MSI 44
Post-Pandemic Recovery & Resilient Health Systems

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

IFMSA is recognized as a non-governmental organization within the United Nations’ system and the World Health Organization and works in collaboration with the World Medical Association.
Serene Majesty: A Glimpse into Nature's Splendor - Gabeen Jabba Swat

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3 years, 7 months, and 26 days ago*, COVID-19 has been declared a Public Health Emergency of International Concern. For many definitely did not feel like it, when the only evidence was on the screens. The screens of our phones, the screens of our TV, the screens of our computers. We had sympathy for what was going on in China, but China was so far away. We were sure it would take forever before it reached us, our hospitals, our families. We believed our governments making public announcements that there was nothing to fear, we were prepared.

Were we?

In May this year, after over three years, WHO announced that COVID-19 no longer constitutes a Public Health Emergency of International Concern. Our lives have mostly come back to normal. The past few years have been a blur. We already know that our preparations and response have not been sufficient and that our health systems have been stretched beyond their limits. We’ve witnessed innovation in real-time, from vaccine development at record speed to the use of telemedicine to bridge gaps in care. But have we learned anything from this pandemic to prepare better for the next crisis? As medical students and young healthcare professionals, we are in a unique position to find these lessons.

During preparations for this Medical Students’ International, I took many lessons for myself. From passionate students and their stories, through interviews with inspiring partners and Alumni. I’ve learned that every step of preparedness for any crisis is essential, and as a youth, we have an important role in it. But as young people, we are also painfully aware of the impact the pandemic has already left. Disruption in medical education and online learning, and deployment to COVID-19 patients without proper preparations have had a toll on our mental health. Exacerbated health inequities, particularly impacting young people and vulnerable communities, are a stark reminder of the urgent need to prioritize equity in healthcare access and delivery. Misinformation and distrust spreading with the speed of light on social media platforms showed us how important trust in science and reliable information sources are for health and well-being.

From every perspective, the pandemic has been a wake-up call. We know that the question is not whether the next crisis will come, the question is when. The next crisis may be different, it may hit harder, and it may forever change our systems and our planet. As young health professionals, we will be living those futures at the forefront of health responses. COVID-19 has challenged us, changed us, and shown our vulnerabilities. But it has also revealed our strengths, our capacity for innovation, and our resilience in the face of adversity. It is up to us to learn from this crisis and actively implement the findings in shaping the post-pandemic reality.

The wake-up call has sounded. How are we going to respond?

Editor-In-Chief
Olga Wdowiczak

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Up Next

**Theme Articles**
*Post-Pandemic Recovery & Resilient Health Systems*
Building Back Better: Youth as the Foundation of a Resilient Health System

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As we inch closer to the 2030 deadline for our Sustainable Development Goals (SDGs) this year, the Special Edition of the Secretary General’s Report towards SDG Progress aims to remind us that the world is far behind its declared commitments, with only 12% of the set SDG targets being on track. Alarmingly, almost all SDG 3 targets are in need of acceleration with almost none on track, the pandemic having significantly reversed the progress made in achieving these targets. In a post pandemic era, only a robust health system with an efficient and able workforce can help shoulder this huge responsibility and fill the lacunas that COVID-19 has exposed.

Looking at recent trends of expansion of the health workforce and increasing absorption rates of graduates into the health system it is safe to assume that the better part of this burden will be borne by young medical graduates and young health professionals. Medical students and young health professionals are the critical conduits of World Health Organisation’s (WHO) health system building blocks framework- whether it be service delivery, health workforce or the spread of information. With growing amount of data around the age distribution of doctors against the preference for technologies, young medical professionals become critical points for the dissemination of information via telemedicine, social media and other platforms. This level of ‘digital literacy’ is beneficial when it comes to combating phenomena such as an infodemic; when misinformation spreads like wildfire, it is the swiftest and the most educated response that saves the most amount of lives. Being comfortable with technology can also lead to various collaborations across sectors- whether it be information technology and the creation of new and accessible digital health platforms or the use of Artificial Intelligence powered surgical techniques and tools.

But the role of youth is not limited to being service providers for the health system. A disproportionate part of those affected by the pandemic directly were adolescents and young people. Some research studies have refuted earlier claims that COVID-19 affects older adults at a greater rate than adolescents, with a significantly greater prevalence found amongst the adolescent population. According to a UNICEF Rapid Assessment Report for Latin American and Caribbean youth, COVID-19 impacted the mental health of adolescents and children greatly, with as many as 27% of the respondents reportedly feeling anxiety and 15% reportedly feeling depression. Adolescent health and access to services continue to be ignored within the healthcare community, and serves as a major hindrance in the attainment of Universal Health Coverage (Target 3.8). This further cements the role and importance of including younger voices in the discourse around resilient health systems and to increase their representation as individuals affected the most by the pandemic.

Beyond the discussion of why young people must be a part of the conversation around recovery and resilience, we must explore the role of youth in policy and as policymakers. According to WHO’s “Policy Recommendations on Building Resilient Health Systems Based on Primary Health Care”, youth clearly fall under vulnerable populations disproportionately
affected by the pandemic and youth-led organizations fall under the roster of whole-of-society engagement. The United Nations Youth 2030 Strategy aims to address both these aspects, creating youth-centered policy and youth policymakers simultaneously. WHO has progressed significantly when it comes to youth engagement: starting from granting Non State Actor (NSA) status to student organizations for example, the International Federation of Medical Students’ Associations (IFMSA) and International Pharmaceutical Students’ Federation (IPSF) to creating the WHO Youth Council composed of diverse youth representatives from various backgrounds to advise the Director General on policy issues. There has been great development for Meaningful Youth Engagement (MYE). Consequently, there has also been creation of opportunities for youth within Member States with nations adopting the WHO Youth Delegate Program, offering young people a seat at the negotiating table. However, the change in seat must come with a change in heart; the fabled ‘seat at the table’ should not be restricted to being a token but rather translate into transformative action, youth centric policies and ultimately, even greater representation at these international decision making bodies.

The concept of ‘Build Back Better’ originally came from the Sendai Framework of Disaster Risk Reduction conceived around the central theme of ‘good recovery’ which translates to recovery across all sectors and all communities, with grassroot level involvement and a whole-of-society approach where everyone builds together. As we transition from the pandemic era to a post pandemic society on a recovery curve, it becomes imperative that we involve young people as active proponents of the future health system, instead of being passive bystanders. Whether we achieve SDG 3 or not is not a question for the future; that very future is being built here and now, and young people all over the world deserve to be a part of it.

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One City, Two Pandemics: How the lessons of SARS have helped Hong Kong combat Covid-19

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Hong Kong has demonstrated both strengths and shortcomings throughout the Covid-19 pandemic. In the first two years of Covid-19, Hong Kong had the distinction of having one of the lowest Covid-19 mortality rates in Asia, only to suffer the world’s worst reinfection in March of 2023. There is no doubt that Hong Kong’s recent experience from the SARS outbreak has prepared the city to tackle the Covid-19 pandemic, but as multiple waves of reinfection arose, Hong Kong struggled to tackle the emerging challenges of late-stage pandemics. Nonetheless, recognising the lessons learnt is crucial to successful contagion control in the future, especially when we live in a world where the next pandemic is a mere plane flight away.

Severe Acute Respiratory Syndrome (SARS) is a viral respiratory disease originating from Guangzhou, a municipality closely bordering Hong Kong. The first confirmed case in Hong Kong was identified in early January 2003, and the major part of the epidemic lasted eight months, resulting in 1718 infections and 253 people deaths. Epidemiological investigations were able to track down a superspreader - a single person that was responsible for 80% of Hong Kong’s infected cases. The superspreader event started on the 21st of February when a Chinese physician by the name of Dr. Liu, a member of staff at a hospital in Guangzhou, came to Hong Kong and checked into the Metropole Hotel on the ninth floor. Despite already feeling ill when he arrived in Hong Kong, the doctor only went to the hospital the next day and was hospitalised until his death two weeks later. Furthermore, the nurses and doctors who triaged Dr Liu at first did not wear protective equipment, and subsequently, five medical personnel who treated Dr Liu were infected. Furthermore, the virus from Dr Liu soon infected seven other guests on the same floor of the hotel, who then travelled to different countries around the world, inadvertently exacerbating the pandemic.

The multiple points of failure in contagion control, in this case, could not be more apparent. Firstly, there was a significant lag in government response. The government only established the specialist workgroup on infectious respiratory diseases on February 13th, 2003, one month after the first confirmed SARS case in Hong Kong. It took another forty days, on March 25th, for the government to create the steering committee that pulled together its existing resources and infection prevention measures to control the epidemic. Secondly, the SARS Expert Committee also found that the different guidelines issued by health authorities were frequently conflicting and confusing, which presented mixed messages to the general public. Thirdly, low compliance by medical personnel on meeting infection control standards proved inadequate, as later reported by the Hong Kong SARS Expert Committee, and that reinforcement of hygiene measures through additional training was recommended. There can be no doubt that prompt and effective responses would have saved many lives. And although tragic, the crucible of the SARS pandemic in 2003 taught Hong Kong many valuable lessons in pandemic response. It has enhanced our government and health authorities’ procedures for infectious disease response while also improving the general public’s responsiveness and awareness towards pandemics.

Behavioural changes in the medical profession were fundamental to combatting SARS and were similarly instrumental in helping Hong Kong maintain a relatively low Covid-19 infection rate. A cross-sectional survey of medical students during and after SARS revealed that before SARS, only 35.2% of students reported washing their hands before physical examinations, but this increased to 60.3% after the outbreak. Similarly, hand-
Enhanced hygiene practices were not only limited to medical staff but were also prevalent among the wider Hong Kong society. A good example of this was masking as it was not universally accepted during the initial phases of the SARS outbreak, with only 40% of people wearing masks when going outdoors. Nevertheless, thanks to government promotion and a mask mandate, masking rates among pedestrians in Hong Kong reached a staggering 94.8% during the Covid-19 pandemic, with 96.6% of residents believing in their usefulness in combating the community spread of Covid-19.

Furthermore, a reverberating effect of the deadly SARS outbreak has been changing the focus of medical research in Hong Kong. According to Professor Ben Cowling, a professor in Epidemiology at the University of Hong Kong, the Hong Kong government has “deliberately invested heavily in infectious disease research capacity.” This investment paid off as a microbiology research team from the University of Hong Kong was the first in Asia to isolate the Omicron variant of Covid-19, only four days after the first cases were confirmed in the World Health Organization’s list.

Learning from the lessons of SARS, Hong Kong’s health system was able to adapt to better face the future epidemiological crisis of Covid-19. For example, during SARS, the scientific advisory mechanism advising the government on pandemic policies was mainly composed of officials from Hong Kong’s Department of Health, the Hospital Authority, and other experts in the medical field. However, during Covid-19 the government started incorporating input and advice from a wider range of departments such as the Centre for Health Protection, an agency responsible for disease prevention and control that was set up in the wake of SARS, as well as four advisory groups: Disease Prevention and Control, Responses and Action, Public participation, and Public communication. The groups focusing on “Public participation” and “Public communication” are of particular interest as they signalled the Hong Kong government’s recognition that public engagement and cooperation were essential in combating the pandemic. Prominent health experts such as Professor Yuen Kwok Yung and Professor Ivan Fan Ngai Hung regularly appeared on radio talk shows, televised programmes and press conferences to give updates on the current pandemic situation and new health policies, which further improved public communication and awareness.

There is a moral obligation to ensure that we use the lessons from our past pandemics to improve our preparedness and responses towards future outbreaks. Hong Kong’s Covid-19 response demonstrated enhanced resilience due to the lessons learnt from the tragedy of SARS, a testament to the importance of preparedness and proactive response in mitigating the impact of infectious diseases. This underscores the importance of continued learning in our approach to infectious disease policy and epidemiology. The calamity of Covid-19 may be over but it is vital that we as a global community reflect on the strengths and shortcomings of our pandemic responses and apply the lessons learnt from the Covid-19 outbreak to future pandemics.
Post-Pandemic Recovery and Resilient Health Systems

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Three thousand, one hundred and fifty-five deaths and none was intentional. As the giant of Africa, this was the toughest blow I had received in the past fifty years. February 27, 2020, was the beginning of an indelible nightmare in the disguise of a cough and stubborn high fever which assailed an Italian expatriate. SARS-CoV-2 was the antagonist that began as an unexplained, pneumonia-like illness and evolved into numerous highly transmissible variants that brought life to a standstill.

Upon the detection of the index case that was imported from Italy, there was an initial perception that COVID-19 was a disease of the elite, more the political bourgeoisie. As the virus raged through the respiratory tracts of plebeians, with one of my States (Lagos) being the epicentre of the outbreak, waves of panic were sent across my people. Private clinics and state hospitals developed a frosty relationship with the suspected infected masses as no person wanted to be on the receiving end of the discrimination against those linked with the disease.

The pandemic had a significant impact on my healthcare system. In addition to the fear of stigmatization, many of those infected were discouraged from taking necessary curative actions sadly, due to limited infrastructure, insufficient resources, and existing health disparities posed challenges. Access to my healthcare was affected, vulnerable populations faced difficulties, and the overall well-being of my communities was disrupted. The endless waiting lines due to understaffing, demoralizing attitude of health workers, lack of medication and dilapidated facilities for treatment were the harsh realities my people were provided with when seeking medical help. COVID-19 exposed the rots in my healthcare system and disposed my people to the tougher side of poverty as they strived for satisfactory medical management. A 2020 survey was carried out by the National Bureau of Statistics and it disclosed that the pandemic caused five out of every ten of my poorest households (45%) to quit working, and four out of every ten (39%) of my wealthiest households to lose their jobs. On the basis of poverty, defective healthcare systems, and other entrenched diseases, many health experts projected that I would face a hard time and struggle to keep the coronavirus outbreak under control. It was true.

But, all efforts on the road to recovery made a difference. There was a remarkable display of durability in responding to the pandemic and initiating recuperation efforts. Various post-recovery measures were taken to strengthen my healthcare systems which included the expansion of the Surveillance Outbreak Response Management and Analysis System (SORMAS) platform, enabling real-time data collection and monitoring of cases of COVID-19 and other infectious diseases. Local organizations played a vital role in
supporting the post-pandemic recovery. For instance, the Dunamis International Gospel Center in Abuja and other philanthropic foundations reportedly distributed household items as palliatives and donated medical equipment worth millions in Naira to my federal administrations to cushion the economic pain caused by the crisis of the pandemic. Non-governmental organizations (NGOs) such as the Nigeria Centre for Disease Control (NCDC) played a crucial role in overseeing, coordinating and implementing response and recovery efforts. Enhancement of contact tracing activities, expansion of treatment centres, investment in telemedicine and surge capacity planning were a few of many measures taken by the NCDC.

The efforts of the government coupled with other local organizations during the pandemic served as an eye-opener for the key elements involved in the building of a resilient health system. It was quickly realized that building a resilient health system requires global cooperation. The sharing of knowledge, practices and resources among myself and others will help safeguard the health of populations worldwide. To facilitate collaboration, international regulatory bodies such as the World Health Organization (WHO) can play a crucial role.

Experiences from not only the COVID-19 pandemic but also the 2014 Ebola outbreak impelled my people to buckle down to the consolidation of the health workforce. It has become a known fact that a resilient health system is heavily dependent on an adequately resourced healthcare workforce. To achieve the project of optimum training of health workers, the Federal Ministry of Health has collaborated with many other health agencies. On account of this alliance, a policy foundation had been laid to guide the adequate response to future challenges and foster accountability. Training programs for health workers have been scheduled to commence in recent months to establish a strong and committed health workforce that is stable even in the face of difficulty and danger. The trainings ensure that the health workforce is aware of current potential health risks to the population from biological and non-biological sources. In the next review of the National budget, sufficient funds will be allocated to the health sector for the funding of equipment that has the capacity to address a broad range of health challenges rather than a targeted few.

Looking forward, I believe addressing health disparities and promoting equitable access to healthcare is crucial for myself and for my people. Disparities exacerbate the impact of the pandemic, particularly among vulnerable populations. Strategies like targeted interventions, community engagement, and health education programs can reduce disparities by addressing social determinants of health. Prioritizing primary healthcare ensures comprehensive and accessible services, while preventive measures like vaccinations and health campaigns mitigate future outbreaks. By addressing health disparities and prioritizing equitable access, I can build a resilient healthcare system that leaves no one behind in the face of future health challenges.

I am Nigeria, and this is my pandemic story.
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AI in healthcare medical education

Letícia De Melo Barreto
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In today’s society, Artificial Intelligence (AI) has emerged as a transformative force in various services, and the field of medical education is no exception. Being in a European or Subsaarian country, AI is changing how to teach medicine. This technology has the potential to revolutionise how healthcare professionals learn, by making education more accessible, personalised, and efficient.

One potential use of AI in medical education is the development of AI-powered learning platforms. They use an algorithm to analyse various materials, such as medical articles, textbooks, research papers, and others. This can be very helpful to democratise the learning process of medical students in underdeveloped countries with educational deficits. A notable example of such a platform is Cram Fighter which employs AI algorithms to create personalised study plans for medical scholars. By analysing students’ performance, Cram Fighter identifies weak areas and recommends targeted learning resources, helping them optimise their study time and improve their understanding of complex medical concepts. Nonetheless, it must be careful with the accuracy and reliability of the information given through the AI algorithm since a few systems may not be updated to new medical discoveries or treatments and, therefore, can propagate erroneous information about some topics and lead the student to a misunderstanding of the subject. Monitoring and regular updates are essential to ensure the content remains current and evidence-based.

Another good practice to use AI in medical education is the integration of Virtual Reality (VR) and simulation technology by creating a virtual patient simulation. The use of VR can help future surgeons and clinical physicians to develop their ability sooner by immersing the students in a realistic medical scenario without the risks associated with real patients enhancing these simulations through dynamics of adapted-based situations by the AI algorithms and on the learners actions, providing instant feedback and facilitating experiential learning. The Surgical Theater is an exemplary VR and AI platform to train surgeons. The platform combines preoperative imaging data with VR technology, providing surgeons with the practice of complex procedures in a virtual environment, improving their surgical skills, and reducing potential risks during actual surgeries. Beforehand, it needs to acknowledge the importance of doctor-patient relationships, and trusting blindly only in AI simulations and forgetting about the importance of the bond is very dangerous to the success of the surgical or clinical procedure.

Therefore, Artificial Intelligence can be a very useful tool in medical education and help democratise the study in many countries worldwide, making medicine a more equal practice. However, as we integrate AI into medical education, it needs more careful thoughts on how to use it in an educational way that takes responsibility related to accuracy, ethics, and privacy. Doing so can create a future where medical education is more accessible, personalised, and effective for healthcare professionals and help others with more acknowledgement.

References:
The Importance of Nutrition in Mental Health

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Literature suggests the significant relationship between nutrition and mental health recovery. People with mental health problems are more likely to engage in poor dietary practices as compared to the general population.\(^1\)

Paleontological evidence demonstrates the direct relationship between access to food and brain size and suggests even minor differences in diet can have large effects on survival and reproductive success.\(^2\) Larger brain size in humans is directly associated with the development of various skills including cooking, accessing food, energy savings, and upright walking and running; coordination of these skills with cognitive strategies enables successful feeding.

Numerous studies have reported significant brain region alterations in major depressive disorder patients, such as in the frontal lobe, hippocampus, temporal lobe, thalamus, striatum, and amygdala. Although these results are inconsistent and controversial because of the different demographic and clinical characteristics. Nonetheless, depressive symptoms, even at a subclinical level, are associated with a reduction in brain volume in specific frontal and temporal brain regions, particularly with advancing age.\(^3\)

Mental health services should also focus on nutritional interventions during the course of rehabilitation. An integrative approach that focuses on thorough evaluation of dietary habits, level of physical activity, environmental triggers/exposures, medications (including any use of herbal supplements), comorbidities, family history, life stressors, level of social support.

The effect of dietary consumption of omega-3 fatty acids is well studied. Docosahexaenoic acid (DHA) is the most abundant omega-3 fatty acid found in cell membranes in the brain; however, the human body can’t efficiently synthesize the DHA, so we are largely dependent on dietary DHA intake.

In the last century, the western diet became rich in saturated fatty acids, linoleic acid, and trans-fatty acids, whereas the consumption of omega-3 fatty acids has significantly decreased. Thus, elevated incidence of major depression has been reported in countries such as the United States and Germany.\(^5\) The consumption of a diet full of essential nutrients is critical for the proper functioning of the central nervous system. Practical implementation of nutritional interventions, for example, recommending the use of specific dietary supplements, such as a multivitamin-mineral high in B-vitamins (especially Vitamin B12), folate supplements, and omega-3 fatty acid would benefit a significant number of patients. B12 and folate.
combined use to enhance the production of serotonin and dopamine.

Special focus should be given to counselling patients about the relationship between food and mood regardless of the underlying cause of the anxiety/mood disorder. In counselling general discussion about the dietary factors and eating habits on cell metabolism and mechanisms that maintain mental function should be carried out as a daily living, such as food intake or exercise, has had a crucial role in shaping cognitive capacity, functioning while aging. Clinicians should recommend a well-balanced diet; low in processed, refined foods and rich in fruits, vegetables, whole grains, and seafood (if not vegetarian), a low-glycaemic food, or a Mediterranean diet for optimization of mental health.

Moreover, a complete physical exam including appropriate laboratory and radiological studies is crucial to rule out the underlying causes of depression or anxiety/mood disorder. Previous studies have noted that clinicians mostly rely on patients' accounts or self-diagnosis of depression, anxiety, or substance use and quickly diagnose it to be a disorder, without evaluating specific criteria. Other times due to limiting diagnostic information, judgment biases while dealing with ethnic minorities, limited time constraints during appointments where some clinicians don’t establish rapport with patients; the differential discussion of symptom areas can easily be neglected which may lead to an increase in the likelihood of diagnostic bias. However, through true professionalism, placing appropriate safeguards, and applying a counterbalancing mechanism in psychiatry one can rectify the effects of the biases. These measures could reduce the incidences of misdiagnosis and improve mental health service delivery.

Many studies done in the field of mental health and nutrition focus on the association, and they do not prove causation. Therefore, further research is needed that focuses only on the nutrition aspect and utilizes specific outcome measures during nutrition intervention without other factors such as physical activity.

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Indonesia is a country with various ethnicities, languages and cultures within it. Javanese culture is characterized by its unity of language and culture. Youth as the next generation of the nation have a central role in preserving culture, especially Javanese language and literature.

Knowing that more than 40% of medical students at Sebelas Maret University, especially the first and second-year students are not someone from the Javanese area, means they do not understand the Javanese language and culture. Of course, this is one of the obstacles in academic activities and supporting skills as a doctor in the future.

As a standing committee that has one of the focuses in the field of improving the intelligence and skills of medical students to support the doctor’s profession, SCOME CIMSA FK UNS wants to make a real contribution to fellow students. Many medical students, especially in Central Java, are not fluent in Javanese and do not know Javanese culture well. Therefore, the ANOMAN activity was created which contains Javanese language training which is the majority of regional languages spoken in Central Java and its surroundings. ANOMAN focuses on improving participants’ ability to speak Javanese, in addition to increasing their knowledge of existing culture. ANOMAN is the first activity that raises the theme of Javanese language and culture for medical students in Indonesia.
The series of activities included Javanese language training followed by lectures on Javanese culture and focus group discussions. On the next day, anamnesa was conducted to the general public in Surakarta (one of the cities in Central Java). Participants were also able to interact with the community directly and conduct health checks (blood pressure). On the last day, the final photography and videography competitions were held. The competition was attended by various universities and high schools from 3 provinces in Indonesia. The ANOMAN event was closed with a cultural session that included a ‘gambyong pareanom’ dance performance and a ‘keroncong’ song performance. Participated by more than 30 trainees, dozens of competition participants and more than 40 communities (health checks) made ANOMAN an activity that had a positive impact on participants and the surrounding environment.

The participants felt happy and helped, especially in using Javanese daily or when they become doctors and examine patients. Language is the best communication tool, and Culture is one of those things that is timeless.
Capturing the Spirit: Kwai Chai Hong’s Post-Pandemic Revival
Law Shen Hong
MAHSA University | SMMAMS Malaysia
Exchanges Week 2023: Unlocking the Exchange Enchantment!

Anika Tabassum Totini
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With the final curtain call and the memories still fresh in our minds, we invite you to journey with us through the vibrant pages of this magazine as we unveil the captivating story of “Exchanges Week 2023” by Bangladesh Medical Students’ Society (BMSS-Bangladesh).

As the name suggests, it was a whole week all about Exchanges. The “Exchangeopedia” put our knowledge and attentiveness to the ultimate test. This exhilarating challenge was centred around the comprehensive sessions, where we delved deep into the intricacies of exchanges. There was no room for slumber during these informative sessions, as exciting prizes awaited the quick-witted and attentive participants. “Merch and Ventory”, the enchanting opportunity to witness our own designs on Exchange Merchandise was nothing short of extraordinary. It was a chance to unleash our imaginations without any bounds. We were encouraged to push the limits of creativity, to let our ideas soar and bring them to life. The “Open Space Discussion” provided a much-needed sanctuary for us to dispel the misconceptions surrounding exchanges. It served as an invaluable opportunity to engage with the Exchanges National Team in a free and open environment, where we could freely express our concerns and seek clarification. The “X-Workshop”, a blend of virtual and physical sessions, served as a catalyst for participants to dive deeper into the world of exchanges. Each workshop sparked curiosity and provided a new concept, igniting a flame of exploration. Guided by expert facilitators, these workshops acted as invaluable guidelines, simplifying the complexities of terms and abbreviations related to exchanges.

And finally, the moment we had all been eagerly awaiting arrived—the grand finale of Exchanges Week! Picture this: a grand hall adorned with vibrant banners and twinkling lights, as if it were a portal to a world of knowledge and exploration. And there, right before our eyes, were stalls filled with an array of mesmerising merchandise. But there was a delightful twist to our “Exchange Fairs Demo”—instead of showcasing different countries as in the international event, various Local Committees took centre stage, infusing the fair with a unique national flavour. However, we were grateful to the Embassies of Pakistan, India, and Nepal, whose generous contributions allowed us to create stalls that beautifully represented their respective cultures. It was a fusion of local and international elements, an exquisite blend that added an extra touch of magic to our event.

The success of the event was about the camaraderie we built, the connections we forged, and the knowledge we absorbed. Exchangeopedia unveiled the secrets of exchanges, while MerchandVentory ignited our creativity and competitive spirit. Exchange Fairs Demo aka The LC Exchange Fair transported us to a vibrant tapestry of cultures, while Open Space Discussion sparked thought-provoking conversations. And how could we possibly forget the exhilarating X-Workshop, where the stage was set for captivating sessions on dynamic topics to unfold? This event marked the inspiring start of a collaborative endeavour to shape the landscape of exchanges, sparking a transformative journey ahead.
Hosting a professional exchange can be an exhilarating experience filled with valuable lessons. I had the opportunity to host a student from EMSA-Ethiopia in August 2022. As a member of my National Team and inadvertently my local committee, I got to experience and participate in the planning and execution of a successful professional exchange. From transportation to accommodation, feeding, securing a tutor and organising social activities, the feeling was entirely surreal. Throughout this journey, I learned several important lessons that I would like to share.

One crucial aspect of hosting an exchange program is to start planning early. Just like Batman needs adequate preparation to become invincible, beginning the preparation process well in advance helps reveal and straighten out kinks in any plan. It also minimises the stress associated with hosting an exchange student. By allowing sufficient time for preparation, you can ensure a smoother experience for both you and the exchange student.

Another valuable lesson I learned is the importance of assigning individual duties. It is not enough to know what needs to be done; it is crucial to have dedicated individuals responsible for each task. By dividing the workload among members of the local committee and creating a timeline for feedback, you can ensure that every aspect of the hosting plan is properly covered. Remember, teamwork is the key to success, and by working together, you can create a seamless experience for the exchange student.

Developing a communication strategy is also essential when hosting an exchange student. It is important to establish effective lines of communication between the exchange student and their designated contact person. By creating a communication strategy, any issues that arise during the exchange period can be easily tackled. This proactive approach helps ensure a positive and productive experience for both the host and the exchange student.

While it is important to focus on the logistics and organisation of the exchange program, it is equally important to have fun. Personally, I was so engrossed in ensuring that everything went smoothly that I forgot to enjoy myself. The exchange period provides a unique opportunity to network, forge bonds, and build lasting friendships that can extend throughout your medical career. So try to have the most fun and create unforgettable memories.

I hope that the lessons I learned from my own experience will assist you in preparing to host an exchange student in your local committee. Embrace this opportunity, learn from it, and cherish the lifelong connections you will make.
Preparing Professionals of The Global New Era: Medicine in Social Media on Bioethics Point of View

Is mass health education a blessing or another hindrance?

Mutia Ammara Widodo & Nadira Adriana Devi
Universitas Padjadjaran | CIMSA-Indonesia

“Moral conduct in the clinical practice demonstrated through attitudes and behaviors is a transcendental element in medical education.”

Information transfer and communication have advanced to unlimited ways in this era of transformation. “Social media” has been evolving into a tool to communicate with a huge number of audiences with an estimated 4.8 billion equating to 59.9% global population that are active social media users per April 2023. This phenomenon facilitates healthcare professionals through many social media types with its features, providing platforms to share information and build networking to peoples and other healthcare professionals across the globe. There are types of information in different forms delivered to the community as a potentially effective mass health education. Photos, Infographics, Videos, Animation or even case studies healthcare professionals once solve in real life, there really are no limitations of information being shared worldwide and sometimes not everyone is happy with it. So with this phenomenon also comes a question: Is mass health education a blessing or another hindrance?

The pro(s) and con(s) of social media usage to share medical information often being the topic of a heated debate in Indonesia since there are no specific verses of the law regulating this issue yet. Creating a big issue to be solved in terms of bioethics. Even though regulation for these issues isn’t available yet, there are a long list of articles and verses of the law regulating matters related and or sensitive to some aspects of the phenomenon like Electronics Information and Transaction and Medicine Practice. But none is regulating the constitution of medical professionals sharing educational content through social media. This condition makes both patients and healthcare professionals uncomfortable. Patients experiencing a loss of confidence in healthcare professionals and healthcare professionals on the other hand are prone to multiple violations of the law.

World Bioethics Day that takes place on 19th October annually is a celebration that reminds us to stick to ethics principles as future physicians. As we live in a rapidly-changing and interconnected world, modernization pushes the field of bioethics
to develop and fill the needs for interpreting and controlling those changes. Thus, bioethics which relevantly applicable regardless of nations, races, and beliefs become one of SCOPE focus areas in our organization.

As an endeavor of us to raise awareness regarding bioethics issues in the medical field especially in the middle of modern society, we conducted an activity named BIOPOSE (Bioethics Practice on Social Media) as a form of celebration. The intervention included mass-posting twibbon in Instagram as one of the most popular platforms nowadays, webinar, and ended with Focus Group Discussion results in 100% of participants having the right attitude when facing the cases. Chosen path to become future physicians involves the process of emphasizing knowledge competencies, codes of medical ethics, and moral development. Early and proper education in the bioethics field shows the development of critical thinking skills to donethical decision-making as well as inculcation of values. Therefore, it is crucial for us, as future physicians, and healthcare professionals across fields to understand as well as be able to handle in respect of bioethics and its issues.

References:
Countries’ Commitment to Universal Health Coverage: Post Pandemic Trends

Ibrahim Abusufian Elkabashi Dafallah
Alzaemi Alazhari University | MedSIN-Sudan

Since the inception of the Sustainable Development Goals agenda in 2015, the promotions and recommendations of Universal health coverage (UHC) have been at the forefront of the global agenda to achieving health equity with considerable progress made up until the COVID-19 pandemic. Over the previous two decades, the health expenditure of countries and external aid has drastically increased. Yet, the majority of the increase was noted in high-income countries- accounting for 80% of total health expenditure, while an increase in external aid has caused a drop in health spending in low-income countries, leading to worldwide disparities and dependency. The coronavirus (COVID-19) pandemic then shook many health systems around the globe with some of the most prepared countries facing the pandemic poorly. Global health reviews suggest that this can be attributed to the lack of evidence-based decision-making and socio-political influences on healthcare decisions.

Regardless of how nations fared against the COVID-19 pandemic, health has transformed into a priority for decision-makers and individuals. Early data on the health expenditure of countries during the start of the COVID-19 pandemic has shown a sharp increase in public health expenditure targeted to curb the spread of the pandemic. This is sidelined by specific country commitments towards achieving health equity through primary care and reducing the financial burden associated with health services through strengthening social health insurance programs.

From these recent efforts, it seems health systems are likely to change radically in the next 30 years and history seems to be on the same side. The 1918 influenza pandemic which matches COVID-19 in scale and scorch was followed by large milestones in public health throughout the 20th century with screening and diagnostic assays, influenza vaccines, antiviral medications, health infrastructure, and personal protective equipment is positive news points out to the same following the current pandemic.

At this stage, it is too early to determine whether the state-led commitments to health will continue. Meanwhile, the COVID-19 pandemic has also lifted the curtain on evasive issues such as health equity and equal access to health for entire populations including marginalized groups, migrants, and refugees to adaptable and affordable health systems. Leveraging the willingness of the global governments to attain approval for health prioritization, it is time for health researchers, advocates, and global health organizations to serve as scientific guides to nations on the road towards achieving health for all.

References:
WHO Simulation 2023 A Powerful Platform to Learn Global Health Diplomacy

Iftekhar Ahmed Sakib
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In view of celebrating the 75th anniversary of the World Health Organization (WHO), Bangladesh Medical Students’ Society (BMSS) in collaboration with WHO Bangladesh organized the WHA Simulation 2023 on 28th and 29th April. This simulation of the World Health Assembly aimed to address critical global health challenges and foster sustainable solutions.

The needs assessment conducted by BMSS and WHO Bangladesh revealed the students’ lack of knowledge on universal health coverage. However, it clearly showed the passion of the medical students to contribute to global health in their professional lives. As a result, the WHA Simulation was planned to empower participants with skills in health diplomacy while enhancing their understanding of health policy formulation and implementation.

With over 500 medical students from 40 medical colleges, this immersive event included pre-event training sessions, policy formulation exercises, negotiation rounds, and plenary sessions where participants presented the resolutions. Participants delved into discussions surrounding universal health coverage, heath technologies, maternal and child health, gender equality, communicable and non-communicable diseases and health literacy. The success of this event is clearly reflected in the post-evaluation where 70% participants will conduct a similar simulation at their medical colleges.

The activity impacted the medical students through these 3 key areas: Global Collaboration, Youth Empowerment and Policy Formulation. The combined expertise and resources of about 30 other key external organizations working on the health care sector along with high profile guests from the Directorate General of Health Services, Ministry of Health, Ministry of Education and Members of Parliament ensured a robust and immersive outcome.

This event was financed by WHO, promoted through the official social media handles of WHO Bangladesh and a post event report was published on the official website. This is the first time in Bangladesh that the country office of WHO collaborated with a medical student organization. Their guidance and support added a layer of credibility and authenticity to the event, and exemplified the importance of synergistic partnerships between all stakeholders in promoting sustainable healthcare practices.

The 5 resolutions of the event will be used by WHO in the context of policy making as a voice of the youth of this country which further added to the innovation and impact created by this event.

A follow-up activity named ‘WHO Walk The Talk’ with the participants of WHO Simulation is being organized in August 2023 to celebrate the impact of WHO on Global Health. BMSS has also signed an MOU with WHO Bangladesh to host WHO Simulation in 10 local committees. By establishing a 8 member youth delegation, BMSS will oversee all these collaborations with WHO.

WHO Simulation 2023 is the biggest activity yet by BMSS and can serve as an example for other NMOs to organize a simulation of World Health Assembly in their respective countries and create the passion amongst the medical students on global health governance.
Towards an Inclusive Healthcare System: Bridging the Gap in the Care of Patients with Cerebral Palsy

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Infantile cerebral palsy (ICP) is the leading cause of childhood disability globally, which can occur between 1.5 and 2.5 per 1000 births. ICP not only has an impact on the patient’s motor skills, but is also evident in the social determinants of health surrounding the patient, exposing the inequalities that may exist in the environment in which patients with ICP lives.

The nutritional management of a patient suffering from infantile cerebral palsy will be affected by a great diversity of organic problems that result in a poor nutritional status or in some cases to overfeeding. A study carried out in Cuba suggests that up to 80% of problems related to ingestion such as swallowing, suctioning or chewing can be found, as well as an 80% incidence of eating disorders in patients with ICP. These disorders, in addition to the difficulties of self-feeding, are evidence of how predisposed these children may be to a far from ideal nutritional status.

The Dominican Republic is a developing country where there is a wide gap in accessibility to health services. This affects the quality of life of this vulnerable population, where it is common to find at least empirically in pediatric hospitals users with malnutrition even without presenting ICP. A national survey named Encuesta Nacional de Hogares de Propósitos Múltiples (ENHOGAR) determined that psychomotor disabilities are the most common subtype of disability in the country, followed by visual, intellectual and hearing disabilities, so it is necessary to create measures that promote a better lifestyle for patients and their families.

Having said the above, we, as medical students, would like to call on both governmental organizations related to public health and medical students to collaborate in an organized manner with families living in precarious situations. We suggest that countries with a similar situation to the Dominican Republic create model centers and sub-centers located in strategic points to facilitate access to them, while these centers provide a multidisciplinary service that involves counseling services for the patients’ caregivers to improve the quality of life of the patient and those around them. We also call on health professionals to continue the work of raising awareness and promoting among the guardians of these patients the need and vitality of continuous medical follow-up, in order to develop an adequate nutrition plan that will facilitate and prolong patients’ well-being. This will result in a decrease in transportation costs and resources diminishing the economic burden for the caregiver, the patient and their household.

As professionals of tomorrow, it is our responsibility to detect the aspects of our environment that need to be improved in order to reduce the inequalities that affect our health systems.

References:
Anatomy of Manipulated Emotions
Caroline Gouveia Borba e Souza
Universidade Tiradentes | IFMSA-Brazil
The quilombola population in Brazil is in a state of social vulnerability, associated with the political and social invisibility to which it is maintained and which can be considered a consequence of the slavery process\(^1\). Thus, they are more exposed to precarious living conditions and greater health risks, remaining more anxious about injuries in general, necessarily making a comprehensive approach to these groups.

Thus, this report aims to describe the experience of the action “Mandacaru em Debate: Approach to health and sexuality in childhood and adolescence”, carried out at a school in a quilombo in the interior of Bahia, Brazil, in May 2023. The activity was developed by a group of medical students, at the request of the community, to promote learning about health and sex education for the school-age population of this location.

Its implementation took place in two stages: (1) Organization, in which there was selection of a team, planning meetings with definition of roles and deadlines, research and training on the subject, in addition to the production of playful material to be used; (2) Realization, corresponds to the day of the action, carried out in the morning shift, using a word cloud as data collection and conversation circles for discussion.

The activity began with a word cloud as a survey of the target audience’s prior knowledge, raising “fear”, “danger”, “touching without permission”, and “hitting”, demonstrating general thoughts on the subject. Then, the discussion was divided into two moments, the first about the prevention of sexual abuse and the second about internet care, both carried out as a conversation wheel bringing didactic materials, such as a simple drawing of the human body to demonstrate the intimate parts as alert regions that should not be touched and animation to demonstrate a case.

After the intervention, the word cloud was modified, with twice as many words, among which “care”, “limited use of the internet”, “do not communicate with strangers”, “bullying”, “privacy”, “preventing them from touching their private parts”, and “talking to their parents”,

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**Approach to health and sexuality in childhood and adolescence by medical students in a quilombola community in Bahia, Brazil**

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demonstrating an increase in the children’s theoretical framework on the subjects.

Addressing sexual health with children and adolescents at school is challenging, due to the need to overcome, above all, the stigmas associated with the subject; however, it is essential to recognize the role of the school in preventing abuse and exposure to the internet, therefore, using this environment as a means of support in the promotion and prevention of health means care in the transmitted information, and pedagogical and multidisciplinary support. Thus, this moment allowed the affirmation of the condition of children and adolescents as subjects of rights, covering them with knowledge of the world and instructing them in the foundation of their own ideas, which makes it possible to avoid and identify possible problems.²

The action increased knowledge about sexual health and internet care for children and adolescents in the community, highlighting the impact of health education activities for quilombola populations by medical students during graduation.

References:
Menstrual poverty: An approach beyond the tampon
Experience Report - Action

Ana Carolina Magnavita Costa, Kamila Andrade Santan, Gabriella Lucas de Assis, Ludiane Matos Garcia Sampaio, Caroline Gouveia Borba e Souza, and Sophia Santana Amaral
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Realization period:

The action took place on May 12, 2023, at Tiradentes University, and May 24, 2023, at Associação Mulheres de Peito, both locations located in Aracaju/SE.

Object of the experience:

It was a communication experience with students and the target audience about the social aspects involving menstrual poverty, emphasizing the effects on the health of people who menstruate.

Goals:

The campaign aimed to educate about the impacts of menstrual poverty on reproductive health, through debate, with medical students, about menstrual dignity and understanding the importance of public policies for the minority affected by this problem. In addition, support was offered through the collection and distribution of personal hygiene products.

Methodology:

About the theoretical training, there was a lecture that had a sociologist giving a class on the theme of menstrual poverty, which was complemented by a class by a sanitary doctor. At the end of the training, there was a conversation with a local producer of non-disposable pads. Furthermore, already in the phase of practical training, a conversation circle was held at the headquarters of the Movimento Mulheres do Peito. During registration, an amount was charged and a hygiene product, which was destined for the collection. In all, pads and personal hygiene products were collected, which were later donated to women who had been affected by some type of cancer. In addition, two impact evaluations were carried out, the first at the end of the theoretical training and the other in practice.

Results:

The action, both in the theoretical and in the practical part, fulfilled its objective. An example that can justify this success are the results of the impact assessment on the educational activity, questions such as “How much do you evaluate your learning on the theme addressed in the event?” and “How many times has the topic been addressed in your training?” were present in the questionnaire. In addition, the engagement of the participants was also very important for the good results of the action.

Critical analysis:

The action reached the most vulnerable group of women through an approach to menstrual poverty.
poverty in its social and health aspects. In this way, the event had a positive impact, since, in addition to the students having given a lecture on the subject, the participants were able to share their experiences, ask questions and, in the end, receive hygiene products collected by the campaign action. Thus, questions such as “Have you ever had to miss school because of your period” and “Have you ever felt ashamed of your period?” were made because of its relevance. Furthermore, it was possible to establish a more intimate moment in order to clarify issues pertinent to the group’s daily life.

Conclusions and/or Recommendations:

Finally, the “menstrual poverty” action proved to be an extremely important event inside and outside the university environment, since students were able to learn about the topic with duly trained professionals and in practice approach and contribute to society.

References:
The Role of The Medical Student Researcher in New Health Emergencies: “We’re Also Part of The Team”

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Universidad Autónoma De Chiapas
Asociación Mexicana De Médicos En Formación (AMMEF)

As humanity, we are constantly threatened by episodes or disasters caused by natural phenomena, biological, chemical or radiological agents, human activities, conflicts or any other threat; called health emergencies; being the Covid-19 pandemic our most recent challenge, it brought changes in the practice of medicine and innovation in medical education.

Medical students were a group involved in health systems with activities aimed at learning rather than problem solving, during this period we were not allowed to support in the hospital setting with expert physicians as we were not prepared for disaster situations, despite the high willingness we would have had to respond to the need; in addition, the high risk of being asymptomatic carriers, promote the spread of infection or over-consumption of limited personal protective equipment (PPE).

As students we feel frustrated at being powerless and unable to contribute anything immediately, and in this new post-pandemic years we ask ourselves: What was our contribution? What could we do in the next global health catastrophe scenario?

The answer may be provided by the knowledge we were able to recover in this post pandemic years, we are part of the health team, and we must demonstrate an active role through scientific research considered as «our best weapon as humanity» against health emergencies.

It has taken a global public health event to evidence the importance of the contribution of the academic community in scientific production of medical students as essential characters in the new emerging health problems.

We believe that the best form of frontline involvement in future health emergencies by medical students is scientific research.

The veracity of this statement was demonstrated by «The Cornell COVID-19 Registry, created by group of more than 70 medical students at Weill Cornell Medicine in New York City, this registry includes the following information, which was manually abstracted from patient charts: presenting symptoms, comorbid conditions, hospital course events, and clinical outcomes for all COVID-19 patients; the registry led to the first published description of the clinical characteristics of a U.S.-based cohort of hospitalized COVID-19 patients.»

Medical students will one day play an important role during pandemics. Therefore, ensuring the resilience of the medical education system is essential even in the midst of a disaster. It remains for us to learn from the mistakes of our past generations and empower the next generations by mitigating the delay of scientific advancement by strengthening the research skills offered by Standing Committee on Research Exchange (SCORE) to continue their research skills development and increase research capacity during pandemic by taking advantage of the opportunity it offers to medical students who don’t have the opportunity in medical schools.

References:
BMSS Open Access Week: Journey of Bangladesh
Towards Equitable and Inclusive Medical Research

Sharif Mohammed Sadat
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Open Science, a concept aimed at strengthening the scientific infrastructure through openly available scientific materials, holds immense importance for the doctors of tomorrow. IFMSA has been at the forefront of supporting and guiding student-led actions in promoting equitable and open access to medical research. Its efforts have been realized through various initiatives, including Open Access Week Campaigns, Delegations to Open Education Conference & sessions at international and regional conferences to promote youth involvement in Open Science.

In line with IFMSA’s vision, BMSS-Bangladesh took its first-ever initiative to promote Open Access through a national campaign during the Open Access Week 2022. This week-long event, held from October 24th to 30th, 2022, aimed to raise awareness about Open Science, Open Access, and their significant role in climate change. This pioneering initiative was a clear testament to BMSS’s firm dedication to advancing medical research that is characterized by equality and inclusivity. Through a dynamic range of activities, workshops, and engaging discussions, BMSS succeeded in empowering its members and fostering a culture of open collaboration and inclusivity.

The campaign commenced with compelling posts shared on Facebook and Instagram, introducing the concepts of Open Science and Open Access. BMSS members were introduced to the fundamental principles of Open Science, emphasizing the importance of transparency, collaboration, and the free availability of research data, lab notes, and research processes. This laid a solid foundation for a deeper exploration of the Open Science movement. A series of workshops, seminars, and panel discussions were organized featuring representatives from 6 Standing Committees. These sessions provided an invaluable opportunity for members to learn from experts and peers, gaining insights into the practical implementation and benefits of Open Science in their respective fields. The inclusion of open access authors further enriched the discussions, as they shared their firsthand experiences of open access publishing, highlighting the increased visibility, broader readership, and potential collaborations it offers. Aspiring authors within BMSS were inspired and equipped with practical advice to navigate the realm of open access publishing successfully. Through these initiatives, over 90% of BMSS members were educated about the basics of Open Access, with a substantial percentage expressing motivation to delve deeper into this transformative approach to research.

BMSS has always showcased its steadfast commitment to advancing medical research that is fair, diverse, and leaves no one behind. As the torchbearer of Open Science, BMSS Bangladesh has set a shining example, paving the way for a more transparent and collaborative scientific community. With no boundaries to knowledge, the impact on global challenges, such as climate change, can be magnified.

BMSS Open Access Week 2022 marked a significant milestone in promoting Open Access in Bangladesh. Through engaging workshops, seminars, and panel discussions, BMSS empowered its members to embrace the principles of Open Science and Open Access. The successful campaign demonstrated the collective effort of BMSS and IFMSA in promoting equitable and inclusive medical research. By embracing Open Access and advocating for its principles, BMSS has pioneered a path towards a brighter future where knowledge is freely accessible, collaboration is paramount, and global challenges are tackled head-on.
The Indonesian archipelago is situated on the ring of fire. We have five active volcanoes. Semeru, one of the stratovolcano mounts, erupted on December 4, 2021. Its volcanic activity is increasing, as evidenced by hot cloud avalanches leading to Besuk Kobokan, Supiturang Village, Pronojiwo District, Lumajang Regency, East Java. The eruption of the volcano has affected 16 districts [1]. On the next day, the early morning eruption resulted in dense white and grey ash clouds, according to Indonesia’s Center for Volcanology and Geological Hazard Mitigation (PVMBG). They warned nearby residents not to conduct any activities within a five km (three miles) radius of the eruption center and to keep a 500 meter (1,500 feet) distance from riversides due to risks of the lava flow.

The death toll has now risen to more than one hundred, 144 injured people (32 severely injured and 82 mildly injured, nine people missing, 43 fatalities, and displacing 6,586 people to 125 evacuation locations) [2]. The National Board for Disaster Management (BNPB) worked with the local board and communities, and the non-profit is now attempting to assist with evacuation and emergency response. According to our interview with a BPBD officer in Lumajang, East Java, BPBD will relocate around 2000 families. BNPB recorded 2,970-unit houses, 31 public facilities, 42 schools, one health facility, 12 praying houses, and one bridge damaged by the hot ashes and avalanches. BNPB has instructed all humanitarian actors and stakeholders to plan for the post-emergency phase and prepare for another eruption.

We responded to the disaster impact by holding crowdfunding and got ten million rupiahs or about 700 USD. The collected fund was delivered by the CIMSA’s Humanitarian Response Team (CHRT) to the beneficiaries. We went to Pronojiwo District with the other four
CHRT personnel (in total: two females and four males). In collaboration with a national NGO named Dompet Dhuafa, we taught primary school students at “Emergency School.”

Our focus in humanitarian reliefs was about education about nutrition and respiratory health for the children. We encouraged the children to draw local food into fruits, vegetables, protein, and carbohydrates. Since they were affected by eruption smoke, it also needed to understand their lung health. So, the children made respiratory system prototypes from ballon, straw, bottle, and plasticine to get more accessible apprehension for their health. We did all these interventions with a cultural-based approach, hoping for a better understanding of beneficiaries.

Aside from did humanitarian intervention for primary school, we gift twenty packages of uniforms and stationery for middle school. In addition, we got the experience of living during the disaster event, and we had a chance to visit the house of Semeru’s eruption survivors. These interventions were live studies about disaster medicine and were very beneficial for improving our capacity as future doctors.

References:
Understanding the disaster risk management cycle to empower future health advocates.

Luis Rodolfo Morales Rosales
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Disasters are catastrophic events that affect communities by disturbing normal activities, causing casualties, and surpassing the response capacity of the affected community, but it is important to mention that each disaster is unique due to specific interactions between vulnerabilities and the hazardous event in the affected population; thus, studying disasters can be challenging. Despite being unique, disasters present similarities, for example, they all result from the interaction between hazardous events, exposure, and vulnerability, and they also share the need to be prevented to avoid casualties. 1 Prevention is unachievable without health leaders with disaster management knowledge; therefore, this article aims to expose key points about disaster management.

Confronting disasters is traditionally performed through the disaster management cycle which includes the following phases: mitigation, preparedness, response, and recovery, but nowadays some authors have exposed that this approach to managing disasters lacks explicit opportunities to involve communities which could lead to ineffective interventions. 2 Indeed, when collecting and analyzing disaster information, specifically through disaster epidemiology, the focus is to empower policymakers and first responders to act, 3 this means that population involvement is often neglected. However, one of the core components of resilience to face disaster is a collaborative approach between policy and decision-makers, populations, and first responders. 2

To clarify, mitigation consists of actions oriented to reduce vulnerability in populations. 1 Vulnerabilities can arise from social, economic, biological, political, or physical characteristics or conditions, in other words, they are a set of conditions or behaviors that increase the negative impact of a hazard in an exposed population. 4 Mitigation is one of the most challenging processes of the cycle and is critical to determine the occurrence of a disaster because it needs a perfect understanding of the population which cannot be achieved without population participation. 1 Whereas preparedness is composed of a planning process carried out to increase and allocate resources to respond to specific hazards. 2 This means that mitigation can be developed whenever, while preparedness can only be developed once a specific hazard has been identified.

On the other hand, the response phase is the complementary phase that occurs after the event strikes the population, during this process it is important to understand that the disaster’s context is uncertain which means that a continuous need assessment must be
conducted to understand the evolving needs of the population and to adapt the response interventions. Then the recovery phase cannot be described in a detailed way unless a retrospective description is done, but the most important of this step is that the population should be reconstructed without the vulnerabilities it had before the disaster but this implies higher recovery costs, in addition, it is appropriate to evaluate the actions taken in the cycle to strengthen disaster knowledge an intervention’s quality.

In brief, the disaster management cycle is still a useful approach to facing disasters, but it needs to be adapted with the understanding of the way modern populations are built, and this process needs to ensure population involvement through health leaders’ guidance.

References:
Temporarily Living in a 1951 Geneva Convention Unratified Country:
They Empower Themselves

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The wind blows the breezy breath, and the window sees the haze. From the bus window’s view, my eyes spotted some markets and buildings with Arabic signs. The local community called that place “Kampung Arab” or Arabic Village [1]. Most of us can’t determine their origin country. We only know they came from the Middle East. At first, they went as a tourist or for economic activities. In the last ten years, they reached Cisarua, Bogor, due to refuge asylum [2].

Due to persecution, they came to another country as refugees. They got that status from the United Nations High Commissioner for Refugees (UNHCR). The UN Agency is mandated to aid and protect the refugees. However, Indonesia hasn’t ratified yet the 1951 Geneva Convention yet. However, the government still preserves the non-refoulement principle by making a “Handling Refugees from Abroad” policy in 2016 [3,4]. Indonesia also temporarily hosted the asylum seeker, which hasn’t got the refugee status. Despite all that, we have human rights, the right to life, to earn a decent living.

Most of the refugees and asylum seekers in Indonesia have a dream to reach Australia. They hope that they’ll be able to work there since here they can’t do the formal job. The clock is ticking; the year changed. For more than three years, they have to wait for the resettlement announcement patiently. They try to recover from the unwanted experience. Then, they established the Cisarua Refugee Learning Center [5]. Education is a starting point for all aspects, specifically empowerment. In August 2014, they built a refugee-led institution that also empowers them to teach refugee children.

Life is challenging, and we, all the citizens, must face the COVID-19 pandemic. It is worse for the refugee community in Indonesia. When distance learning has to begin, physical mobilization is limited [6]. However, they make a substantial effort to ensure physical, mental, and social well-being by supporting each other. Besides the learning center, other workshops or community empowerment have appeared. Remarkably, the empowerment by sewing fabric and culinary business.

Apart from Cisarua, Bogor, the refugees and asylum seekers also stay in Sumatra Island, specifically Riau Province. There is good news that the local stakeholders have started the vaccination for the refugees in collaboration with the International Organization for Migration (IOM) [7]. Hopefully, the other areas are going to start soon. Talking about access to healthcare, they can go to the UNHCR-recommended Public Health Center. The language barrier and health workers’ incapacity on refugees issues have to be reduced.

Today is the best time to
build our capacity as future health workers, particularly for vulnerable populations. As the youth, we can do some unthinkable projects that may improve and empower the people of concern. Eventually, a change needs to be made, but it also requires time. So the question is, are you ready to improve the health of the vulnerable populations, notably the refugees and asylum seekers?

References:
Up Next

Stories from around the world
A conception of life that could revolutionize your minds.

Have we ever thought about how we got here? Or in scientific terms, how did we get to the egg? We have always been taught that the fastest and strongest gamete is the one most likely to reach its destination. That it was because of the race of life that we are here. That being the most competent made us survivors, and winners, of the race.

So according to this narrative, the sperm cells that carry within them, mutations and malformations would never have been born. Since these cells are not strong or competent enough to be able to reach the egg. For example, according to the alternative description of natural selection «survival of the fittest», sperm cells that carry within them a trisomy 21, or Down syndrome, would never have been born. Why, simply because they are not fit or competent enough to reach the goal?

If I were to mention how many barriers these gametes must pass in order to reach the egg, the chances of you and me getting there diminish. These reproductive cells must pass through barriers such as cervical mucus, vaginal pH, and immunological actions. All of these barriers are deadly, as these cells are susceptible to these barriers, and this would cause them to lose the race of their lives.

According to this teaching, we arrive at the egg in a race against life and death, by chance.

Here is the narrative from the other side of the coin. The other perspective has never before been exposed to the human eye. I reiterate my initial question; how did we get to the egg? To answer this question, I ask you the following: Have you considered in your consciousness the fantastic possibility that the cell carrying part of your genetic information was the one chosen to become fertilized?

This new perspective rules out «the race of life», since it was not by chance that we arrived at the egg. It was never a question of whether we were the fittest or most competent. This other side of the coin announces the fact that we were chosen.

We are actually beings composed of trillions of cells, cells capable of creating connections that allow us to function in our environment. But as we grow we lose the humility of our origin. We fantasize about looking for answers, and these are at the origin of life.

Under this new perspective, we did not run a race. We traveled a trajectory accompanied by our millions of friends who sacrificed themselves so that we could get to where we were meant to be. These millions of friends already knew who would be chosen. There was never a race! For them their goal was never to impregnate, their goal was to protect the chosen one from all barriers.

Do not forget, you were chosen before the foundation of the world.
"Our marriage will reflect my unbridled need of you, your love, our love, every single day. I will worship your feet all the way up to your lips with tender kisses every night. I will profess your unparalleled beauty with my eyes, mouth, hands, body, soul, night and day. I will keep you warm and safe in my embrace for all your days. I will make your happiness my most imminent goal each day, for all my days. Adérónkẹ́, I will love you forever and a day more."

A lioness gave birth the day it happened. I know this because the sun shone brightly while the skies let a river escape. The rapid drops reflected my racing thoughts as they flitted one to the next, each leaving me with more worry and anxiety than the last.

Your accident was the most unpleasant surprise. It had only been a fortnight since I pledged my undying love for you before God, family and friends. We were only two weeks into happily ever after, and there I was, glued to the ground, phone pressed tightly to the ear, face ashen, as I listened to the strange voice drone on about how it happened.

I do not know how I made it to the hospital. I was in a haze until I saw you. The sight of you jolted me awake. You had been crushed in several places, bleeding from everywhere, unspeaking, unmoving. It was so you, yet unlike you that I had to do nothing but stare for several seconds. I was brought out of my haze a second time when you jerked. Only then did I notice the defibrillator. Was this the end of our love story?

It has been a year since that day, 4 weeks since you were finally discharged from Physiotherapy, and I still cannot bring myself to tell you. How do I tell you that we need a second miracle? That the newborn became a cub and the cub has been weaned, but it is still raining inside me, and the sun has yet to prevail (and perhaps never will)? How do I explain that I have but a month left of the estimated six months I was given to live? That I still cannot bring myself to break the news that will undoubtedly break you even though I know your breaking is ultimately inevitable?

Adérónkẹ́ mi, when I said I will strive for your happiness all my days, I knew that my days were numbered, but what I did not know was that they were numbered in hundreds. When I said I will embrace you all your days, I did not foresee that it will be in memories that cannot be relived. When I said I will love you forever, I thought I could love you until you were old and grey. So forgive me, Ìfẹ́ mi. Forgive this foolish ignorant man for letting you down, for crushing you a second time.

Glossary:
- Adérónkẹ́: Yorùbá name that means “The Crown found something to care for”. It is used a name given to children born into royal families of the Yorùbá Tribe of Nigeria.
- Mi: My. “Adérónkẹ́ mi” means my Adérónkẹ́. It is added as a term of endearment in this context.
- Ìfẹ́: Love. “Ìfẹ́ mi” means my love.

Other Explanations:
- It is folklore in Nigeria to tell kids that when it rains while the sun is shining, it is because a lioness is giving birth somewhere at that point.

Maya Hemdanieh
Beirut Arab University | LeMSIC

“I want to quit medicine. I can’t tolerate tons of tasks every day. I am physically tired.” Those were the words of Mary, my closest colleague, on one of the hectic duties. I tried to calm her down and listened to her. I thought it was an overwhelming day, but it was more serious than this!

It was our internship year - seventh year of medical school- and we had several new tasks to hold the responsibility of a patient’s life. Doctors working as front liners during COVID-19 pandemic, in an under equipped hospital, and in a country with a severe economic crisis would be stressful enough to burn out easily. I could relate to all her problems especially that we were at the stage of our lives building the first block for our future.

Her words reflected the black thoughts and unsatisfactory feelings.

As a medical doctor, I was sure that she is not only physically tired but mentally as well. Thus, I supported the idea to seek help from a psychologist.

It was a turning point and her journey to become a better version of herself started. Since then, Mary underwent therapy sessions including cognitive behavioral therapy and psychoanalysis. It was indeed tough for a 25-year-old female to confront all her traumas and fears. Day by day, I started realizing her change in our work. Her cheerful spirit still radiated positivity any patient’s room she enters, but her threshold to tolerate load of work increased. Moreover, she accepted failure and alleviated her sense of perfectionism.

Mary always updated me with what she is passing through. Reflecting how hard it was to adapt and excel she once confessed, “it seems like an endless tornado”!

Nevertheless, Mary was blessed to get support and advice from the psychologist.

She sustained her progress over months reading books and changing her approach to situations in life.

Seven months passed when Mary thought she can’t do any more effort. She thought pills would help her so she consulted a neurologist. The latter couldn’t diagnose her with any disorder yet she thought a pill of fluoxetine would be supportive to all the internal effort she is doing alone. She started with a dose of 10 mg for the first week and then shifted for 20 mg the second week. Mary told me that she was not feeling fine but thought it was normal until the drug effect started showing. It was acceptable to know she had dizziness, fatigue or nausea, yet definitely alarming when she started to forget patient’s information or state death wishes. As medical doctors, we both questioned her condition and started reading articles about the drug’s side effects. To our surprise, we figured out that the drug could be harming her with all effects, so she called the neurologist that asked her to seek a psychiatrist as soon as possible.Mary’s appointment went well and she was advised to taper the drug over 3 days and continue her life normally without any drug.

Mary is back to her normal performance with a better mentality and great will to achieve her dream. She is now more self-conscious and neglects all the distractions.

She is living now a happy smooth life and her words turned to “I will never quit medicine. I will do my best to handle the tons of tasks every day. I will always take care of my mental and physical health to accomplish my dream!”

It is indeed important for every medical student to know that he/she is not suffering alone. We as future doctors know that people see one side of the coin. They see drs as well reputed, rich, happy and successful, but they don’t realize the other side that has failure, hardships, scars, and sadness.

Everyone could be in Mary’s shoes. It will pass no matter how hard it is. It is worth fighting to purchase your dream. It’s so true what Theodore Roethke stated “In a dark time, the eye begins to see.”

Enjoy your journey doctors while taking care of your mental health!

PS: this is a true story and the consent was taken with changing the true name
Fatimazahra Yusuf Wasili
University of Maiduguri | NiMSA Nigeria
Up Next

Poems
From Shadows to Light: The Resilience of the Ugly Ducklings

Samaa Tarek Fathi Hassan Hassan
Mansoura university- Faculty of medicine | IFMSA- Egypt

In a world of sorrow, tangled and tight,
Where borders breed darkness, and fear takes flight,
Let us weave a tale that speaks of plight,
Of refugees and immigrants, hidden from sight.

In shadows they dwell, the dispossessed souls,
Bound by their past, with burdens untold,
Like the ugly duckling, deemed different and strange,
They navigate a world where acceptance is estranged.

Their journey begins in lands of despair,
Where conflict and chaos have ravaged the air,
Leaving behind homes that crumble and fall,
They’re forced to depart, answering destiny’s call.

With hope as their compass, they tread unknown lands,
Facing prejudice and judgment, with strength in their hands,
Yet their dreams are eclipsed by the label they bear,
The stigma of strangers, the burden they wear.

Misunderstood voices, whispers of disdain,
Society’s echoes inflict anguish and pain,
But beneath the surface, a spirit does rise,
Resilience unyielding, a fire in their eyes.

For within each refugee, a story unfurls,
A tapestry woven with courage and pearls,
Through hardships and trials, they learn to survive,
Their spirits unbending, forever alive.

Let us kindle a flame, ignite empathy’s light,
Extend a warm hand, dispel the night,
For the ugly ducklings, deserving and true,
To find solace and hope, a world that’s anew.

Together, we’ll build bridges, not walls of despair,
Embracing diversity, breathing love in the air,
Their struggles, our catalyst, for a world that’s united,
Where acceptance is cherished, and differences are invited.
In this second act, hope takes its cue,
As the symphony of compassion breaks through,
A chorus of voices, uplifted and strong,
Creating a future where they truly belong.

Let us erase the boundaries, dissolve the divide,
Where their dreams and aspirations coincide,
For the ugly ducklings, transformed by their might,
Shall blossom as swans, taking flight in delight.

In the radiance of hope, a new narrative unfolds,
Where humanity triumphs, and prejudice erodes,
A world of compassion, where scars find their balm,
And the once-ugly ducklings find peace and calm.

So let the sorrows of yesterday guide us today,
To forge a path where kindness holds sway,
For within the struggles, the beauty is found,
In the refugee’s journey, hope does abound.

And as we rewrite their story, let it be known,
That the ugly ducklings, no longer alone,
Shall be cherished and celebrated, with love evermore,
As they dance in the light, their spirits restored.

In this tapestry of life, each thread finds its place,
A mosaic of cultures, blending with grace,
For in the tapestry of life, hope forever weaves,
A future where all find solace and peace.
HOPE

Likhitha Mahashiva Bhattu
Kamuzu University of Health Sciences | MSA Malawi

The beginning of this story
Starts with an overwhelming worry
The dawn of a chapter, a new phase in life
Though scared and anxious, you never felt more alive

It seemed like the saddened sun wouldn’t shine
No matter what you did, the stars did not align
It was when darkness had swallowed the way
That you decided to have faith and move on come what may

You can do better than tell yourself twisted lies
For after falling, you too can rise
The balance is tipping as the pressure puts its weight
All you can do is work hard and have faith

With hope as your compass and courage your guide,
You embrace the path, with passion beside
You stumble, you fall, but never stay down,
For strength lies within you, a resilient crown

Through shadows of doubt and valleys of fears,
You rise with determination, conquering tears
The laughter, the pain, the sorrows you bear
A symphony of experiences, beyond compare

With every step taken, you will surely grow
Through the heights of success and mountains below
So let the journey continue, ever onward you stride
Led by determination and your deepest fears inside

Like a sunflower, you and I shall bloom
When we fight through and end our days of gloom
Its all worth it when you stand where you are
Looking behind at the struggle you’ve left so far

The skeleton intimidates you no more, the fear you now lack
For now that you know all the bones, you can gladly say «I’ve got your back»
So stick to the fight when you’re hardest hit,
Its when things seem worst that you mustn’t quit
Embrace the struggle, for it will not define,  
The brilliance of your spirit, which will always shine  
Within you lies a spark, fierce and bold  
Ready to demolish the fears that you hold  

It’s only the end of the beginning now,  
The pathway of the journey is now known  
The past has its secrets, but the present does too,  
In order to establish the future, you must do what you do  

The beginning of this story  
Started with an overwhelming worry  
But you turned things around  
And stayed rooted to the ground
The Call for Change
Khadijah Sajjad Sahi
Rawalpindi Medical University | IFMSA-Pakistan
Up Next

Interviews
Healthy planet, healthy people
the interconnectedness of our health

Health Care Without Harm works to transform health care worldwide so that it reduces its environmental footprint, becomes a community anchor for sustainability and a leader in the global movement for environmental health and justice.

How does Health Care Without Harm work towards transforming healthcare systems worldwide to reduce their environmental footprint and become community anchors for sustainability?

Shweta Narayan: There’s a lot to unpack in this question. To reflect on the mission of Healthcare Without Harm - we are an international nonprofit and we primarily work with the health sector and we believe in the oath of First Do No Harm. Believing in that, we find that the health sector itself, through its operation, has a serious environmental and climate footprint. And a sector that is engaged in healing people cannot be harming them. So to carry on the mission of health care, the health systems themselves cannot be a reason for illnesses and diseases in the communities that they serve. Almost 27 years ago we began working with health systems in cleaning up their environmental and climate footprint. We started with mercury that was used in the hospital equipment. Mercury is toxic, it causes death if there’s exposure. So working with the hospitals and health systems and making a case for phasing out mercury, phasing out incinerators in the U.S., the medical waste incinerator or waste management, chemical management, planning buildings, and systems that are complementing the environmental and planetary health. In a gist, this is what the mission, the vision of Healthcare Without Harm is.

We also need to understand the huge economic power of the health sector - it constitutes 10% of the global economy. And if the health sector leverages its power in the right direction of sustainability, its processes in harmony with the environment, then systems move. The health sector does not just have a role in improving its footprint, but it can influence other sectors. And that’s a very important thing to understand. When it comes to environmental and climate justice we must understand that the health sector is at the epicentre of this climate trauma that we are experiencing. Of course, it is at the forefront of taking care of people who are hurt by extreme weather events or air pollution and respiratory distress. However, the health sector itself contributes significantly to the climate crisis. Their climate footprint is 5% or more. And its greenhouse gas emissions are increasing. The predictions are if the health sector continues business as usual, their footprint is going to triple by 2050. To put the numbers in perspective, 5% of global greenhouse gas emissions make the health sector the fifth largest emitter. If the health sector was a country, it would be the fifth largest emitting country of greenhouse gasses when it comes to adding to the climate crisis. It is absolutely important to work within the sector to make its practices aligned with the environmental and planetary boundaries and to make it a sector that is truly on the mission of healing people.
Pandemic was just a trailer of the scale and the magnitude of disaster that climate crisis can bring.

Shweta Narayan
Health Care Without Harm
Hearing those numbers is definitely shocking. We want to make sure that we do all we can for our patients and it turns out that the health sector is heavily contributing to climate crisis and its consequences. So as a global climate and health campaigner, can you share with us some examples of successful collaborations between your organization and the healthcare sector?

Shweta: I’ll take two examples. One within the sector itself and influencing the ways the sector has moved and one relating to a wider leadership. So these numbers are indeed shocking. In 2019, when we did this estimate in collaboration with an organization called Arup, we were also quite shocked. We had anticipated it, but it was still shocking. In 2021 we went ahead, did an analysis, and produced a road map of what would health sector climate action look like and what those pathways through which the health sector itself can become a climate leader. We identified seven very important interventions. So powering the health sector with a hundred percent renewable, clean, healthy energy; sustainable procurement of pharmaceuticals by this I mean low carbon pharmaceuticals and vaccines; sustainable production of food that is procured by the health sector; zero carbon buildings; zero carbon transportation; and overall health systems efficiency, which includes telemedicine and better-networked health services. Now, if we implement those seven interventions now, by 2050, we can reduce 44 gigatons of carbon. And, again, putting those numbers in perspective, 44 gigatons of carbon was the entire world’s economy’s carbon emissions for 2017. So in terms of scale, this is the kind of impact the health sector can have.

Now, what happens with this data and this knowledge in terms of partnerships? We have health facilities, systems, and institutions in different parts of the world already incorporating these transformative pathways to climate action in their programs. We have our flagship program called Global Green and Healthy Hospitals. It’s present in about 81 countries and represents about 74,000 hospitals and health systems around the world. Every one of these institutions is incorporating climate action, sustainable practices, and environmentally friendly ways of functioning as part of the UNFCCC’s climate champions race to zero program. In the last three years about 14,000 hospitals and health facilities from 21 countries have joined the Race to Zero program, pledging net zero by 2050. And that’s a significant momentum in the health facility. Let’s also reflect on what data and information can do in terms of weaving that global policy collaboration. We have the roadmap, we have the race to zero commitments. And then in 2021, at COP26, Health Care Without Harm was part of the COP26 health program in collaboration with the World Health Organization and the UK government. This collaborative program is now called ATACH - Alliance for Transformative Action on Climate and Health. Now we have 67 countries, and national governments that signed up as ATTACH and have committed to low carbon and climate resilient health care. And that’s a huge commitment from the sector. Especially in the journey where at one point nobody thought that health care could even make this kind of damaging impact on climate change. Realizing the problem and realizing that governments need to take action. And national governments are committing to it, G7 countries are committing to it, and G20 countries are in the process of committing to it. For me, this is an example of a successful collaboration. You have data, you have evidence, and you’ve been able to influence policymakers at a global, local, and regional scale to recognize that this is a problem and to commit to action. As I said before, if you don’t recognize the problem, you will never find the right solution. This is the first and most difficult step of accepting that yes, indeed, there is a problem we need to tackle.

Now, an example from within the health community. With the climate crisis itself, accelerating at a pace that nobody had imagined and at a scale that exceeded our predictions, we are now seeing the health community coming to the forefront and leading a lot of climate action. And not in just changing the ways of working of the health sector itself, because that’s still the 5% only, but also using health leadership to influence policy-making and guide...
communities. So health professionals are sort of lending solidarity to communities who are on the frontline of climate disasters or air pollution, providing testimonies to courts, or in countries like Australia advocating for better climate policies and influencing the election.

From the scale of providing evidence, testimonies, and data to mobilizing support across communities, to influence policymaking in the countries. Health professionals are leading those roles and that’s for me an example of success.

**It is very inspiring to hear how collecting data and getting evidence answer the question of what is wrong and what can be done next. How this step can influence everyone, on every level. Let’s go back in time now, to 2020, COVID-19. Of course, the COVID-19 pandemic revealed multiple disparities and inequalities. How it has impacted your work when it comes to working towards climate justice in health systems?**

**Shweta:** In the most recent times, of course, COVID has been sort of a shock. I always feel it personally when I look back and I try to remember something in the past, this moment of the pandemic has been a blur. I think it’s also how we process trauma and that we try to forget about it. But it was also a moment of a stark realization of everything that is wrong with the way our policymakers, the way our practices harm the planet. It also showed how deeply connected human and planetary health are.

From the health systems perspective, I think a lot of countries realized that our health systems are not prepared for multiple stressors. So when the pandemic hit, and I can especially speak from India example, regular services in hospitals were suspended. So for example pregnant people, people who needed dialysis, or people who had mental health issues, had no way to access medicines or care. It was chaotic because the whole system was focused on dealing with the pandemic. So other diseases were not addressed.

What COVID pandemic also reiterates how important the health voices were. And how quickly governments and people adhere to the advisories of health professionals, be it a mask or be it precautionary travel, or basic measures to keep themselves safe. It reiterated the credible, trusted voices, of health professionals and what influence they had in keeping society safe.

In a lot of places, COVID-19 also brought forward a lot of existing inequities. Everything is interrelated and we saw a sneak peak of what Disasters at this scale can do to people how it can hurt communities and how inaction can hurt communities. The pandemic was just a trailer of the scale and the magnitude of disaster that climate crisis can bring. The pandemic response was a trailer of what’s wrong with our systems in times of crisis and how to deal with a crisis. So for us, it’s a lesson. The way the pandemic manifested is a lesson and a warning of how worse the climate crisis can be. And there are lessons learned from the pandemic, on how to do things right, and how not to do them.

I think for us this is a big learning in terms of keeping to the planetary boundaries, making sure that the environment and health, which are so deeply interrelated, are balanced, and making sure that within the health response, no one is left behind. And of course to make sure the health sector is prepared to deal with these kinds of crises.

**The Pandemic also showcased that digital health technologies and telemedicine played a significant role during the pandemic response. So how does your organization also utilize and view the integration of those technologies into health systems to overall improve the healthcare?**

**Shweta:** If you remember, I reflected on the seven pathways. And overall health system effi-
iciency is one of them. Bringing in efficient ways of care, including digital and telemedicine is not only effective during the pandemic. It’s sustainable. It’s also low carbon. And it also increases health systems’ efficiency and resilience. Innovative and successful solutions that have been successful in ensuring that nobody’s left behind are also effective solutions such as climate actions. So if somebody is working on digital health and telemedicine, they are already contributing to climate action. What I’m trying to say is that all of these solutions, all of these lessons from the recent examples and crises are lessons to be learned and integrated as climate action measures. If you’re able to use digital medicine and telemedicine for minor care, you’re also reducing the transportation burden to the hospital. So the transportation emissions are taken care of, right? That’s the connection. And that’s what is required in terms of better efficiency, better utilization of services, and innovative services when we are looking at the climate crisis.

It’s really important to realize that everything is interconnected, whatever happened during the pandemic, we can learn from it for another crisis and so on. It is important to have this perspective because we can achieve much more if we consider a lot of different backgrounds and lessons learned. So to build on that but also getting medical students into the perspective. We play a vital role in shaping healthcare in the future. So how can we engage meaningfully to help in driving your organization’s mission, and vision, and to to further connect both healthcare systems and climate justice?

Shweta: Yes, you’re right. Medical students have a very critical role and very important role as the leaders of the present, not even the future. One would expect the medical students also to break certain barriers and, and to move ahead with just and sustainable action. Realizing how critical the role of young health professionals and students is very important. And we are in a moment in history where we know that we don’t have much time when the time for the window for action is closing really fast. So it’s no longer going to be enough to just work on sustainability within health care. With everything that’s happening around us and everything that we see online and in the news, it just feels like we need to act. In every possible direction and every urgent manner possible.

So health professionals have a role to ensure that their systems are sustainable and not harming people and not harming the climate, yes. But at the same time, they also have a role to lead some of the conversation. Push policies outside the health sector. They should not li-

**Collaborate, educate, talk to anybody willing to listen and act.**

**Organize and speak up.**

**Now.**

What advice you would give to someone who just wants to start integrating environmental health and justice into medical education, into research, into exchanges that happen between student organizations, and also in IFMSA?

Shweta: Collaborate, educate, talk to anybody willing to listen and act. I would say organize. And realize the power that young people have. And I think that to a very good extent, young people are using that power. So continue to collaborate, and continue to develop evidence. But it’s not enough to just develop evidence. Share it. Give it to people who would use it if you are not able to use it. But let that data, let that evidence, let that any indication of action speak
and speak louder. I’m not trying to overwhelm anybody here, but the task is mammoth and only collectively we’ll be able to deal with it. Whether we will be able to resolve it or not, we need to at least put up a fight, we need to be together. And young people, young health professionals are at that moment where they should collaborate with a diverse group of people, with environmental justice groups, with frontline communities, and with policymakers to understand what actions are being taken, and what implications are there. Organize and speak up. Now.

Thank you for this powerful call to collaborative action. Do you have anything else to share with the medical students’ community?

Shweta: I have just one more thing to add. I also see this climate crisis as an opportunity. It sounds kind of weird to say, but it is an opportunity to fix some of the problems that we have been either causing or being part of. And it is an opportunity for the health systems and health sector to reimagine health and transform the sector. Focus on prevention, rather than just on a curative part. Invest in people, invest in health workers, invest in communities. Invest in local solutions, and sustainable solutions, and build that resilience.

Because I frankly think that health systems are not just places where you go and cure yourself. These are places where you heal yourself. And to play that role of healer, you have to anchor communities. And that has to happen along with people and along with communities. So this is an opportunity to rethink the way we’ve been operating, reimagine the way we can operate, and ensure that no one is left behind.

Shweta Narayan in conversation with Olga Wdowiczak

Shweta Narayan is an India-based environmental health researcher and has over two decades of campaigning and advocacy experience in environmental justice issues in India. Her work focuses on providing legal, media and scientific research support to the residents of pollution affected communities and workers exposed to toxic chemicals.

Since 2014, she has been coordinating the Healthy Energy Initiative (HEI) program in India. As part of the program, she has worked with several sub-national governments and health professionals in developing climate and environmental health policies. She is a trained Social Worker with specialisation in Criminology and Correctional Administration from Tata Institute of Social Sciences, India.
We tend to focus on disasters only when one is happening, but we need to remember that this is and should be an ongoing process.

Martina Valente
CRIMEDIM
In the context of MSI’s theme of Post-Pandemic Recovery and Resilient Health Systems, what topics or experiences from CRIMEDIM’s work could be particularly insightful and relevant for medical students to learn from?

Martina: One of the main focuses of CRIMEDIM when it comes to disasters, global health issues, or humanitarian crises is to always have the health system perspective and to consider a whole-of-health system approach to disaster response and preparedness. Quite often this perspective is either absent or restricted. CRIMEDIM considers having this holistic perspective of great importance. We are not only trying to understand the impact on the community and the general population, but also the impact on the health system, health system performance, health system functioning, and considering the health system in its broadest perspective. So not only hospital response, which is perhaps a bit more common when it comes to disasters but also the pre-hospital system and primary care system. It also means understanding that there are other actors that work for the well-being of the communities, such as non-governmental organizations and the third sector. They play a huge role in disasters, especially when it comes to vulnerable and marginalized populations.

When it comes to COVID-19, we can share our experience based on the recent studies that we have conducted, which actually adopted this health system lens. We wanted to explore the main strategies that were implemented during COVID-19 and how those strategies and lessons learned could improve future health emergency and disaster risk management. We conducted a case study based in Italy, involving a broad spectrum of stakeholders from different levels of the health system. We included representatives of the hospital sector, of pre-hospital, and primary care, people from the third sector, NGOs, community members, but also representatives of the public administration, politicians, policymakers, and so on. The view we could grasp from them was very comprehensive and we really managed to understand all the different perspectives on what is a health system response.

Could you share with us your personal experiences and impactful moments during your involvement in disaster medicine and humanitarian aid that have shaped
ped your perspective on the importance of building a resilient health system?

Martina: Personally, I’m not a medical doctor, I’m a global health researcher and therefore my involvement is always from a research perspective. I can share my recent experience regarding health system perspectives and community strengthening. I was recently deployed and involved in a project in the field in Afghanistan to explore how access to healthcare changed following the government change in August two years ago. It was in collaboration with the non-governmental organization EMERGENCY, which has been working in Afghanistan for a very long time. We had the opportunity to explore from both a health system and community perspective, whether there were some changes in access to care following the change of government and all the sociopolitical changes that Afghanistan went through in recent years. It was very interesting to see that while, at times, disaster researchers might expect drastic changes when a crisis or disaster happens, they may be confronted with chronic challenges instead. So besides the disaster, many times the health system has some chronic issues or problems, some institutional barriers that are the real problem even when there are no disasters. It also inspires us to take into account long-term health system-strengthening interventions rather than only focusing on intervening in disaster situations. Many times the limitations, problems, and challenges are really structural in certain contexts.

Monica: This question is particularly relevant to us and to me specifically since my PhD is about this topic. Its title is “Being a migrant woman during disasters” and with this project we also recently won a research grant from Fondazione Cariplo, a philanthropic foundation in Italy, to specifically investigate inequalities. We are conducting a mixed-method study to address and explore the impact of the COVID-19 pandemic on migrant women in Milan, in Italy. When it comes to disparities and inequalities, at CRIMEDIM we try to always adopt an intersectional lens. This is paramount to not consider groups of people as silos. We are aware that multiple identities that people have may increase their vulnerabilities when it comes to disasters, and this has been shown by the COVID-19 pandemic. So in this project, we are going to intersect the vulnerability arising from being a migrant and from being a woman to see how this community was impacted. We are already exploring this phenomenon through different sources of data and information. And we think this is very important when it comes to understanding vulnerabilities and disparities. So for example, we analyze data coming from the emergency department, as this is the first access point, especially for migrants seeking care. But we also seek data and information from NGOs. This helps us understand what happens to all these people who can’t make it to the emergency department, who have difficulties in accessing care at the emergency department, or who can’t access care from the general practitioner. In general, and then when it comes to vulnerabilities, disparities, and inequalities, we always want to hear from the affected communities. We are going to conduct many interviews with migrant women to hear in her country and she’s planning with them for a refugee camp to be opened. And she’s putting into practice the principles she learned from the training. You, medical students, will be the key actors in health systems in the next few years. So for me coordinating such a huge project helped in understanding the importance of preparedness and training in disaster medicine and global health. This is a very enlightening experience.

Let’s also talk a little bit about how the COVID-19 pandemic highlighted the health disparities and health inequalities within and also between the countries. How does CRIMEDIM address those disparities in disaster medicine and humanitarian aid efforts? Could you tell us about your efforts to ensure equitable access to healthcare for vulnerable populations?

Monica: This question is particularly relevant to us and to me specifically since my PhD is about this topic. Its title is “Being a migrant woman during disasters” and with this project we also recently won a research grant from Fondazione Cariplo, a philanthropic foundation in Italy, to specifically investigate inequalities. We are conducting a mixed-method study to address and explore the impact of the COVID-19 pandemic on migrant women in Milan, in Italy. When it comes to disparities and inequalities, at CRIMEDIM we try to always adopt an intersectional lens. This is paramount to not consider groups of people as silos. We are aware that multiple identities that people have may increase their vulnerabilities when it comes to disasters, and this has been shown by the COVID-19 pandemic. So in this project, we are going to intersect the vulnerability arising from being a migrant and from being a woman to see how this community was impacted. We are already exploring this phenomenon through different sources of data and information. And we think this is very important when it comes to understanding vulnerabilities and disparities. So for example, we analyze data coming from the emergency department, as this is the first access point, especially for migrants seeking care. But we also seek data and information from NGOs. This helps us understand what happens to all these people who can’t make it to the emergency department, who have difficulties in accessing care at the emergency department, or who can’t access care from the general practitioner. In general, and then when it comes to vulnerabilities, disparities, and inequalities, we always want to hear from the affected communities. We are going to conduct many interviews with migrant women to hear
directly from them. In general, we always try to implement approaches such as participatory research, and transdisciplinary research to hear from different stakeholders and communities.

Martina: I just want to point out that in general the understanding, assessment, and monitoring of inequalities may be quite challenging. Oftentimes we’re talking about marginalized communities or groups that tend to be hard to reach. And understanding inequalities through the lens of access to care can be quite useful. Many times when a disaster happens the inequalities are seen as a lack of access. Besides this recent project, we also have other projects, such for example a PhD project that looks at how different factors such as migration, conflict, and the COVID-19 pandemic have affected the continuity of maternal and child health care for refugee women in a particular area of Pakistan. It is quite useful to check how a specific service has been disrupted by the COVID-19 pandemic, and how a vulnerable population like migrant women in the postpartum period or mothers with children under five are experiencing disruption of care.

Monica: I would like to add one last thing. It’s very important to explore and study disparities and inequalities in ordinary times because disasters and public health emergencies exacerbate those disparities rather than create new ones. For example, we have also conducted a review of the literature exploring inequalities between migrant and non-migrant populations when it comes to access to the emergency department to analyze what happens in ordinary times, and which inequalities are there. We can also tailor some interventions that can be effective during a crisis. So, we always try to not improvise during a disaster or crisis, but rather to explore vulnerability in ordinary times.

Digital health technologies also played a significant role during the pandemic. Can you share how CRIMEDIM utilizes those innovations to support your work?

Martina: CRIMEDIM considers technology as a useful tool to improve disaster preparedness and disaster response. One case that comes to my mind is the involvement of CRIMEDIM in a project called NIGHTINGALE, funded by the European Commission. The main aim is to improve the health response in major emergencies, in particular, to develop, test, and deploy an integrated toolkit for medical emergency response, which is also aimed at

Monica Trentin
She joined CRIMEDIM in 2020 as a research fellow. Her research interests include, among others, vulnerable population’s disaster preparedness, the relationship between gender and disasters, and menstrual health during disasters. In 2021, Monica began her PhD in Global Health, Humanitarian Aid and Disaster Medicine, with a project focused on the impact of the COVID-19 pandemic on migrant women. She is also the Principal Investigator of the project “Being a Migrant Woman During Disasters: A Mixed-method Study Exploring Multidimensional Inequalities During the COVID-19 Pandemic in Northern Italy”, funded by the Fondazione Cariplo. Monica is also the coordinator of the Training Disaster Medicine Trainers (TdMTr) project, an educational program in disaster medicine for medical students, organized in partnership with IFMSA.

Martina Valente
She works at CRIMEDIM as a postdoctoral research fellow. She is mainly involved in the Doctoral Program in Global Health, Humanitarian Aid and Disaster Medicine: she provides lectures on research methods, collaborates with the coordination and organization of the PhD program, and provides ongoing support to PhD students throughout their research projects. She obtained a PhD at the Athena Institute (Vrije Universiteit Amsterdam), and she gained experience in research, education and supervision of students in the field of global health. Besides that, Martina is involved in other research-related activities and lectures at CRIMEDIM, and she contributes to designing new research directions.
improving pre-hospital triage and interventions and overcoming the outdated technologies and methodologies that are employed in these circumstances. Technology plays a very important role and we have a great team at CRIMEDIM focusing on this specific project.

Monica: When it comes to the use of technology for training at CRIMEDIM, we must mention the European Master in Disaster Medicine (EMDM), which is an advanced master, but also the TDMT and Disaster SISM, which is the Italian version of the TDMT project in collaboration with SISM Italy. We always expose students to computerized simulations, for example using XVR, which allows conducting simulations in a virtual setting, where students can play like they are conducting the response to a large-scale disaster or a mass casualty incident. So, for example, when it comes to XVR, students have triage cards on the screen and they have to decide very quickly what to do. So that’s very realistic. You feel like diving into the response. In this case, technology and software can support us in delivering training and making students feel prepared. Because when a disaster occurs, there’s not enough time to prepare ourselves. Using this very realistic software is very, very useful for students. And this is also feedback that we receive a lot.

We already discussed TDMT, training, and their impact on how students use those skills in real life. Can we expand on this topic? How can medical students play a role in disaster preparedness and response, both within their communities, but also on a global level?

Monica: I think that the most important aspect is Preparedness. Think about COVID. Many students were asked by their universities or hospitals to be deployed and to respond to the COVID-19 crisis without any preparation at all. And this can be very, very harmful to their mental health, also when it comes to making very important, sensitive decisions that would require ethical preparation. So the first thing that I would like to mention is the importance of being prepared in advance. We cannot improvise during a disaster. At CRIMEDIM we try to do our part in this with the TDMT project that we mentioned earlier. We try to fill the gap because as you may know, universities around the world often do not offer courses in disaster medicine. Every time I meet TDMT students, they underline this gap. Often times our project is the only opportunity to do courses on this topic. So, we try to fill this gap by training students to become disaster medicine trainers, who after obtaining the final certification, can go to their universities but not only to deliver courses in disaster medicine. And this is already a significant outcome. When it comes to building students’ roles in their communities or at the global level, we think that it’s very important to rely on authorized, well-known entities or organizations to start a collaboration.

Martina: I also wanted to mention the role not only of medical students but each and every one of us in the disasters. It’s important to consider all the phases of disasters, not only disaster preparedness or disaster response. At times we forget about mitigation and that’s something that very easily everyone can play a role in. And if we think about mitigation it’s just a matter of a sustainable lifestyle as well as a sustainable diet in the long term. It’s really impressive how much behaviors we have today can bring change in the future and perhaps at least decrease the disasters caused by natural hazards and climate change-induced disasters.

So let’s look into the medical students’ future for a bit. What would be your recommendations to medical students who in the future want to work in disaster medicine, humanitarian aid, or global health based on your experience in the field and lessons learned from COVID-19?

Martina: In terms of being involved in research which definitely plays a big role in disaster medicine, global health, and humanitarian aid, being informed about courses and opportunities within CRIMEDIM and other organizations might be a starting point. At CRIMEDIM TDMT or EMDM are excellent opportunities to deepen knowledge in the field. A bit more advanced, but the same goes for Ph.D. program opportunities or starting research in these fields. And of course, they must have an idea of a topic they might want to go more in-depth with so that they can refer to professors or institutions that might endorse the idea. So reach out to institutions that can collaborate with students and support them. Going into the field, collecting data, and being operational in the research can advance disaster medicine research and increase the chances of collaboration in bigger projects and institutions. Try joining International projects, as this is also a way to build experience and gives you more opportunities to have a say in terms of disaster medicine.

Monica: Another thing that medical students could do is conduct research projects, and
training activities in many countries around the world to deepen their knowledge and broaden their perspectives. I’m sure this could be very beneficial for their careers and daily work. To see and learn from other communities, and what they do to learn best practices from each other, is a very beneficial approach.

So we mentioned the international collaboration and its importance in responding to disasters and humanitarian aid. Building on that, how can we as medical students contribute to the promotion of international collaborations, but also information sharing, as it’s also very important in times of crisis?

Martina: I want to underline the importance of opening communication channels with important institutions. For example, the WHO or other international bodies might be very helpful in enhancing international collaborations. Participating in various projects can also be an opportunity for different partners and organizations to join their efforts toward a common goal. In terms of information sharing, advocacy projects can be a good way to start spreading information.

Do you have any final message to share with the medical students worldwide?

Monica: You as medical students should be brave and make your voices heard. Don’t be afraid to push communities, governments, your professors, research centers, universities. If you think there is an opportunity that you want to take, don’t be afraid to push, go there and fight for it.

Martina: And do not wait until there’s a disaster to focus on disasters, but consider disasters also in peacetime in terms of research, in terms of preparedness, in terms of training and preparation, because otherwise, it would be too late. We tend to focus on disasters only when one is happening, but we need to remember that this is and should be an ongoing process.

You as medical students should be brave and make your voices heard. Don’t be afraid to push communities, governments, your professors, research centers, universities. If you think there is an opportunity that you want to take, don’t be afraid to push, go there and fight for it.
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