5°C temperature warming), outlined in Fig. 1.\(^4\) However, this has limited impacts upon overall concentrations of CO\(_2\) and greenhouse gases, as these substances remain in the environment for long periods and reductions may be reversed by returning economic activities creating pollution.\(^1\)

![Figure 1: global CO\(_2\) emissions from 1970-2020, available from (4)](image-url)
Learning points from the COVID-19 response applicable to climate change and health responses

Parallels have been drawn between COVID-19 and climate change responses as they are both huge public health threats.1 There are many unknowns in climate change, e.g. tipping points, global action levels, highlighting the importance of adaptable and durable policies.5 Key lessons emphasised by the COVID-19 response are applicable to the global climate change response.1,5 Reduction in health inequalities is imperative for universal health care; public health crises drive existing inequalities, having the largest impact upon the most vulnerable individuals.1 Global health security prepares for potential health hazards and scientific expert advice is increasingly being considered.1,5 Therefore, studying environmental health determinants is imperative in improving population’s health.1

Prompt responses to global health threats (e.g. finding resources, investing money, establishing safety nets) reduces negative consequences for biological and socioeconomic health.1,2,5,6 This pandemic illustrates that dramatic behavioural changes are possible when health is at risk and evidence-based, transparent policies are supported.1,2,5,6

The Global Commission on Adaptation outlines that investing $1.3 trillion in 2020-30 could create a maximum $7.1 trillion net benefit due to reduced losses, new industries, and socioeconomic improvements.6 Climate change should also be treated as a global health priority with rapid action points to prevent widening of existing inequalities and meet the 1.5°C global warming target.6

This is an opportunity to advance the climate change agenda through the socioeconomic recovery from COVID-19 leading to a sustainable global future, e.g. investment in reduced carbon energy sources.7 The current decline in industry and consequent fossil fuel consumption can support the transition towards cleaner energy alternatives.7

References:
Every 31st of May, World No Tobacco Day is celebrated all over the world as a reminder of tobacco usage's negative impacts on people’s health, which vary from respiratory diseases to many types of cancer. Tobacco use is still one of the biggest public health problems in the world, causing up to 7 million deaths due to direct tobacco use and 1.2 million caused by exposure to secondhand smoke. The number of tobacco active smokers continued to increase in the past few years, especially in developing countries, including Indonesia. Approximately 39.5% of Indonesians are active smokers and the number is growing every day. Moreover, with the emerging COVID-19 pandemic, smoking is one of the factors that can aggravate the impacts of the disease.

As both medical students and youth, we are obligated to address this issue as a critical priority. We, CIMSA Indonesia, as one of the biggest medical student organizations in Indonesia, feel that it’s important to take action to tackle this issue. We would like to raise public awareness regarding the harm caused by smoking and stop people from normalizing smoking, especially during the COVID-19 pandemic. To amplify our impact, we collaborated with other IFMSA members of Asia Pacific; FMS-Taiwan and IFMSA-Japan through World No Tobacco Day 2020 Joint Campaign - Fight and Save: Fight Smoking and Save the Future Generation.

In this campaign, we emphasized the importance of youth participation towards this issue and the urgency for our respective governments to create more strict tobacco use regulations. Not only that, but we also tried to present the efforts and approaches that had been done by the World Health Organization (WHO) in tackling this issue. There were three kinds of activities carried out in this joint campaign. First, we issued some infographics that displayed the data and facts about the tobacco usage conditions and regulations that have been applied in each country. Second, we conducted a webinar with WHO Indonesia regarding tobacco control and the efforts that have been made to educate people more about tobacco and its harmful impacts. Lastly, we made a video as a promise that as youths, we promise to stay away from any tobacco product, spread accurate information to raise public awareness about smoking and its danger, and always try our best to encourage people to quit smoking to make a healthier world.

As the generation that will carry the consequences from the decisions that are made today, we have a huge role in shaping the future. The small steps that we take today will have an enormous impact tomorrow. Act now to ensure a healthier world. Let’s fight smoking and save the future generation!
...who will teach in the future, if nobody protects the wise?"
Some say the only thing certain is death
Tonight I thought about it
We all know it is true
But none of us is prepared to accept the departure of those we care for.

In this crazy time of furore and ecstasy
I have learnt to fear old time words
The plague doctors do not seem to be far from home
The beak was replaced by particles filtering masks
But the warm heart and solid feelings of ethics and social responsibility were not.

Tonight I fear for my teachers
I fear for my country
Healthcare workers are dying around the world
And I can only think about those who have taught me
Those that have guided my hands,
cultured my words,
and even corrected my posture.

I now can only say:
who will teach in the future,
if nobody protects the wise?

Who will?

David Fabian Ramirez Moreno
Universidad pedagógica y Tecnológica de Colombia | Ascemcol-Columbia
Community

John Eroll Yabut
Ateneo de Manila University School of Medicine & Public Health
Philippines | AMSA Philippines

Community is a Friday, 6AM aboard the light rail transit. It is getting off Recto, and walking through the variegated lives and livelihoods thriving in the overpass. It is getting on Doroteo Jose, and singing “Bang Bang” by Nicki, Jesse & Ari to your classmate, as you pass Bambang to alight in Tayuman. It is racing each other while speed-walking to the jeep going to Pritil, and being tempted to buy Jollibee from the corner. It is falling asleep on your second jeep ride, en route to Velasquez, your classmate waking you up at your stop.

Community is a good morning! to the guard and overall attendant. To the health volunteers you thought were the cutest ahjummas. To the nurses who are fearless and gentle in their leadership. To the coolest nuns you’ve come to know (the only nuns you know, to be fair). It is a good morning! to the patients, old and new. Hoping to feel better, hoping to better their lives. Hoping to go back to school, back to work, back to their families. It is a good morning indeed. To your weary and disillusioned self; the promise of refreshment to your parched spirit.
Community is your station at the OPD, taking blood pressure. It is explaining in the simplest of terms things you recently learned yourself. Remarking that it takes work—mindfulness, empathy—to communicate well. It is remembering that in high school algebra you found it tricky to express yourself in the simplest terms. It is understanding that the ordinary words are the most useful ones: the ones that change behavior, the ones that change minds. It is finding joy in the moment of clarity that flashes across your patient’s face—a first step.

Community is a side trip one of the cool nuns will suddenly take you to. Let’s go to the pre-school. Or to a community bible reading. Or to the house of a patient who did not show up this morning. It is walking through the streets of Tondo you only know from TV. All senses hyperaware, taking in the sights and smells. It is a procession of growing anxiety, asking if it is safe to cross this highway. It is being shocked by the state of things around you. It is asking how did we let all this disparity come to be?

References:
1. Train stations in one of Manila’s railway systems
2. Areas in the city of Manila
3. Outpatient Department
Community is the conversation with the mothers who repack garlic to make ends meet. It is the many stories they tell—about their house burning down earlier this week. About the drug problem. The police problem. About their children recovering, graduating—from treatment and from school. It is realizing how distanced you are from the people whose living conditions you like to talk about. You have fancied yourself an activist against a fascist regime, and a broken capitalist system. But you find that there is so much more listening and understanding and working to do; There is still so much work to be done in the community.

Community is a Friday, 4PM aboard the light rail transit. You walk the same sidewalks, ride the opposite jeeps. You think about what you are doing. What you are thinking. Am I intruding? Am I judging? Am I simply coursing through like a passing ship? Am I making things better? For whom? You like to think you are working on the community, but perhaps it is the community that is working on you. Community is your heart sighing, your spirit quenched, your mind re-minded—that the world is so much bigger than the school and the hospital. And you are every inch part of that world.
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