



**MSI**

MEDICAL STUDENT INTERNATIONAL

# Adolescents and reproductive health

# IFMSA TEAM 1997-98

## EXECUTIVE BOARD

President, Bjorg Thorsteinsdottir ([president@ifmsa.org](mailto:president@ifmsa.org)) Iceland  
Secretary general, Aleksandar Bodiroza ([secgen@ifmsa.org](mailto:secgen@ifmsa.org)) Yugoslavia  
Treasurer, Kevin Mani ([treasurer@ifmsa.org](mailto:treasurer@ifmsa.org)) Sweden

## BOARD OF DIRECTORS

SCOAS director, Maria Rydevik ([scoasd@ifmsa.org](mailto:scoasd@ifmsa.org)) Sweden  
SCOEE director, Elba Gonzales de Linares ([scoeed@ifmsa.org](mailto:scoeed@ifmsa.org)) Spain  
SCOME director, Paola Erba ([scomed@ifmsa.org](mailto:scomed@ifmsa.org)) Italy  
SCOPE director, Hazem Vafa ([scoped@ifmsa.org](mailto:scoped@ifmsa.org)) Egypt  
SCOPH director, Remco Visser ([scophd@ifmsa.org](mailto:scophd@ifmsa.org)) The Netherlands  
SCORP director, Tigran Vilotijevic ([scorpd@ifmsa.org](mailto:scorpd@ifmsa.org)) Yugoslavia

## PROJECT COORDINATORS

Sudan I Village concept project, Lars Almoth ([sudan@ifmsa.org](mailto:sudan@ifmsa.org)) Sweden  
Sudan II VCP, Tiina Karumo ([sudan2@ifmsa.org](mailto:sudan2@ifmsa.org)) Sweden  
Zimbabwe VCP, Dorte Lyngby Skovbolling ([zimbabwep@ifmsa.org](mailto:zimbabwep@ifmsa.org)) Denmark  
Calcutta VCP, Tony Manuppelli ([calcuttap@ifmsa.org](mailto:calcuttap@ifmsa.org)) Italy  
Burma Refugee project, Gorazd Sveticic ([burmesep@ifmsa.org](mailto:burmesep@ifmsa.org)) Slovenia  
Sudan RP, Marina Machacek ([sudanrp@ifmsa.org](mailto:sudanrp@ifmsa.org)) Switzerland  
Uganda RP, Meike Nitschke ([ugandap@ifmsa.org](mailto:ugandap@ifmsa.org)) Germany  
Friendship clubs, Judith Ortiz Sanchez ([friendsp@ifmsa.org](mailto:friendsp@ifmsa.org)) Spain  
Orphanage initiative, Trond Velken ([orphanagep@ifmsa.org](mailto:orphanagep@ifmsa.org)) Norway  
Book aid, Raz Dekel ([bookaidp@ifmsa.org](mailto:bookaidp@ifmsa.org)) Israel  
ASPIS project, Mohamed El Batta ([aspisp@ifmsa.org](mailto:aspisp@ifmsa.org)) Greece

## LIAISON OFFICERS

WHO, Francesca Porta ([lwho@ifmsa.org](mailto:lwho@ifmsa.org)) Italy  
WHO-ROE, Christoph Schlimp ([lwhoe@ifmsa.org](mailto:lwhoe@ifmsa.org)) Austria  
PAHO, Ana Carolina Rodrigues ([lpaho@ifmsa.org](mailto:lpaho@ifmsa.org)) Brazil  
WHO-ROSEA, Sheng-Wen Hou ([lwhorosea@ifmsa.org](mailto:lwhorosea@ifmsa.org)) Taiwan R.O.C.  
WHO-AFRO, Nuyen Raju ([lwhoafro@ifmsa.org](mailto:lwhoafro@ifmsa.org)) Zimbabwe  
UNICEF, Marja Kuopusj ([lunicef@ifmsa.org](mailto:lunicef@ifmsa.org)) Finland  
UNESCO, Thiago Monaco ([lunesco@ifmsa.org](mailto:lunesco@ifmsa.org)) Brazil  
SSC (Scientific Students congress), Michele Compagno ([lssc@ifmsa.org](mailto:lssc@ifmsa.org)) Italy  
IPPNW, Ellen-Ann Antal ([lippnw@ifmsa.org](mailto:lippnw@ifmsa.org)) Norway  
UNFPA/UNAIDS, Jelena Zajeganovic ([lunfpa@ifmsa.org](mailto:lunfpa@ifmsa.org)) Yugoslavia  
MEDNET, Maria Teresa Bernal ([lmednet@ifmsa.org](mailto:lmednet@ifmsa.org)) Spain  
ECHO, Sarah Bernhardt ([lecho@ifmsa.org](mailto:lecho@ifmsa.org)) Italy

## SUPPORT GROUP

Fundraising director, Jakob Krarup ([fund@ifmsa.org](mailto:fund@ifmsa.org)) Denmark  
PR & marketing director, Mira Rahikkala ([marketing@ifmsa.org](mailto:marketing@ifmsa.org)) Finland  
Leadership training programme, Patrick Sandstrom ([ltpd@ifmsa.org](mailto:ltpd@ifmsa.org)) Finland  
Homepage coordinator, George Soldakis ([web1@ifmsa.org](mailto:web1@ifmsa.org)) Greece  
Homepage coordinator, Yu Clun Liu ([web2@ifmsa.org](mailto:web2@ifmsa.org)) Taiwan R.O.C.  
Homepage coordinator, Jozef Sorsak ([web3@ifmsa.org](mailto:web3@ifmsa.org)) Slovakia  
Project committee, Jet Derwig ([projectsc1@ifmsa.org](mailto:projectsc1@ifmsa.org)) The Netherlands  
Project committee, Oliver Hoffman ([projectsc2@ifmsa.org](mailto:projectsc2@ifmsa.org)) Germany





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### EDITORS

Jelena Zajeganovic, Yugoslavia  
Pritpal S Tamber, UK

### DESIGN

Jelena Zajeganovic, Yugoslavia  
Pritpal S Tamber, UK

### CONTRIBUTORS

Bjorg Thorsteinsdottir, Iceland  
Dr Nafis Sadik, UNFPA  
Thiago Monaco, Brazil  
Ljubica Latinovic, Yugoslavia  
Alejandro Soto Romero, Mexico  
Jet Derwig, The Netherlands  
Dr Charlotte Gardiner, UNFPA  
Patrick Okello, Uganda  
Maria Günzel, Zambia  
Izukanji Sikazwe, Zambia  
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Régis Eric Maia Barros, Brazil  
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Jim Aisire, Uganda  
Chanakya Jonnalagadda, South Africa  
Jane Ferguson, WHO  
V. Chandra-Mouli, WHO  
Clementine Maddock, UK  
Nikola Jagodic, Yugoslavia  
Tigran Vilotijevic, Yugoslavia  
Meike Nitschke, Germany  
Elske Hoornenborg, The Netherlands  
Musana Bazil, Uganda  
Ellen-Ann Antal, Norway

### PHOTOS

UNICEF, WHO, UNFPA  
and IFMSA archives

### COVER

Tigran Vilotijevic, Yugoslavia

### PREPRESS

Aleksandar Skripka - **HARD**DESIGN  
Belgrade, Yugoslavia

### PRINTERS

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James Chui, UNFPA

IFMSA, The International Federation of Medical  
Students' Associations

IFMSA General secretariat  
c/o Mrs. Mia Hilhorst  
Division of Social Medicine  
AMC - PO Box 22700  
NL-1100 DE Amsterdam  
The Netherlands  
Phone: +31 20 5665366  
Fax: + 31 20 6972316  
Internet: [info@ifmsa.org](mailto:info@ifmsa.org)  
<http://www.ifmsa.org>  
Telex: 11944 AZUA NL

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# President's corner

## Reproductive health

BJORG THORSTEINSDOTTIR (president@ifmsa.org)  
IFMSA PRESIDENT



Man's reproduction has been an important part of the doctor's role since the beginning of medical practice. However, few societies openly discuss issues of reproduction in their educational institutions or in their media. For these reasons, the doctor-patient relationship—which should be protected by confidentiality—becomes an important venue for sexual education and the promotion of reproductive health. The medical profession also has an obligation to society as community teachers and fighters for reproductive health and rights all over the world.

It is imperative to prepare doctors for this role and this preparation should start as early as possible. Medical students need a firm basis in the medical aspect of reproduction as well as an understanding of both the social context of sexual behaviour and how it affects the individual. Awareness of local problems and available preventative measures are important to plan appropriate health promotion. To deliver the message to the individual as well as the general population, training in interpersonal communication and teaching are vital. IFMSA believes the best way to prepare medical students for any aspect of the complicated world of medicine is to involve them in projects and policy-making during their formative years. By confronting them with themselves, their values and beliefs, and by sensitising them to important problems, they will be more likely to act on the issues and try to make a difference.

With the undeniable strength of its medical background, IFMSA hopes to take a leading role in youth action for reproductive health and to collaborate with other local and international organisations. Our contacts with United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organisation (WHO) and other international associations are promising and we are looking forward to increased co-operation on project level.

This ambitious publication demonstrates the potential of youth activities. By documenting the activities of national and international medical students' associations in the field of Reproductive Health and Rights, IFMSA hopes to act as an educator and motivator. The aim is to increase the awareness of medical students worldwide and to motivate them into action. IFMSA invites all medical students with projects or ideas to contact the director of the Standing Committee of AIDS and Sexually transmitted diseases (Maria Rydevik; scoasd@ifmsa.org) to discuss them further, offer advice, and provide support. Other groups interested in collaboration are always welcome.

UNFPA has generously supported IFMSA in this publication and we hope that this contribution to the global discussions will serve to generate new ideas and approaches to this important field.

# From UNFPA

## The message

DR NAFIS SADIK  
UNFPA EXECUTIVE DIRECTOR

On the occasion of the release of this special issue of Medical Student International, the IFMSA magazine, on „Adolescents and Reproductive Health“, I wish to send my warmest personal greetings to medical students all over the world.

The latest United Nations projections show that, as we are moving into the new millennium, some 17.5 per cent of the estimated world population of 6.09 billion in the year 2000 will be between the ages 15 and 24. These numbers alone show that young people are not only the future, they are also the present.

The International Conference on Population and Development which was held in Cairo in 1994 focused the world's attention on adolescent reproductive health, highlighting the needs of adolescents for information and services, and setting as an objective the substantial reduction of all adolescent pregnancies.

In 1996, UNFPA organized a youth essay contest under the theme „Promoting Responsible Adolescent Reproductive Health Behaviour. Thousands of young people from 107 countries told us that they want appropriate sexuality education and, where necessary, services, so as to avoid early and unwanted pregnancy, to avoid abortion, and to protect themselves from reproductive tract infections and STDs, including HIV/AIDS. Just as important, they so eloquently said that they want to be heard. Taking heed of this, we are systematically integrating young people's opinions in our work, by involving them, wherever possible, in the design and implementation of information and service activities that seek to address their needs.

UNFPA is also increasing support to adolescent reproductive health programs in response to requests from countries. In addition, UNFPA strongly advocates for basic education for young people, particularly for girls; gender equity and equality; and the elimination of gender-based violence and sexual exploitation, particularly of young people.

On these fronts, there is much that needs to be done, in collaboration with governments, in order to promote young people's life options, so that they can develop to their full potential and can contribute effectively to their communities.

IFMSA is uniquely placed in this regard. It is an organization of young people who are going to play a key role in their societies. IFMSA and its member national medical students' associations have been conducting many worthwhile activities, be it fostering health as a human right, or promoting reproductive health, including family planning and sexual health.

This is a historic occasion, because, for the first time, IFMSA is focusing the world's attention on this all-important concern of adolescent reproductive health. UNFPA is pleased to sponsor this issue of the Medical Student International, in the sincere hope that it will inspire young doctors and their teachers to address earnestly the needs of adolescents in the area of reproductive health.



# From the editors

## Talk about sex

JELENA ZAJEGANOVIC (scoas@EUnet.yu), YUGOSLAVIA  
EDITOR

Communication is one of the most important skills of our profession. When we talk about twisted ankles, fevers, headaches or the problems of chronic breathlessness, we rarely have problems in understanding or being understood. But what happens when the „aches and pains“ of our patients are sexually related issues - relationships, sexuality or perhaps even abuse? Do we find ourselves keeping quiet, or blushing when asking the questions or, even worse, changing the subject? Why? Have we confronted these issues for ourselves? Have any of us ever analysed our own feelings, sexual experiences and fantasies? Are we aware of our barriers, rights and fears? Are we close enough with our body, our genitalia, and our emotions to raise this awareness? Can we talk about it, to protect both ourselves and others?

And will we be able to help or empathise with people of different cultures, sexual orientation, or background, if it is something we do not understand? How far will we go in respecting, blaming, or even judging others, deciding what is right and what is wrong? Will our ignorance, prejudices, and fears get in the way of educating and influencing the reproductive health of our patients, especially adolescents? „Where, now, are the text books and the simple patterns that we can learn, off by heart, and follow when dealing with these types of illnesses? Where do we start now, professor?“

This MSI opens up the subject of adolescents and reproductive health by offering you some questions and answers from around the world. Hopefully, it will make some of us become better doctors of tomorrow.



## Making mistakes

PRITPAL S TAMBER (fmd2pst5@novell4.bham.ac.uk), UK  
EDITOR

Her bra was difficult to take off. I had her trousers open, that was easy. The room was dark, the kisses were passionate. We fell over the furniture but just kept kissing, wetter and deeper, my hands feeling her body. I left the bra and took the rest of her clothes off. She removed mine, sometimes with her mouth. We lay down, stroked, caressed, and without a word, knew it was time - for sex. We rolled around, searching for the best position. It didn't take long. We weren't wasting any time.

It felt beautiful, heavenly.

But it changed. Her eyes widened, she looked angry and before I knew it she pushed me off.

I did not have a condom.

I know how easy it is to have unprotected sex and think you can get away with it. In the heat of the moment, the voice of desire can shout louder than the voice of logic or reason. And often desire shouts loudest when we are young and impulsive, experimenting with life. That is what makes this issue of Medical Student International so important. Jelena and I have done our best to make this a good publication, now it is your turn to do your best for adolescents and reproductive health.

# IFMSA and the United Nations system

BJORG THORSTEINSDOTTIR (president@ifmsa.org)

IFMSA PRESIDENT

*Ever wondered how IFMSA works with the United Nations?  
Bjorg Thorsteinsdottir explains how*

IFMSA, like the United Nations, was founded just after the second world war, with the same noble and idealistic vision to build a culture of peace in the world. The UN system is something every human pays into, in one way or another and it has all the potential to make a difference to the world. To some it is a ray of hope in the suffering of everyday life. The UN is constantly seeking ways to increase efficiency and achieve more with the work they do. Two recent changes have been aimed at refocusing the UN system. Firstly, it has recognised that Non Governmental Organizations (NGOs) are a valuable source of manpower and initiative. And secondly, it has increased emphasis on the participation of youth in policy making and projects. This helps to both prepare them for future leadership and recognise their value as peer councillors and motivators when reaching other young people.

IFMSA linked up with the UN at an early stage through a formal relationship with the WHO in 1969, then UNESCO and the Economic and Social Council, ECOSOC. Presently the relations with UNFPA, UNHCR and UNICEF are being formalised and IFMSA has taken on an active role in the World Youth Forum of the UN system.

The fact that IFMSA holds an official NGO status within the UN system is important for a number of reasons.

- It gives medical students a voice within the UN and ensures that IFMSA is included in global consultations. This way the message gets through to the global forum and the ministries and governments of member states. Participation in discussions is also an important training ground for future leadership as it increases awareness about global issues and gives a valuable experience in tackling difficult ethical questions.
- A formal NGO status gives access to UN expertise and builds a platform for joint projects and co-operation at all levels. The wealth of information gathered and distributed via the UN is of value for the development of IFMSA projects.
- The UN has many different funds for projects that IFMSA can apply for. Official recognition also opens other doors in the international forum giving access to different financial incentives.

IFMSA is a project oriented, student NGO and as such a valuable compliment to the work of international agencies. The fact that most of the global issues have to do with health promotion and disease prevention ensures IFMSA's continuing importance. IFMSA has all the potential to claim a leading role in youth action related to medicine and health.

The IFMSA has a role to play in building the future. The UN can help in this work by enabling IFMSA to participate actively to the discussions on medical education and by endorsing IFMSA to other players on the international field. A strong network of medical students, aware of global issues and responsive to the current questions is an invaluable asset for the medical profession in general and global health.

## UNFPA and IFMSA

There is now excellent collaboration between IFMSA and UNFPA at the Headquarters level. For example, the former IFMSA President and the present UNFPA/UNAIDS Liaison Officer were invited by the UNFPA Executive Director to participate in the 3rd Meeting of the NGO Advisory Committee which was held in New York last year to provide advice on how UNFPA could strengthen its relations with NGOs.

It is high time now to deepen relations at the country level. National medical students' associations which are interested to promote adolescent reproductive health may like to contact:

Mr. James Chui  
Manager, Youth Theme Group  
United Nations Population Fund (UNFPA)  
220 East 42nd Street  
New York  
NY 10017, USA  
Tel: (212) 297-5242  
Fax: (212) 297-4915  
e-mail: [chui@unfpa.org](mailto:chui@unfpa.org)

# News

## Drug abuse: a new issue for IFMSA?

THIAGO MONACO (lunesco@ifmsa.org) BRAZIL  
UNESCO LIAISON OFFICER 97/98

*Drug abuse is an increasing problem amongst the youth of the world. Thiago Monaco tells us why it is time for IFMSA to act*

Drug abuse is now a global problem, especially among young people. The abuse of drugs can lead to health problems, but this is often the end result of a more complicated process. Social, economic, and perhaps even moral declines can force individuals to abuse drugs, maybe as a means of escape from a life devoid of opportunities. There are also those for whom recreational drug abuse is a natural part of their culture. This is not a healthy situation for the youth of the world to grow up in.

We all know that preventative measures and education are important. But this no longer just about illnesses but also about the consequences of social (or dissocial) behaviour. For many communities, drug abuse has become a „normal“ activity—whether it be socially or individually based. However, the short term benefits of these drugs are counteracted by long term physical, psychological and potentially psychiatric problems.

Communication is central to education. However, most health programmes aimed at youth are created and run by doctors who speak in complicated medical terminology and may not understand today's youth

culture. Can you imagine a socially deprived, drug addicted youth feeling close to a middle aged, wealthy doctor? Is this effective communication? I know this is a generalisation, but it is often true. Medical students, however, are in the unique position in being both „youth“ and part of the medical profession. We are beginning to understand the human body and pharmacokinetics, but at the same time we see drug abuse around us in our age group. That means that we experience the issue from both sides—we understand it better than anybody else.

It is this „unique position“ that makes us invaluable to the campaign against drug abuse. By telling organisations, such as the United Nations, what we know, what we have experienced, and what we think is the best way to act, they can pass on the information to governments. This information can then be translated into national policy, and so it is as though the policy was formulated by the youth for the youth—the youth helping each other, as only they know how.

The United Nations recognised this and invited IFMSA to be part of the „International Young Meeting for a 21st Century Free of Drugs.“ Together with other youth NGOs from all over the world, we helped formulate a „Youth Charter for 21st Century Free of Drugs.“ This, however, is only the beginning. In June 1998, at the general assembly, the United Nations will discuss the issues further—especially with UNESCO, the United Nations International Drug Control Programme (UNDCP), and Environment Sans Frontiere. This should mark the beginning of the world wide campaign against drug abuse and IFMSA is invited to be involved. We have been asked for our opinions on drug abuse and young people—this is our opportunity to make use of our „unique position.“

Of course getting involved will mean proposal papers. Remember that students can get involved in a number of ways—writing the papers, being in contact with organisers and other NGO's, and, of course, being the fountain of ideas that will make such projects successful. We, as the future of health care delivery have to act now. So, if you have any suggestions on how we can help with the campaign against drug abuse, please contact me as soon as possible. Remember, the idea is to give to people what is ultimately the focus of our lives: health.



UNFPA / SHEHZAD NOORANI

*Social, economic, and perhaps even moral declines can force individuals, especially adolescents, to abuse drugs.*

# Surfing into the future of medicine

LJUBICA LATINOVIC (ljubica@EUnet.yu), YUGOSLAVIA  
 ALEJANDRO SOTO ROMERO (buanasoto@hotmail.com), MEXICO  
 WORKSHOP COORDINATORS

*Businesses are increasing efficiency and cutting costs with the help of new technologies, but the medical profession has a lot to learn. Ljubica and Alejandro begin to educate us after the workshop on new technologies and medical education*

After three workshops dedicated mainly to the inclusion of primary care and community care to the medical curriculum we realised the need to consider the role of new technologies in medicine. Having the patient's history on file, access to medical databases, visual teaching programmes, and MedNet are some of the many possibilities that lie in front of us. The question was, how can we, as students, make the best of them? The workshop gave us many of answers.

The workshop was held on 30th November to 6th December 1997 in Monterrey, Mexico. There were lectures on a variety of subjects including computer assisted teaching, research in medical education, technology and humanism, and the trends in how students used the new technologies available to them. There were also lectures on the role of the Internet in medicine, telemedicine and the use of multimedia medical education—arranged by a guest speaker from the faculty of medicine at the University of Valladolid, Spain. But what made this conference special was that participants were able to try some of the medical software programmes in the computer rooms. As well as this, all the lectures and presentations were given with the help of the latest audiovisual technology, making them all more interesting.

By far the highlight of the workshop was the demonstrative sessions where medical software was exhibited. For most of the participants it was their first chance to experience this "visual" way of learning and studying. We did plan to have thematic poster sessions but as there were only two posters presented—from Mexico and Yugoslavia—the remainder of the time scheduled for posters was spent "surfing" through medical homepages on the Internet.

In the focus groups we discussed the usefulness of the technologies and the topics presented during the workshop as well as the possibility and probability that these technologies would be implemented into our educational structure. The general opinion was that classical book-based studying remains common and that, although computers and other technology would be needed for the future practice of medicine, most medical schools and perhaps more importantly, teaching staff is still not prepared to give us adequate knowledge.

One of the really nice things about this Workshop is



IFMSA

*Technology in medicine is new for both medical students and the established doctors*

that even professors participated—not only as observers but as active members in the discussions. Perhaps this is because technology in medicine is new for both medical students and the established doctor. Their views were highly appreciated and gave us lot of new ideas to think about. It also helped us to remember that the student-professor relationship is essential for good education.

We were astonished to see how little we needed and yet how far we still have to go to update our medical curriculum to make it more useful for the doctors of the next century. However, if the workshop succeeded in changing the students' opinion of new technologies, and made them more open to new innovations, then it can only have been a complete success. Maybe it is not possible to ask our faculties to use the latest technological miracles in our education but the fact that innovations can be made available for everyone to try through a workshop like this can only be the beginning of something good. I hope we can make the best of what we learnt.

Some might say that the workshop was not that successful because there were only 50 participants. However, there were people from Iceland, Italy, Spain, Yugoslavia, Brazil, Venezuela, Colombia, South Africa as well as Mexico, and they did a great job to make this IFMSA event unforgettable. The success was also only possible due to the professionalism of the Medical Students Research Section (SINESP) of the faculty of medicine of the Autonomous University of Nuevo Leon, Mexico. To them we offer our thanks and to those that were not present we can only offer our commiserations.

# News

## IFMSA and human rights

JET DERWIG (Jet.Derwig@mail1.remote.uva.nl)  
PROJECTS COMMITTEE, THE NETHERLANDS

*Unfortunately doctors are sometimes willingly involved in the violation of human rights. Jet Derwig believes it is our collective responsibility to stop that happening again*

This summer saw the first IFMSA training workshop on Human Rights and Medicine. The enabled medical students to attain knowledge and skills needed to observe, document and report human rights violations. It also defined their responsibilities in practising medicine without violating human rights. The training aimed to create „human resources.“ This means that the participants would be able to pass on what they had learnt to medical students at their home universities through training workshops and by advocating the inclusion of human rights and health into their medical curricula.

Health promotion is a key role in the work of health professionals who therefore have an individual and collective responsibility to fight for the promotion of the prevention and early detection of human right violations. Medical professionals are often unaware of their potential in this area, largely due to a lack of skills or knowledge.

IFMSA, as a federation representing 600,000 medical students from over 50 countries, believes that knowledge of human rights and laws are essential. Since human rights education is not included in the medical curricula of most countries, we are dedicated to actively advocate the incorporation of these issues into the medical curricula,

and to initiate a series of extracurricular training programmes for medical students on human rights and health to respond to the current need.

Tables 1 and 2 contain information about the workshop including the demography of the participants and a guide to the topics covered, respectively. As well as lectures there were workshops and small group discussions. On the sixth day we moved to Mbarara University in the south west of Uganda, near Rwanda. While in Mbarara, we visited two refugee camps - Nakivale and Orukinga - known through the IFMSA Uganda refugee project. On the last days, we concluded with brainstorming sessions on possible future activities.

### The highlights of the workshop

Table 3 shows the outcomes of the workshop. Here I will discuss the main highlights of the ten days.

Khama Rogo's lecture was inspiring. He is the president of the Kenyan Medical Association and he told of the dreadful conditions in most of the African hospitals and introduced us to the right to health care and the role of the medical profession. He stressed the responsibility of the health profession; „It is the duty of future doctors to



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*We have to include ethics and human rights in the medical curriculum to prepare doctors sufficiently for their profession*

Table 1: Workshop information

Date:	23 August-1 September 1997
Location:	Uganda
Duration:	10 days
Total participants:	91 from 24 countries
They were from:	67 from Africa (Egypt, Ghana, Kenya, Rwanda, Sudan, Tanzania, Togo, Uganda, Zambia and Zimbabwe) 22 students from European countries (including Belarus, Turkey and the F.R. of Yugoslavia) 1 from Israel 1 from the Philippines
Male:Female:	61:30
Women:	14 European and 16 African
Law students:	7
Lecturers:	5-10 (including from ICRC, UNHCHR, PHR, Trauma centre, Swiss, Government).

# News

use the strength and power they have, due to their profession and prestige, to address the human rights issues. It is essential to spread out the issue of maltreatment, torture and absence of health care to the general public, which is not aware of the minimum standards they are expected to get. What we need in the future is...great commitment by medical doctors to work for these issues and constitutional review of leadership. Those who are willing to take risks and work for the profit of others should be in the leading positions. And finally, to start at the basis, we have to include ethics and human rights in the medical curriculum to prepare future doctors sufficiently for their profession."

Another highlight was the presence of five students from Rwanda. Their experiences of the massive violations of human rights, that recently happened in Rwanda were a valuable contribution. They reported the horrible violations that were executed with the full co-operation of medical professionals. Fortunately, they also told us that not all Rwandan health professionals violated the Hippocratic oath and the Geneva conventions, although they were often the ones that were in greater danger.

## The declarations

The two declarations made at the workshop are of great importance in our campaign for the prevention of human rights violations. The Uganda Declaration focuses

Table 2: Topics covered

- Human rights: including children and gender rights, the Universal Declaration of human rights, the role of the United Nations High Commission on Human Rights (UNHCHR), torture and prisoners and the role of medical professionals.
- Medical ethics: ethical codes and principles of health professionals, violations of ethical codes and dilemmas.
- International Humanitarian Law: Geneva conventions and the mandates of the International Committee of the Red Cross and Federation of Red Cross and Crescent Societies, changing conflicts and the role of NGOs (Medecins sans Frontieres, Amnesty International, Aide Humanitaire, Human Rights Field Operation).
- Human Rights Violations: experiences of NGOs (including the International Rehabilitation Centre for Torture Victims and the Trauma Centre), IGOs and UN agencies and experiences of individual physicians: sexual abuse, women beating, torture and disabled people.
- Refugees and Displaced Persons: refugee law, role of the United Nations High Commission of Refugees (UNHCR) and violations of these rights.

on the importance of human rights education in the medical curriculum and on the importance of health professionals never to co-operate in torture. The Right to Health Declaration will hopefully help us in the prevention of „brain drain“ and the improvement of quality health care services in Africa. Proposing a curriculum on human rights for inclusion into undergraduate training was one of the key achievements of the workshop. It answered one of the objectives the workshop was set out to achieve.

## The role of Africans

There is a definite need to build a society and culture that respects, protects and promotes the rights of its people. In this, there should be a role for African medical students. To this end, a Human Rights Union for Medical Action in Africa „HURUMA“ was founded („humura“ also means „mercy“ in Swahili). Its primary objectives would be to spearhead the struggle for this building process by mobilising medical students and doctors to define and participate in the role of promoting human rights observance in the continent. The network of doctors and students would stay in contact, improving involvement and mapping out grass-root strategies.

I would like to thank FAMSA, IPPNW, our sponsors, the participants, all resource persons and above all the entire organising team for putting together this workshop; Uganda was a perfect host. It was a fascinating experience. Although, we had some hard days, we learnt a lot and hope to pass on our knowledge to the organisers of the next workshop on human rights and health in Zimbabwe. I hope IFMSA in co-operation with HURUMA, FAMSA and IPPNW will continue to work for the promotion of human rights and health and will keep close relations with the Ugandan and other African medical students. Note that the final report will be ready and available in February 1998.

Table 3: The outcomes of the workshop

- 1 The Uganda Declaration of 1997
- 2 The Right to Health Declaration
- 3 The human rights curriculum for undergraduate medical education
- 4 The Human Rights Union for Medical Action in Africa - HURUMA
- 5 The International Human Rights network group within SCORP/ IFMSA
- 6 Projects - Refugee projects (Zambia and Kenya)
  - Prison project
  - Rwanda counselling and book aid project
- 7 Guidelines to assist victims of human rights violations
- 8 Case study material for future workshops

# Focus

## Sexual and reproductive health and medical student organizations

CHARLOTTE GARDINER ([gardiner@unfpa.org](mailto:gardiner@unfpa.org)) UNITED NATIONS POPULATION FUND  
SENIOR TECHNICAL OFFICER, TECHNICAL AND POLICY DIVISION

*Do you want to know what you can do, as a medical student, in reproductive health?  
Dr Charlotte Gardiner explains the current situation and the possible role of medical students*

The International Conference on Population and Development was held in Cairo in September 1994. It was a landmark conference for two reasons. Firstly, it served to unite a large variety of governments, non-governmental organizations and professionals concerned with sexual and reproductive health. Secondly, it acknowledged and underlined the link between population and developmental issues and stressed that national action is required in both of these spheres for optimum improvement in the quality of life—for individuals, couples and communities.

The Program of Action stipulates that the fundamental basis of programs in reproductive health should be the promotion of responsible exercise of reproductive rights for all people. This applies to all policies, whether they are supported by the government or the community.

### Gender Inequity

In 1993, estimates by the World Bank on Disability Adjusted Life Years (DALYS) showed that reproductive morbidity accounted for approximately 33% of female morbidity compared to approximately 13% of male morbidity across the life span. Even though DALYS are a crude measure of ill-health, this showed that there is a gender inequity in worldwide reproductive health status both in the short and long term.

Research has shown that adolescent girls are particularly vulnerable to gender based violence, most often perpetrated by family members. Also, and often in conditions of extreme poverty or during conflicts, there are violations of their right to voluntary sexual relations and little protection from forced prostitution. Furthermore, female genital mutilation (FGM) is commonly practiced in some African and Middle Eastern countries and this

constitutes an infringement on the rights of young people to bodily integrity and sexual health.

Gender roles for females and the low status of women in many countries have commonly prevented women from being able to protect themselves from reproductive ill-health effects due to attitudes that restrict their ability to negotiate safe sex.

### The role of medical students

For all these reasons, issues of reproductive health and reproductive rights naturally fall into the purview of medical students' associations. Medical students are part of the age group classified as „youth“ (10-24years) and encompass the age group classified as „adolescents“ (10-19yrs). They are often the group of people with the most information on this topic. Their status as future doctors affords them credibility that enables effective communication with the general public and their peer groups—this means better informing and, hence, educating. They are also able to advocate national policies and this may help to create an environment for the enjoyment of reproductive health for all. Furthermore, as medical students, they are poised to play a key role in the availability and accessibility of reproductive health services in the future.

Given that the concept of reproductive health is relatively new, one of the first tasks facing medical students' associations will be to ensure that the topic is given adequate attention during their training—both as undergraduates and postgraduates. It will be important to work with the medical faculty to define and to teach medical students the ways



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*Medical students are poised to play a key role in the availability and accessibility of reproductive health services in future.*

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in which reproductive health and well-being is undermined by harmful traditional practices, gender inequity and domestic violence.

## ...and of the medical curriculum

Teaching programs will need to emphasize the validity of a life span perspective on health; the extra vulnerability and reproductive health needs of adolescent girls; the role of men in promoting and maintaining reproductive health; and the centrality of family planning to reproductive health.

In particular the medical curriculum should ensure that reproductive health is seen as an essential component of primary health care systems. It should aim to include issues like family planning counselling, informing and educating; education and services for prenatal care, safe delivery and post-natal care, especially breastfeeding and infant and women's health care; prevention and appropriate treatment of infertility; prevention of abortion and the management of complications arising from abortion; treatment of reproductive tract infections; sexually transmitted diseases (including HIV/AIDS) and other reproductive health conditions; information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood.

Medical training should always include knowledge and skills for the development of referral systems for family planning services and further diagnosis and treatment for complications of pregnancy, delivery, abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, and sexually transmitted diseases, including HIV/AIDS. Active discouragement of harmful traditional practices, such as female genital mutilation (FGM), should also be an integral component of primary health care and the medical school curriculum.

Special attention should be given to the need for „youth friendly“ services that cater to the special needs of adolescents and unmarried young

people for information and clinical services, including contraceptives and HIV/AIDS prevention. Advocacy efforts should emphasise the key role that counselling plays for all population groups in order to promote voluntary, informed choice and medical students need to promote the development of curricula that lay particular emphasis on counselling skills.

Medical students' associations should be aware of these dimensions to reproductive health and advocate for their inclusion not only in basic medical training, but also in the basic

training of all relevant health care providers. These changes need not entail major additions or revisions of existing medical school curricula. Indeed most can be included in existing curricula. What is needed is the will to incorporate them in on-going training programmes and adequate training of members of medical faculties to ensure their implementation. Doing so will increase the quality of medical training in general whilst at the same time meeting the reproductive rights of individuals and couples for relevant information and services.

Terms used by the United Nations Population Fund and defined by the International Conference on Population and Development

### Reproductive health

„...is a state of physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

„Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice, for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

„In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

This concept of reproductive health has highlighted the underlying concept of reproductive rights. During the deliberations of the International Conference on Population and Development, the definition of what constituted a „reproductive right“ was hotly debated. Finally, it was concluded that „reproductive rights embrace certain rights that are already recognized in national laws, international human rights documents and other consensus documents.“

The Programme of Action goes on to say, „these rights rest on the recognition of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.“

The Programme of Action makes it clear that „in the exercise of this right, they (ie all couples and individuals) should take into account the needs of their living and future children and their responsibilities towards the community.“

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## What role can we as medical students play?

PATRICK OKELLO (pokello@uga.healthnet.org) UGANDA  
 CHAIRPERSON, HUMAN RIGHTS UNION FOR MEDICAL ACTION IN AFRICA (HURUMA)

*As medical students we can get stuck thinking of conferences, workshops, and projects, and it makes us forget what we are working for. Patrick Okello thinks it's time for a story*

„Julie is a 16 year old girl, the seventh in a family of 10. She is now in the third level of her secondary school education and her teachers say she is doing very well in class. Both parents are alive. Neither of them obtained any formal education and they practice subsistence farming. Julie's older siblings could only go as far as primary school in their education and for various reasons got married. Julie is now the shining star and hope of the family. A year ago she got into a relationship with one of the boys in her class and at one of the school parties after dancing and a couple of beers, that her boyfriend had stolen, he lured her into having sex. It is now five months later, and she has discovered that she is pregnant. The school authorities are greatly disappointed with her and have expelled her from school. She is crying her heart out! Her boyfriend Robert is scared and has run away from school too. Fearing to go home after the expulsion and with no one to turn to, Julie decides to go to one of her far away aunts. Her family is looking for her everywhere not knowing where she is While at her aunts she attempts to procure an abortion. Abortion is illegal in Uganda. A few days after the abortion she is taken very ill. Her aunt is a poor and sick old woman and is unable to take Julie to hos-

pital. One week later, she dies.“

How could you, as a medical student, have prevented all this happening?

I have been prompted to pen a few of my thoughts on reproductive health and adolescents because:

- For a long time in my country, Uganda, and in Africa in general there has been inadequate attention paid to reproductive health making discussions on the subject more relevant in our circumstances than anywhere else

- Adolescents are much more predisposed to ill effects of ignorance on reproductive health than anyone else.

For purposes of discussion I have highlighted some statistics on reproductive health as it is in Uganda in table 1 and table 2. The figures above shows the width of the gap that needs to be filled. This indicators per se point at the state of health services in Uganda.

Thus taking Uganda as a case study, you can see that the general access to health are limited. The fertility ratio is high in one of the poorest economies in the world. The education standard is very low and even worse for females. And at young ages girls, married or unmarried, have undergone reported abortions, aware that in Uganda abortion is illegal. There are no figures on abortion rates.

We can not leave the responsibility of improving this state of affairs to the government alone. We have to ask what we can do as medical students. We must, either individually or in our organisations like IFMSA, ask ourselves the big question; could we have played a role in saving Julie's story?

I think so. We are a very privileged group in society. We are young. We receive professional education and, moreover, are set to be part of a respected and noble profession. We are often seen as role models amongst our peers, a majority of whom, as in my country, may not have been to school. The opportunities for us to play an instrumental role to improve the state of reproductive health amongst our peers are immense.

We should spearhead the health education campaigns on reproductive health. More than anyone else medical students could be engaged in the peer education and counselling of adolescents on reproductive health. This could be through forming health clubs at village, town and national levels or designing programs targeting adolescents. We can promote reproductive health programs such as the making available and distribution of condoms and pills. All this will require the support of our medical schools, universities, local governments and international agencies like UNFPA. Julie's story could have been so different.

These are a few of my suggestions. I would like each and everyone to answer, for themselves, the question. How could you have helped Julie? Weren't Julie's rights trampled upon?

Table 1: Statistics about Uganda - health and schooling

- 27% of the population live within 5 kilometres of a health clinic
- 43% of the population live within 10 kilometres of health facility
- School enrolment 1990: 40% of those aged 6 - 24 years
- Of the general enrolment ratio: males 46.1% : females 35.3%

Table 2: Statistics about Uganda - marriage and childbirth

Age	Percent of total mothers 1991	
	Never married	Married
15 - 19	16.26	79.14
20 - 24	9.66	83.84
25 - 29	5.92	85.28

- Total fertility rate as per 1991 census 7.09
- Maternal mortality rate at Mulago Hospital Complex (the country's biggest referral and university teaching hospital) is 700 per 100,000 live births

# Traditional values versus infection control

MARIA GÜNZEL (mgunzel@zamnet.zm), IZUKANJI SIKAZWE (isikazwe@hotmail.com)  
SCHOOL OF MEDICINE, UNIVERSITY OF ZAMBIA, LUSAKA, ZAMBIA

*Cultural differences can make previously successful infection control measures woefully inadequate. Maria and Izukanji take us to Zambia, show us the problems and offer some solutions*

Our community based education took us to Mbaya Musuma in the Mazabuka district. There we decided to study the people's knowledge, attitude and practice in the field of sexually transmitted diseases. The results of our study encouraged us to look further into the relationship between culture and STDs.

## About Mazabuka

This district is in the southern province of Zambia. Half the population are between 0-14 years, and the rest are between 15-64 years, the majority of the latter group being women. Less than 5% are above the age 65 and the life expectancy is 44 years (UNICEF). The people are of a variety of origins, but the indigenous population are called the Tonga. They are mainly subsistence farmers and immigrant workers who have settled there and work on the commercial farms. And, finally, there are commercial farmers who are old colonialists.

This region has been going through a process of modernisation but this is somewhat in conflict with the traditional values of the local people. It has resulted in a steady breakdown of cultural, traditional and religious values leaving a moral vacuum for the young and old alike. The low socioeconomic status of these communities also has a strong bearing on their morals and way of life.

The Tongas were the first tribe to settle in Zambia. Their culture is male dominated and the woman's role in the society is to serve and facilitate the man's life. Girls are taught to be submissive to her husband to promote peace in the home. This means they



WHO / TONY WARD

*Tonga's culture is male dominated and the women's role in the society is to serve and facilitate the man's life. Their tradition allow polygamy.*

should not complain or give a cold shoulder to her husband as this may send him to other women. She is also taught to satisfy the man's sexual appetite at all times. However, it is estimated that 20-40% of the people in the reproductive age in Mazabuka district are HIV positive.

## Their knowledge, attitude and practice

In our study we hypothesised that the high incidence of STDs could be attributed to poor knowledge, attitude and practice. Previous studies have insisted that, despite their low level of education, the people had good knowledge about STDs. This is attributed to the extensive anti AIDS campaigns that the government and NGOs had performed. The media and health

centres also play an important role in distributing this information. The good attitude is thought to exist because the people have extended families and they are taught from an early age to look after each other and the community.

Good knowledge and attitudes, however, were not put into practice and this is confirmed by the high prevalence of STDs. Illnesses like AIDS have resulted in an increase in orphans who are then taken care of by families that are already large and can not bear the financial burden. We believe the poor practice is attributed to both the traditional culture—which is in conflict with the western culture and the prevailing low socioeconomic status. The factors that can account for the high incidence of STDs include:

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- Poverty
- Polygamy
- Dry sex
- Cleansing
- Religion

Some of the above are oppressive in that they serve to violate and distort a woman's dignity and worth in both obvious and subtle ways.

## Poverty

This is the main reason for the spread of HIV in the sub-Saharan Africa. The incidence of HIV is highest in girls less than 20 years and men between 30-40. Men below 20 years have a far lower incidence of infection and this suggests that young girls do not have sex with men their same age but with older men—so called „sugar daddies.“ Older men have young women (girls) and provide them with money and clothes in return for sexual services. They also believe it is safer to have sex with younger women (girls) because there is lesser probability that they will have HIV. The commercial farm workers, especially parents, recognise this as a major problem but do not know how to tackle it because of their poverty.

## Polygamy

The Tongas are patriarchal and their tradition allow polygamy. A man enters into marriage at an early age and acquires more wives with time. In the past it was important to have many wives and children to help cultivate the land (free labour) both for money and for a higher status in society. Initially polygamy served to prevent extramarital affairs. A man acquired a wife by first approaching the elders of the woman. They, together with respected members of his family, arranged the marriage. Proof of a woman's virginity was required in the form of bloodstained bed sheets which were shown to the elders who in some cases sat in on the first sexual contact between the couple.

The girls were also taught what it means to be a woman—to respect their elders, and husbands. Premarital sex was considered a taboo, and females were only allowed one sexual partner. These practices, if strictly adhered to, can prevent promiscuous behaviour and would minimise the spread of infections. Today, however, marriage is no longer arranged by the

elders and a man can take „wives“ who are not legally married to him and therefore she in turn is free to have affairs with other men.

## Dry Sex

The Tonga tradition, with its strong male dominance, has practices orientated toward male comfort and pleasure. One of these practices is dry sex. The vagina is dried of its natural secretions before or during sexual intercourse through use of herbs, pieces of cloths or cold water. This characteristic is considered to be desirable in a woman's body.

## Cleansing

This is a traditional ritual performed on a person who has lost a spouse or an unborn child. This is done to cleanse the affected person from evil spirits and spirit of the dead spouse or fetus. It is believed that if this is not done the surviving spouse or mother will have no peace from the gods and the person is cursed for life, and will be haunted by the dead persons spirit. Cleansing involves several procedures and the most dangerous, with respect to infections, is when, for example, a man dies, his brother, who may be married, has to have sexual intercourse with the widow, who may have an STD.

Traditionalists believe that when a woman has an abortion, spontaneous or induced, she has to undergo cleansing. If this is not done the spirit of the fetus will haunt the woman by giving all men she has sexual intercourse with the disease that we call AIDS. They also believe the disease can be cured by herbal and spiritual therapy, this gives a false picture because people might think that the condition is curable, and it is a stumbling block in the education of people. The traditionalists do not believe that AIDS is a new disease because they say it has always been there but not as prevalent as now. A good percentage of the people in this community believe in the traditional healers, who have a strong influence of people's behaviour.



UNFPA / SHEHZAD NOORANI

*People in this community believe in the traditional healers, who have a strong influence of people's behaviour.*

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## Religion

Religion inadvertently promotes the spread of infections by condemning condom use. Many churches focus on the weakness of condoms instead of discussing the advantages. Many religions emphasise abstinence but this is not a realistic solution for many people. A mission hospital that we were attached to only gave condoms to married women for family planning purposes. The men did not get condoms in case of promiscuity.

## Potential solutions

Preventing the further spread of infection requires a change in the practices and beliefs of the people. The knowledge the community has is clearly not being put into practice, and this can be due to the way that the misleading way the community is being informed about the disease.

Health promotion slogans are in conflict with the traditional measures of a man's worth—i.e. the number of wives and children he has. Condoms are also not used as the men believe they will both reduce the excitement of the sexual intercourse and also promote promiscuity among their women.

Traditional healers and community leaders are held in high esteem and their word is taken as the gospel truth. They should be targeted and educated about the disease and their traditional culture should be incorporated into campaigns to prevent the spread of infection. Ideally the socioeconomic status should also be improved so that women do not have to find „sugar daddies.“ This aspect is already being considered by the Zambian government which have embarked on an extensive restructuring of the economy. The emphasis of this programme, we believe, should be the improve-

ment of the standard of living for the people at grass root level.

Traditional marriage counsellors should also be involved in the anti-infection campaigns as these are the people who teach young girls to be submissive. This trend is now changing as girls are receiving sex education as well as boys. They are taught the dangers of having sex outside marriage, family planning and enjoyment of sex for both man and woman.

Women and girls should be educated and empowered with their rights. This is a sensitive topic, especially for those living in a traditional setting where they have learnt early in life to be submissive and that everything they do is for the man's comfort. The process of change must involve the traditional healers and community leaders by sensitising them to how some of their customs are oppressive toward the females.

# Family planning in Uganda

AGNES ANYAIT (agnes@uga.healthnet.org)  
MAKERERE UNIVERSITY, KAMPALA, UGANDA

*Agnes Anyait, and his colleagues, research women's knowledge, attitudes and practices on methods of family planning in a peri-urban area*

The population of Uganda according to the 1991 population census is 19 million, and is growing rapidly at a rate of 2.8%. The growth is due primarily to the high level of fertility in the country. Each woman has an average of 7 children but most families cannot look after this number of children as there may be little or no income for the parents and food and land scarcity in some parts of the country. The costs of living and education are also rising. The economy cannot provide essential services, such as health, as such infant mortality and maternal mortality are as high as 92 deaths per 1000 live births and 500 deaths per 100,000 live births respectively. Mothers continue to die due to conditions associated

with frequent and late pregnancies, short birth intervals and lack of support—financial or otherwise—due to large family size.

These problems could be minimised if use was made of family planning services and methods. Unfortunately only 5% of the population use family planning methods, according to the 1995 Demographic health survey (DHS). In view of all this there is a need to carry out further analytical studies to find out the various factors which contribute to this behaviour. Research has been carried out on these issues—some of which have been done in pilot areas in Uganda—by postgraduate and undergraduate medical students during their

community clerkships.

The information gathered will be used by the Family Planning Association of Uganda, the government, and concerned non-governmental organisations in Uganda. Their aim is to organise appropriate interventions to increase acceptance and use of family planning methods and decrease the high infant and maternal mortalities in Uganda.

It is hypothesised that low use of family planning may be related to:

- Background characteristics of the people such as age, sex, religion and customs, education levels, marital status.
- Service related factors such as lack of access to health services and

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facilities in terms of availability and affordability, and poor motivation of health care providers.

- Client related factors, traditional beliefs and value and pride customarily attached to children and large families.

## Our study

Twenty one undergraduate students, including myself, decided to study family planning services and community health diagnosis. We did this in Kasangati, a peri-urban establishment 14 kilometres north of Kampala city, served by a health centre (which is also a teaching centre for medical students doing community training) with a population of 30,000 people.

Two villages were chosen for the study. A questionnaire with both open and closed ended questions was administered to 60 heads of household in each of the villages. 74.2 % of the respondents were women. Some of the topics covered included:

- Marital status
- Religion
- Level of education
- Details on knowledge, availability and use of family planning methods.

## The results

57.5% of correspondents were married, 23.3% were single, and the rest were either widowed or separated. In terms of religion, 26.7% were Catholics, 54.2% were Protestants 54.2% and the rest were either Muslim or other denominations. 90.8% knew how to read and write. The rest of the results can be found in table 1.

These results did not reflect the state in the country overall. 90% of Ugandan population is rural and the further you are from the urban centre the less chance of access to information, health services and facilities. The setting of the research was in a peri-urban area, only 14km from Kampala city. Nationally, adult literacy levels are 46.1% for males and 35.3% for females. In terms of religion, 10-20%

Table 1: Family planning coverage

Method	Heard of it?	Used it?	Currently using it?
Pill	94.4%	50.0%	25.0%
Condom	96.0%	20.8%	12.5%
IUCD (coil)	87.8%	5.3%	0%
Injection(DMPA)	92.2%	34.0%	32.5%
Spermicides	52.2%	0%	0%

are Islamic, ~40% are Catholic and ~40% are Protestant. The total fertility rate is 7.2.

However, from the results of our survey, the family planning awareness correlated with the level of literacy, sex and the religious affiliations of the respondents. Most of the respondents had attained some education, female respondents being as high as 74.2%. Catholics, in accordance with their faith, did not use artificial methods of family planning.

Family planning awareness on condoms was high. This could be because of the high level of education on the usefulness of condoms in the protection against HIV/AIDS. Regrettably, though, their use was low. Knowledge and use of contraceptive pills was highest of all the methods. Least used was the spermicides and the intrauterine contraceptive device (IUCD/coil). Preference for pills and the injection (DMPA) was attributed to their ease of use and the fact that some women had to conceal these from their husbands who were opposed to contraception.

## What we learnt

From this study we learnt some of the myths and negative ideas towards family planning practices. These included:

- Clients were worried that they would become infertile or sterile.
- Condoms prevented full enjoyment of sex as there was no mixing of the partners secretions. Some one said, „it is like eating in its cover!“
- Condoms were seen by men as a sign of mistrust by their partners.
- Stories were circulating that a condom could get retained in a

woman, blow up and kill her.

- Condoms were a sign that a man had an STD.

- That condoms should only be used with prostitutes but not with one's own married wife.

- Use of condoms was believed to inhibit frequency of sex and „sexual rounds.“

- Spermicides were said to be messy.

A significant number of respondents blamed lack of use of family planning methods on lack of availability and their being expensive.

## Conclusions

Having considered the results of the study I think that:

- Medical students should be fully integrated into the primary health care system throughout their training and not only at the time of a community clerkship.

- Medical students could be used reach the wider community and age-groups, to disseminate information on family planning and to dispel misguided beliefs and provide services.

- As evidenced by our results, knowledge about family planning is not lacking. What remains is to design programs and campaigns to address the issue of acceptability of the methods and their use. Government and non-governmental organisations need to develop relevant programs.

- With greater improvement in educational level, hand in hand with the socio-economic improvements, acceptance of family planning will improve. It is imperative thus to address the issue of access to education of the masses and the eradication of poverty.

# The pregnancy project and sexuality

RÉGIS ERIC MAIA BARROS, HEVELINE BECKER DE MOURA, CÍCERO CLÁUDIO DIAS GOMES (boavista@ibeuce.com.br)  
UNIVERSIDADE FEDERAL DO CEARÁ, BRAZIL

*Don't sit in your faculties reading about health issues. Do what Régis, Heveline and Cícero did; go out and offer a new perspective for the adolescents of low income*

There is a high incidence of problems related to infantile-maternal health in Brazil. Faced with the need for preventative activities, students of medicine, monitored by teachers of the Universidade Federal do Ceará, created the „Pregnancy Project.“ It was designed to motivate prenatal programmes, family planning, the prevention of sexually transmitted diseases and provides information about issues such as sex in adolescence, pregnancy and delivery, as well as the harmful effects of tobacco, alcohol, and drugs.

The project used techniques such as role play and lectures to give information to adolescents of low income that attend public hospitals, public schools or groups of pregnant girls in the community. In 1997, the year the project began, it concluded that sexual education, both at schools and at homes, was inadequate amongst the adolescents analysed. This lack of instruction occurred mainly because parents had little knowledge, or because they felt ashamed to approach sex related themes. Some teachers also seemed unable to trans-

mit the information, even though they are aware of the lack of basic concepts of sexuality among adolescents.

Although the adolescents had a reasonable understanding of contraceptive methods, they did not use them correctly.

They avoided using condoms or the oral contraceptive pill as they were afraid of their parents' reaction. The contraceptive drugs that were used were obtained without medical prescriptions and this meant that often they were incorrectly administered. The marketing to promote condoms does not emphasise its contraceptive effect, but almost exclusively to prevent AIDS. The lack of information causes a high number of unplanned pregnancies and abortions.

Adolescents do not usually know their bodies and when the menarche occurs early, it is directly related with early sexual activity and poor sexual orientation, and so many unplanned pregnancies occur.



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*The techniques used in project are role play and lectures.*

nowadays. They associate only to the disruption of the hymen—that is, it is related to as an anatomical aspect. Therefore, other sexual practices (for instance, oral sex or anal sex) are not considered as loss of virginity.

Masturbation is considered by the majority of the adolescents as a natural practice, though many adolescents think that it should be avoided. Homosexuality is considered as an option in life, being relevant among adolescents of the masculine sex, the association of diseases to homosexuality.

## Continuity

The Pregnancy Project has achieved considerable success in minimising sexual difficulties in its target public. Just like the communities it works with, the Pregnancy Project needs to fight against the limits imposed by financial difficulties. One of its biggest worries is to continue this fight for preventive health before any of these factors hurts another adolescent for life.

Virginity is less relevant to the adolescents



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*Sexual education was inadequate amongst the adolescents*

# Focus

## Female genital mutilation and the student-run development project

LARS ALMROTH (lars\_almroth@hotmail.com), SWEDEN  
INTERNATIONAL CO-ORDINATOR OF THE SUDAN VILLAGE CONCEPT PROJECT

*Getting angry and screaming about the treatment of young girls is not always useful. In order to abolish it, perhaps we should try to understand it. Lars Almroth searches for its roots*

For those that do not know about female genital mutilation it is very difficult to understand why parents who love their daughters would let them undergo this procedure. It is easy to condemn the practice as the barbaric treatment of children (which it is) and to look at the parents, and the societies they live in, with loath and disgust. It is also easy to blame them for being ignorant and cruel, but this may not be the case. The key to abolishing female genital mutilation may be in understanding its practice from its sociocultural roots and to nourish the already existing doubts and resistance against the practice. This is what the Sudan Village Concept (see table 1) has tried to do in its programme against harmful traditional practices.

Female genital mutilation (FGM) is a painful fact of life for more than 120 million girls and women and another 2 million are at risk of genital mutilation every year (1). It is a traditional practice that today has become a public health issue because it potentially affects the physical and mental well being of every girl who undergoes the procedure. It is practised mainly in eastern and north-eastern parts of Africa, but, as table 2 shows, in many other regions too. The age at which FGM is performed varies between regions and ethnic groups. Most often it is performed on girls between 4 and 10 years of age, but sometimes on babies or in adolescence (1).



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*Many families believe that female genital mutilation is in their daughter's and family's best interest.*

### Why female circumcision is mutilation

The term „female circumcision“ is used to describe FGM, but this implies that the procedure ranks in the same category as male circumcision. This is not true from both medical and religious points of view. To circumcise a penis means to cut away the prepuce. In female circumcision there is also the cutting away of the clitoris, the labia minora and sometimes even the labia majora. Embryologically these parts correspond to the glans penis, the penis and scrotum in men. To cut away these parts is mutilation—and it should be named as such.

In Judaism and Islam, male circumcision is a procedure that is obligatory, but neither the Koran (2,3) nor the Bible mention any surgery of female genitalia. Prophet Mohammed mentioned some kind of genital mutilation of girls, but Muslims today interpret what he said in different ways. Some find support for FGM in Mohammed's sayings and thus call the procedure Sunna. However, neither Mohammed's wife nor his daughters underwent FGM (4). In Saudi Arabia—which is the locus of Islam—and many other Muslim societies FGM is not practised (5). Besides Muslims, FGM has also been reported to be performed by some Christian and Jewish groups in North East Africa (6).

### What is the mutilation procedure?

The World Health Organisation (WHO) recognises three degrees of severity of FGM (7) with the mildest concerning only the removal of the prepuce (the clitoral hood) and sometimes all or part of the clitoris. This is the procedure known as Sunna in the Islamic faith. But many Muslims do not agree with Sunna and so the term clitoridectomy is more accurate. In the most severe forms of FGM the clitoris is removed together with the labia minora and labia majora to create raw surfaces which are brought together, leaving only a very narrow opening. This covers the urethra and most of the vaginal opening. This form is called infibulation or, as in Sudan, pharaonic circumcision. The latter name hints to the origins of the practice and, in fact, ancient Egyptian mummies dating back to 200 BC have been found to have undergone FGM. (8)

Between these extremes there is a wide range of intermediate forms of FGM. It is important to remember that the terms described above can be subject to wide variations in their translations. Sometimes what people call „Sunna“ and „Intermediate“ can be as severe as infibulation.

# Focus



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*Education builds girls' self-esteem and enables them to take control of their reproductive lives.*

## Why is the mutilation performed?

The reasons for FGM are:

Religious (although neither the Koran nor the Bible mention it)

As a means of gender identity

Tradition

Hygiene

To increase fertility (9)

As evidence of virginity and dignity for a future husband (5)

Because of these reasons many families believe that FGM is in their daughter's and family's best interest. In most regions men may refuse to marry a woman who has not undergone FGM (1). This is then considered a poor reflection of the family.

## What are the health risks?

The operation is often performed by traditional midwives with unsterilised knives, razors or pieces of glass and without anaesthesia—thus it carries many risks (7). The immediate physical effects—acute infection, tetanus, bleeding, hypovolaemic and septic shock—can even cause death. Difficulties in micturition and urine retention are common immediate complications in Sudan (10).

There are many life-long physical and psychological debilities resulting from FGM, such as sterility, incontinence, depression, anxiety, psychosis and obstetric complications, with risks both for the mother and the infant (7). There is also a risk for recurrent urinary tract infections, chronic pelvic inflammations and menstrual difficulties (10). Under certain conditions FGM carries the risk of HIV infection (7).

It is important to remember the problems these women will have in their sexual life. Those who have undergone infibulation need to be „opened“ to allow penetration dur-

ing sexual intercourse, which will cause yet more suffering and potential complications (8). All forms of FGM will reduce sexual satisfaction because the external genitalia—the most sensitive parts—have been taken away.

## How is the Sudan Village Concept programme acting against FGM?

More than 90% of the women in northern Sudan have undergone some form of FGM (8). Infibulation is the main form (8). In the Village Concept area FGM was one of the major underlying causes for morbidity among women. The practice of FGM is a part of a complex psychosocial and cultural process which is very important to understand. However, one must not forget that FGM leads to profound impairment of women's potential for development as a result of trauma and chronic suffering (7). This makes it even more important for development projects to take action.

The Sudan Village Concept chose a co-operative strategy for the programme against FGM. The intention was to avoid the pitfall of getting into a „superior“ position by imposing our thoughts on them. Instead we chose to have

Table 1: What is the Sudan Village Concept Project?

- Sudan Village Concept 1994-97 was a student-run development project focusing on public health and prevention. There were three main principles: integration with the local community, inter-disciplinary cooperation and international involvement of students.

- The project was supported by Sida (Swedish International Development Authority), WHO and UNICEF.

- Sudanese and international students from different sectors (medicine, veterinary, agricultural and dentists) worked together in close co-operation with the villagers.

- In total, 37 students from 12 countries outside Sudan and more than the double that number of Sudanese students worked with the project. Many of the participants got credits for their participation in their studies at the home university.

- The Sudan Village Concept Project is an example that students with their pure social and professional interest are capable of guiding a local community to development and increased health.

- Village Concept projects are now running in several countries and regions and this concept of how to run a development project has been recognised as an official activity between IFMSA, IMISO (Intersectoral Meeting of International Students' Organisations) and WHO.

- The success of the first Sudan Village Concept has led to a second opening in central Sudan in May 97.

# Focus

discussions and arrange activities together with the villagers with the goal to reach a common conclusion. FGM was included in the programme against harmful traditional practices together with early weaning and intermarriage. Initially there were meetings with the women to find out their ideas and attitudes about these topics.

In the beginning of the project a workshop on harmful traditional practices for influential villagers and religious leaders was arranged. The Sudan National Committee on Traditional Practices (SNCTP) organised a three-day programme for the workshop. Ten midwives and about 30 people from the six project villages were invited. These were health-workers, teachers, representatives from the women union and the Imams.

The lectures seemed highly appreciated and there was a lot of discussion afterwards. All believed there is no support for FGM in the Koran. A committee was formed with representatives from all villages to follow up the work against harmful traditional practices.

During the workshop there were also evening activities so as to reach out to more villagers. There were discussions with small groups of women with representatives from the SNCTP and students.

## What did the local adolescents think about FGM?

During the workshop on harmful traditional practices there were lectures and discussions on these topics (mainly FGM) in girls' and boys' secondary schools in the area. A health visitor held the lectures, but Sudanese and international students also participated. The pupils were shy to ask questions, but they got round this by writing them down. In the girls' school one group filled out a questionnaire. The boys were more eager to discuss issues, which justified their inclusion in the programme. We learned that these topics are rarely discussed in the family or community, especially not among men.

## Understanding their attitudes and beginning the educative process

We interviewed 120 villagers to assess their knowledge and attitudes to FGM. They were made up of men and women of different age groups. At the request of the villagers, lectures were held for men and women after the interviews were completed. In these lectures we presented the results of our study and in that way the information was brought back to the villagers. The SNCTP helped us with posters, full scale models and video tapes, but the lectures were based mainly on what the villagers had told us during the interviews. It created an interesting overview of the present situation, the possible complications, and the motives for and against FGM as well as helping us to understand the attitudes towards women who have or have not undergone FGM. The Imam participated in the lectures to explain the religious point of view (they reiterated there was no religious support for FGM).

Table 2: Regions of the world where female genital mutilation (FGM) is practised (1)

Eastern Africa North-eastern Africa Western Africa Southern parts of the of the Arabian peninsula The Persian Gulf Migrant populations in Europe, North America and Australia
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The attendance at the lectures was high and we got a lot of positive feedback. We think this approach made it more interesting and relevant for the villagers and hopefully also had greater impact than any methods previously used. The results of the study will be presented and published later this year.

The original Sudan Village Concept Project finished in November 1997. Hopefully the project activities will continue as planned with the village health workers taking the responsibilities the project had before.

We have learned that FGM is a sensitive but important topic to work on. A change of attitude is the first step towards changing practise and finally abolishing FGM. We hope that the activities the project have initiated or strengthened that change. A follow up is planned to take place in a few years—hopefully we will see the changes then.

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# Academic League at São Paulo

FERNANDO JOSÉ AKIRA SAITO, (fsaito@sol.com.br)

COUNSELLOR OF THE ACADEMIC LEAGUE AGAINST SYPHILIS AND OTHER STDs  
MEDICAL COLLEGE OF SÃO PAULO UNIVERSITY, BRAZIL

*Clinical experience is essential to be a good doctor, but often there are few opportunities. Fernando José Akira Saito shows us how some students can help both themselves and the community*

At the medical college at São Paulo University, medical students are involved in a public service for the treatment of sexually transmitted diseases. It began in 1920 and remains a popular activity among medical students (see table 1). Every year the new students enjoy working in the service, and here I aim to present how it operates, perhaps as a model for future projects elsewhere.

The Academic Leagues (AL's) are a non governmental organisation (NGO) linked to the Academic Centre Oswaldo Cruz and formed by students from different years at medical school. The League is also linked to one of the medical departments of the university, depending on its activity. Each Academic League is dedicated to a single speciality, with independence and management autonomy.

At present there are 27 Academic Leagues including ones in paediatrics, heart transplantation, hepatology, rheumatic fever, and diabetes mellitus to name a few. Medical students are specifically educated for the AL's, and those that achieve the best grades are allowed to participate in the pro-

gramme—they are called „academics“ and from now on we shall refer to them as this. The role played by the AL's is based on a triad of activities.

### Medical attendance to the community

The AL is given a fully equipped room at the General Hospital of São Paulo. Each patient receives individual attention from an academic that plays the role of the physician. The academic must be able to perform the anamnesis, the physical examination and achieves a diagnostic hypothesis. The academic then discusses the patient case with a tutor/doctor and together they perform all the necessary tests.

### Scientific research

The medical department also performs research in the subjects of the AL and academics are invited to take part. In this way they learn of the importance of medical publishing and furthering medical knowledge, and may even coauthor articles written by the department.

### Teaching

This is the major role played by the AL. In this way the academics learn how to teach others effectively, which requires them to understand their subject thoroughly and to improve their communication skills. It is hypothesised that this structure helps to form more experi-



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First year student: application of intramuscular injection for penicillin-based treatments.

enced, confident, and communicative physicians. A more detailed description of the course is in table 2.

### A brief history of the Academic League

The Academic League against syphilis and STDs (ALS/STDs) was the first AL at the university and began in 1920. At that time syphilis was a major health issue and was even called the „great plague.“ Syphilis killed thousands of people until 1945 when penicillin was introduced into its treatment. The changes in health care meant that the ALS/STDs had to adopt different approaches. As the patients with syphilis decreased, other diseases were focused on, and in the 1960s the ALS/STDs diversified to include other diseases (see table 3). Even though the ALS/STDs can only accommodate a small number of students, it has produced some of the foremost physi-



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Those that achieve the best grades are allowed to participate in the programme of the league.

# Focus

cians dealing with sexually transmitted diseases.

## Conclusion

For many years the Academic League has been a positive experience for the medical students at medical college of São Paulo University, Brazil. Not only do medical students further their knowledge and clinical experience they also learn to teach others and to pass their experiences on to fellow students. Even if the academic does not follow a career in that speciality, they will have gained an invaluable amount of experience that will always be useful.

Patients also benefit because the ALs mean they have access to over 20 trained and well supervised members of



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First year student: venous puncture for serological tests of syphilis.

the medical profession. Without this service they would have had to both pay and wait for their health care. There is also the benefit that the academics are young students, and this may be less inhibiting to younger patients with sexually transmitted diseases as they will be better understood and perhaps more openly and more practically advised.

Although the medical profession continues to successfully fight many diseases, there are still numerous conditions that need a lot of attention. And so, while some ALs may become less and less necessary, others will be needed, ensuring the future of this enterprising and innovative scheme at our university.

Table 1: Some facts about the ALS/STDs

- Location: General Hospital of Medical College of the University of São Paulo, Brazil
- Association: with the Department of Dermatology of the University of São Paulo
- Functioning period: Mondays and Wednesday; 16.00 to 20.00
- Community attendance: 2.000 patients annually
- Common STDs: syphilis, urethritis, cervicitis, vulvovaginitis, HPV-infection, genital herpes and chancroide;

Table 2: How the ALS/STDs operate

- Admission: the candidate must be a first year academic of our medical college. He/She must take part in the annual course of STDs. The top 24 candidates are accepted.
- Activities: the students are trained in all steps of the clinical management in STDs according to his/her year at medical school.

### Role of first year students

- Venous puncture for serological tests of syphilis
- Application of intramuscular injections for penicillin-based treatments
- Control and application of podophillin for HPV infected patients
- Preparation of clinical specimens for laboratory assays
- Introduction about the theory of STDs and their major clinical aspects

### Role of second year students

- Tutors of the first year students
- Handling minor administrative services of the league
- Introduction to the propedeutical and clinical aspects of STDs
- Initial training for correct management of patients presenting STDs

### Role of third year students

- Tutors of the second year students
- Direct attendance to the ambulatory's patients
- Major administration services of the league including organisation of research projects, lectures, seminars, prevention strategies and condom distribution

After three years of participation, the student might withdraw from the ALS/STDs. If the student decides to stay in the league he/she will be able to choose which activities to participate in such as helping the third year coor-

Table 3: ALS/STDs activities with HIV/AIDS

- Serologic counselling before and after the test
- Screening of HIV seropositive patients in the clinic
- Introduction in the clinical handling of HIV-seropositive patients and visits to the „AIDS Home,“ one of the major services for people living with HIV/AIDS in Latin America
- Annual course about AIDS aimed at all health care workers
- Lectures in other colleges, schools
- Distribution and education for the use of condoms
- Health education about STDs and AIDS

# SCOAS: fighting for reproductive health

MARIA RYDEVIK (scoasd@ifmsa.org)  
SCOAS DIRECTOR, SWEDEN

*Sex related issues can be difficult and awkward to approach. Maria Rydevik explains why it is a sensitive but important matter*

There are many reasons for the difficulties encountered when trying to achieve good reproductive health for all. Social taboos, cultures constraints and religion influence reproductive behaviour. In addition, practical aspects like the availability of contraceptives, medical care and support are often more decisive than good intentions.

As doctors of tomorrow we attempt to educate ourselves both to become better doctors and to behave more responsibly in matters concerned with reproductive health. However, perhaps more important than our attempts at self improvement are the many projects run by medical students all over the world aimed at reproductive health for all. Examples of such activities are given throughout this special issue of MSI (see contents page). One example of these groups is the Standing Committee on AIDS and STD's (SCOAS) that has been active since 1993 (the aims of SCOAS are in table 1). Today the activities within the committee are growing quickly. While there are several projects established all over the world, new ones are constantly being introduced. This article is a short overview of the ongoing projects of SCOAS, together with our aims.

There will always be a psychological component to ill health. Irrespective of how effective the treatment is, there will always be areas where help can not reach and where the person's environment makes life a struggle. Even when there is effective treatment, where there seems to be help, many diseases are related to feelings of anxiety and perhaps even

guilt. These feelings are stronger if the disease is associated with taboos—behaviour that is considered to be „bad“, perhaps due to issues of sexuality. As many of the reproductive health diseases are considered to be within this group of „bad“ diseases, it is often twice as difficult to work for good reproductive health. When a situation is sensitive it becomes increasingly difficult for the affected and his/her relatives, as well as for the health practitioner, to handle the situation. On both sides of the doctor-patient relationship individuals poten-

tially have to deal with fear, anger, prejudices, disgust, sorrow and uncertainty.

It is a harsh environment in which to work but we can prepare by self-educating as well as by working with our natural feelings rather than trying to hide them. In this way we will probably be able to handle the situations to come in a better, and more productive, way—by considering both the patient and the carer. We can also work on prevention where we, through educating and motivating actions, can try to stop the harsh envi-

Table 1 The aims of the Standing Committee on AIDS and STD's (SCOAS)

## Working internally

- Increase knowledge and awareness of reproductive health and rights among medical students, through changes of the medical curriculum, workshops, summer schools and international exchanges programmes
- Provide medical students with the knowledge, skills and motivation to talk to and educate their peers and patients on reproductive health, including HIV/AIDS
- Raise awareness of future doctors concerning safety procedures within the health care system, in order to decrease the risk of transmission of HIV, thus diminishing discrimination among medical workers towards people living with HIV/AIDS
- Increase the sensitivity and understanding of medical students as future doctors, in order to improve the doctor-patient relationship
- Prepare the medical students for possible psychological stress from working with, for example, people living with HIV/AIDS, those discriminated against, end stage patients, and the sexually abused

## Working globally

- Through open discussion, to benefit from the experiences of other nations and cultures, and to implement this knowledge on a local level with a view to holistic reproductive health for all—including psychological, biological, supportive and preventative aspects of the infection
- Establishing projects on a national level, including preventative projects as well as supportive actions for people living with HIV/AIDS

# Focus

ronment developing. Thus, by preventing the spread of a disease, less people will suffer. In fact it is a simple equation. And perhaps this is the most important way by which we can act—by influencing our peers towards healthy behaviour.

A good way of working is to look within ourselves, to identify the difficulties among ourselves. If we understand ourselves we can work towards others with our feeling as guidance. We have to accept our responsibility and help others to accept their responsibilities. Thus we have to teach, motivate and engage for people to act in a responsible way.

## Projects within SCOAS

- Knowledge, attitude and practice (KAP) studies: In order to change health related behaviour we must first understand what people know (knowledge), what their feelings are towards health issues (attitudes) and how they behave in day to day life (practice).

One of the recent KAP studies in SCOAS dealt with pregnancy rates in high institutions of learning in Uganda. These studies are ongoing and continue to further our knowledge and help us to channel our efforts.

- World AIDS Day project: This is every year on December 1st. For the last four years SCOAS has encouraged a great variety of activities engaging medical students in accordance to the WHO and UN aims with respect to HIV/AIDS.

- International Summer School STOP AIDS: Every year SCOAS organises a two week workshop open to all students to discuss issues surrounding HIV/AIDS. It equips participants with the skills and knowledge required to understand and adapt their own attitudes, to learn about different population groups potentially affected by the disease—including youth, sex workers, and drug abusers—and to begin to empathise with people living with HIV/AIDS. The ultimate aim of the

school is for participants to be able to teach their peers about HIV/AIDS. The 1998 summer school will be in Slovenia.

- SCOAS elective: This is an international exchange programme for medical students. It offers participants the chance to understand HIV/AIDS—in the context of another country and culture—as a disease that affects many areas of an individual's well being, as well as that of the society they live in.

- Kawempe community health project: This is a combined project of SCOAS and Standing Committee on Public Health (SCOPH). It is an interdisciplinary project that covers issues like improving water supply and sanitation, maternal and child health, and HIV/AIDS prevention.

- Kenyan youth clubs: The principle is to get to the youth through activities that interest them, such as sport, music, art or interactive games. Once we have their interest and attention, we can teach them about HIV/AIDS.

## Searching for better AIDS education

KATHY FALKENSTEIN (kathy.falkenstein@lrz.uni-muenchen.de)  
INTERNATIONAL SCOAS ELECTIVE COORDINATOR, GERMANY

*All too often our medical curricula can not prepare us for reality. When it comes to the holistic approach to HIV/AIDS perhaps SCOAS can offer some answers*

The education we get from our medical curricula on HIV/AIDS does not always equip us with the knowledge and skills needed to deal with people affected by the disease. It often approaches AIDS through its clinical manifestations, neglecting the importance of its psychological, social, and economic implications. The disadvantage of our education is usually just a lack of time and practice. But HIV/AIDS affects people from a number of socially distinct groups including youths, parents, teachers, health workers, sex workers, homosexuals,

and drug abusers. By introducing HIV/AIDS through preventative work with these groups and through counselling, medical care, research and social work, medical students get a better understanding of the disease and learn both when and how to give appropriate help and support.

A SCOAS elective is an international exchange programme for medical students. It offers participants the chance to understand HIV/AIDS—in the context of another country and culture—as a disease that affects many areas of an individual's well

being, as well as that of the society they live in. The 4-6 weeks programme includes participants' activities in HIV/AIDS research, preventive programmes, and medical as well as social care of people living with HIV/AIDS (PLWA). It gives the student the chance to learn and experience the opportunities, problems, and day to day life of those affected by HIV/AIDS in another country and culture. But SCOAS electives do not only give individual education. The international flow of people, and hence knowledge, means that new ideas can

# Focus

be passed on to other countries, perhaps resulting in changes in medical curricula or organising extra-curricula educational programmes for medical students and other members of society.

You can participate in one of the current SCOAS electives on HIV/AIDS—at present it is offered in Mexico, Brazil, Romania and Germany. Alternatively, you can organise this kind of project in your home country. It may sound like hard work but among the many advantages in organising a SCOAS elective, you will become familiar with the structures of care offered to those affected by HIV/AIDS.

Ask your professors and/or doctors specialising in HIV/AIDS to offer

placements on wards or in private clinics. When you have confirmed the number of placements available you can start to arrange an accompanying programme. Excursions to facilities like counselling centres, cafes and drama groups run by PLWA, if available, can be a complementary part of the schedule. My experience was that the people we asked show interest and joined the program with creative suggestions and contributions. They offer lectures and visits to their departments, such as laboratories, and may provide rooms and information. To get a better idea of what is involved, have a look at the two examples included in tables 1 and 2. And if you have any questions, I am waiting for your emails.



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*SCOAS elective is an international exchange program for medical students.*

Table 1: SCOAS elective in Mexico

### Programme

- Immunology: To participate in laboratory techniques, be able to do the morphological and immunologic diagnosis of opportunistic diseases, diagnose cryptosporidium, cyclospora and nocardia, and discuss scientific literature related to AIDS
- Public Health and GIPSIDA (Group for investigation and prevention of AIDS): To educate the community, manage patients, understand local and national AIDS epidemiological data, work together with organisations to help AIDS patients, participate in AIDS prevention programmes, meeting other NGO's and using the media to disseminate information
- Infectology: To participate in clinical activities, discuss scientific literature, and to collaborate with the different tutors of the specialties concerned in the illness
- Psychiatry: To discuss literature related to AIDS and psychiatric disorders, collaborate with tutors about psychiatric disorders of patient with AIDS, and visit patients with AIDS in infectology department who present psychiatric condition

### General information

- Requirements: Finishing all basic areas of medicine, to have basic knowledge of immunology, immunopathology and interest in the community area.
- Language: Spanish and English
- Duration: 4-6 weeks
- Location: Monterrey, Nuevo Leon, Mexico

Table 2: SCOAS elective in Germany

### Programme

- health care management and psychosocial counselling of patients
- clinical picture of AIDS patients
- new ways of prevention and therapy of HIV and AIDS
- methods of health education
- risk groups and epidemiology
- social and legal implications
- scientific knowledge of HIV/AIDS

### Methodology:

- 4-6 week clerkship on a HIV ward during the morning (weekly rotations possible)
- accompanying program in the afternoons
  - lectures from various areas (ie pharmacology, prevention, law)
  - workshops to learn educative skills
  - visitation of departments (ie dermatology, ophthalmology, gynecology)
  - case discussions
  - anamnestic explorations
  - self studying in libraries, internet, etc

### General information

- Requirements: medical students of pre- and clinical semester can apply. International and non-Munich students should give a report of the situation of HIV/AIDS in their home country/town upon arrival.
- Location : Munich and Hanover
- Language: should be able to speak German

# Focus

## Together we can help

JELENA ZAJEGANOVIC (scoas@EUnet.yu), YUGOSLAVIA  
UNFPA/UNAIDS LIAISON OFFICER

*It can be difficult to talk about sexual issues, especially if the listener is just too different from yourself. Jelena Zajeganovic explains how youth can help youth*

Being young and living happily shouldn't be a problem these days. Information on everything can be found anywhere. We can find out what is good and what is bad, what is considered right and what is wrong. In terms of reproductive health, we can find out what is HIV/AIDS, how it is transmitted, what a condom is and how it should be used. Why, then, is it so difficult to protect ourselves?

Simply promoting a healthy lifestyle is not enough. Changing someone's attitude and behaviour demands an approach that will make them understand and feel comfortable with that change. This is exemplified by an old Chinese proverb:

„Tell me ... I'll forget,  
show me ... I'll remember,  
involve me ... I'll understand.“

It shows what is crucial for truly effective education.

Who would you tell about your first sexual experience—your parents, your teachers, a physician or your friend? Family life and school channel our lives but during puberty and in our youth they are usually too „conservative“ for what we feel. We look at our brothers and sisters, our older friends and we try to grow up as fast as possible. Often, however, we are then faced with questions that we either cannot answer, or are too embarrassed to ask. Some how, at times like that, there seem to be no books to help us and soon our sexual behaviour becomes intuitive and established. When that happens, it is difficult to change.

### How youth can teach youth

International summer school STOP AIDS (ISSA) is in its fourth year. It is a two week workshop that gathers stu-

dents from all over the world to exchange experiences, learn and clarify their role in preventing the spread of HIV infection. In its friendly and relaxed atmosphere, the students are encouraged to talk openly about HIV and „risky behaviour“, and can help themselves and each other to overcome their misconceptions and prejudices towards the infection and the people living with HIV/AIDS (PLWA). All this is achieved through lectures, discussions, modern teaching methods, interactive games, and even through socialising. The students are trained to become youth leaders in their communities. The aim is that they will return to their countries as peer educators, capable of teaching about healthier sexual behaviour. To meet this aim, they are also taught skills in project planning, managing and leadership.


Amongst the educators, and one of the most powerful parts of the programme, are people living with HIV/AIDS (PLWA). Their lives and struggles against discrimination and fear, and their passion in trying to stop others getting infected, gives participants an experience they will never forget. It helps them to understand and accept HIV/AIDS as part of their lives, and helps them confront their own behaviour.

The programme has participants from different professions and this helps to create an approach that is broad and not simply focused on the medical aspects. It helps medical students understand the

variety of problem faced by the patients.


In the last three years the school has educated more than 150 students, creating large network of peer educators all over the world. In many countries students have already started similar programs and are educating their peers to live healthy and responsible sexual lives, as well as to help them understand HIV/AIDS and support those affected by it.

## THE CONDOM




Modern condoms-sheats, johnnies, rubbers-are...

### STRONG...




### ...SENSITIVE



a good condom can keep out the AIDS virus (and herpes and other sorts of VD) as well as sperms.  
But only if it's used all through sex and doesn't get damaged!  
The AIDS virus can get right into your bloodstream through any bits of your skin that are soft and moist-or cut or sore. And sperms can swim a long way to start a baby.

### SAFE...



### ...AND SIMPLE

Putting it on can be part of the fun-especially if your partner puts it on for you. But take care-sharp and bitten fingernails can tear the condom!

Hold the tip of the condom between finger and thumb to remove any air and unroll the rest all the way down the hardened penis.

Hold the condom on when you pull out-so nothing is spilt.

# The SCOAS declaration of human rights, ethics and law

JIM AISIRE (qxjimoh@uga.healthnet.org), UGANDA

KATHY FALKENSTEIN (kathy.falkenstein@lrz.uni-muenchen.de), GERMANY

MODIFICATIONS: FERNANDO SAITO, MARIA RYDEVIK

*In August 1997, at the human rights workshop in Uganda, the people of SCOAS drafted a declaration on human rights and HIV/AIDS. It was described as a „stepping stone for the committee's future plans“*

For the protection of human dignity and for effective prevention and care programmes, human rights and ethical principles must form an integral part of the response of the HIV/AIDS epidemic.

In the context of HIV/AIDS there is no conflict between individual rights and public health. In fact, experience has shown that respect for human rights is necessary to protect public health and implement the global AIDS strategy. Coercive and punitive measures such as mandatory HIV testing, detention, and a lack of confidentiality are counterproductive and impede efforts to prevent infection and provide care.

The following rights and principles are essential:

- The right to life; non discrimination; freedom from inhuman or degrading treatment; liberty; privacy including confidentiality; education; work; social security; health care; adequate standard of living; freedom of movement;
- The right to seek and enjoy asylum; the principles of tolerance, compassion, solidarity, empowerment and engagement.

## Key elements

- All should have access to information, education, health services and preventative measures that will enable them to reduce transmission of infection and receive counselling and care. If the individual is infected, particular measures should be taken to ensure access for vulnerable groups such as women, children, minorities, migrants, refugees, the poor, the disadvantaged, men having sex with men, sex workers, and injecting drug users.

- Testing for HIV should be done on a voluntary basis after the individual has been informed of the nature and the implications of the test and has consented. Consideration should be given to those legally not competent to give consent such as minors and the mentally disabled. Informed consent should also be provided for participation in HIV related treatment and research.

- Confidentiality of HIV status should be ensured at all times including during testing, treatment, notification, employment and in the health care setting. Any disclosure should be strictly justified on the basis of law and professional ethics.

- There should be no discrimination or restriction of rights because of HIV status or suspicion of HIV status. People living with AIDS (PLWA) should have equal access to education, travel, employment, housing, health care and social benefits. Mandatory testing or disclosure of status should not be required to gain access to the above.

- People living with AIDS (PLWA) should not be denied liberty or freedom of movement by arrest, detention, isolation, quarantine, compulsory hospitalisation, segregation or exile, except as justly imposed by law. Travel restrictions which discriminate solely on the basis of HIV status have no public health justification and therefore violate human rights.

- Premarital and prenatal HIV testing should be voluntary and based on informed consent. There should be no restriction to marriage because of HIV status. Women should be advised of the risk of perinatal transmission and means to avoid such. Women of reproductive age living with HIV/AIDS should be informed of the maternal depletion syndrome—for instance, following subsequent pregnancies. If pregnant, she should have equal access to assistance during pregnancy and during and after delivery. There should be no coerced abortions and involuntary sterilisation's due to HIV status.

- People over whom power is exercised through tradition, custom, poverty or criminal organisations should be empowered so as to be able to protect themselves from infection. Such groups include women in economic and sexual subordination; men, women and children in the sex trade, illegal immigrants, and disenfranchised groups.

# Focus

## Effective warriors against AIDS?

CHANAKYA JONNALAGADDA (jnncha02@mediclib.uct.ac.za), SOUTH AFRICA  
SOUTH AFRICAN MEDICAL STUDENTS' ASSOCIATION (SAMSA)

*It is difficult to educate when you are a world apart from your potential pupils.  
Chanakya Jonnalagadda starts to build the bridge*

The notice in the shop-window read, „Die of AIDS if you want to, but do not die of ignorance.“ I thought to myself, „Yes, it is a waste that so many people are dying of a disease that is so easy to prevent. All I have to do is tell a few people about the dangers and how it is spread and I can be sure they will not get this dreaded disease.“ But is that the truth? I wish I could say it was.

AIDS is Acquired Immuno-deficiency Syndrome, caused by HIV, a virus that is spread by contact of bodily fluids. An infected person has a life expectancy from 2 to 20 years. That is what a doctor would say. To a man on the street of a third world country, AIDS is anything from a curse of an enemy to punishment from God—for sleeping around or for being gay. It leaves one with a death sentence preceded by a life of stigma.

### Our world, their world—a bridge

Doctors cannot assume that their patients share similar world-views. For example, many people in rural Africa do not believe that disease is caused by a microorganism. A didactic lecture on immunosuppression or the role of body fluids would have no effect on them. It would not fit into their understanding of the world and they would simply reject it. Even in less extreme cases, the doctor would still need to convince his audience to accept his or her viewpoint.

Excuse the lack of a better term but the doctor has to be a „salesperson.“ The doctor has to sell his concept on how AIDS is spread. To do this, he or she has to begin by selling it to himself. A man would not buy a car from a shady (untrustworthy) dealer. He is even less likely to buy a revolutionary

sex-related concept from an authoritarian or confused doctor. The doctor has to first win the man or woman's trust and respect. He or she has to look honest, with the patient's interests at heart; has to know well what he or she is talking about; and has to be able to express it in words that the audience can understand. This requires the doctor to understand the person's view of the world.

As a doctor, one would need to know why a person behaved in a certain way. Why does Stacey, the teenage prostitute, still continue to work the streets at night when she knows she can get infected with HIV? Ask her! Listen to what she says. What you feel about the subject should not matter. If you want to help Stacey, you have to help her on her terms. Find out her needs, her views, her fears. From there, see how you can provide her with information so that she can make the right decision. Forcing a view on her would make her resent you, not believe you.

### Taboo, but for who?

Sex is a very sensitive issue. In many societies, talking about sex is taboo. In all societies, criticism about one's sexual behaviour is taken personally. However, in every place, a way still has been found to effectively discuss the issue. It is every doctor's responsibility to find out how—either from organisations or from people in the area, or both. It is often important to work with these organisations and people. Unfortunately, appallingly few doctors actually do this.

We have obstetricians, paediatricians and geriatricians. Why don't we have „teenage-atricians“? With the number of problems so highly concentrated in this population, especially sex-related, I am surprised that we do not. They may not have many diseases exclusive to their age group but they do, however, have many behaviour traits that make them more susceptible to certain diseases. It may seem that they do not want to listen. Indeed, many a doctor may have tried to be



Interactive approach in education - Workshop „HIV/AIDS & cultural issues“, Cape Town, South Africa

# Focus

„cool“ to make an impression, so as to influence their behaviour. Some may just have given up. There is no fool-proof method to success but there are suggestions. How about teaching „life skills“ as a whole, in contrast to just reproductive health education, so that they can see it as part of the greater picture? Working with their role models also seems effective. Talking as a teenager, I also think that it is important that we be given a chance to talk. Discussion groups and question time are an integral part of any educational exercise. What is important is to leave the communication channels open.

## Sharing the future

AIDS kills. No one wants to die. Be sensitive about how the results are delivered. An HIV positive person still has a life ahead of them. There are many infected people who have been giving the world long years of dedicated service. They are both as ordinary and diverse as the people around them. They might die a couple of years into the future but my plea to you is that you offer them your support, as friends and as well wishers. Research shows that HIV+ people with support live longer and die happier. That must be the decent way for any human being.

All this information and yet it is still but a summary of the discussions held at the last IFMSA workshop on AIDS and cultural perspectives. All the participants would recommend that the most effective way of gaining knowledge is by listening and understanding. It allows one to learn a lot in a short space of time. And it is interactive. Whenever you get a chance to participate, give it a shot. The rest of us medical students are always here to support you in your learning, to help you become a noble warrior in this war.

Thank you for WHO, UNFPA, IFMSA and all the other bodies with their great work that have made it possible to work with so many other people to combat this immediate threat called AIDS.



IFMSA

*One can learn while having fun - Workshop „HIV/AIDS & cultural issues“, Cape Town, South Africa*

### More stories from the workshop

- At one point, a coffin was brought into the room. The room seemed in a state of shock, with everyone's heart heavy. They seemed to be staring death in the face. Everyone left that session with a clearer idea about how they, themselves, saw the process of dying of their patients.

- In another session, all the participants got in touch with their teenage feeling and tackled the issue of how to effectively communicate with the youth by self-assessment.

- And we met the inspiring Suzie. Suzie is a twenty-something year old mother who had contracted AIDS from her husband. She was very weak and fragile but though this elderly body, shone a will of iron and compassion that one cannot describe. She was on a mission to educate people about this disease. She had so much to tell, and for many people, there was finally a person who gave a face to this horrible disease. The session lasted about twice as long as it was meant to but no one minded.

- There is also the evening session on Religion and AIDS. Many people finally got a chance to open up and talk about how their societies dealt with AIDS and this was roller-coaster ride of expression of hidden thoughts. The participants learnt as much about each other as they did about other beliefs.

- This meeting put away the notion that one cannot learn while having fun. To start off with, we had Dr Bob, with his lively but educational party games. Swear words were flung around in the name of education. Sex and sex appeal took centre stage and the whole idea of sex being taboo was questioned while we played. Condoms were blown up like balloons and burst and underwear was thrown across the room. And it was all truly very educative, very thought provoking.

- We went to a nightclub, a gay nightclub. The music was very good, the atmosphere flashy. While we checked out our dance moves, we also checked out how we felt about being standing near and interacting with gay men and women. Although, it was very awkward to start off with, in the end no one seemed to mind.

# Focus

## Meeting the needs of adolescents

JANE FERGUSON (fergusonb@who.ch), V. CHANDRA-MOULI (chandramouliv@who.ch)  
FAMILY AND RH, ADOLESCENT HEALTH AND DEVELOPMENT, WHO

*Promoting and safe-guarding the health and well-being of adolescents calls for concerted actions. Mrs Ferguson and Mr Chandra-Mouli believe that the new orientation program on adolescent health for health care providers is one of them*

In the past because of consideration of mortality rates alone, adolescents have been viewed as a healthy population segment, and have been accorded a low priority for health related interventions. However, there is growing recognition that because of a combination of biological, psychological and social reasons, adolescents face many different health problems (including those resulting from unprotected sexual activity, substance use, and intentional and accidental violence).

The health sector - just like many other sectors - has a critically important role to play in maintaining health and well-being of adolescents. Specifically, health care providers can make a very valuable contribution to helping prevent the health problems mentioned above, and in insuring that they are detected early and treated effectively, if and when they do arise. Unfortunately however adolescents are reluctant to utilise health services, for a variety of

reasons, as the following extract from a WHO publication points out: „They (young people) may not realise that they need the help of health workers; they may not know that a service is available, where it is how much it costs or whether they would be accepted as clients; they may be afraid of seeking help if they think that their confidentiality will be violated, that they will have to reveal confidential information about other people that they are likely to be reproached or punished, or that other people will become aware that they have problems“

In conjunction with its partners, both within and outside the United Nations system WHO's Adolescent Health and Development Programme is working to build the capacity of the health sector in WHO's member nations, to respond to special needs of adolescents. Human resource development is central to this effort.

### Health care services for adolescents

The intended trainees of the orientation programme are health care providers (doctors, clinical officers and nurses in Africa, Asia, Eastern and Central Europe, and South and Central America) who provide clinical services - including both preventive and curative services. It would be fair to say that only a microscopic minority of health care providers in these settings provide clinical services to adolescents alone.

The focus of the orientation programme is on the following two areas:

- tailoring clinical practices to meet the special needs of adolescents: there is growing recognition that the clinical practices that health workers

employ to prevent health problems and to respond to them if and when they do arise in adults, need to be tailored to meet the special needs of adolescents.

- reorienting the delivery of health services to meet the special needs of adolescents: there is wide-spread acknowledgement that a range of barriers operating at different levels hinder the delivery and utilisation of health services to/by adolescents

Drawing upon the experiences of the participants, the orientation programme will examine whether and if so, how and why, health care providers can do what they are currently doing - differently, in order to meet the needs of adolescents more effectively and sensitively. It will also examine effective and sustainable approaches of reorienting the delivery of health services, in order to expand their availability, increase their accessibility and improve their acceptability to adolescents. The table 1. provides you with the basic structure of the orientation programme.

### Clinical practices

The term clinical practices refers to all the actions taken by a health care provider in the course of a professional interaction with an adolescent patient. This includes:

- being aware of the care seeking practices of adolescents
- establishing rapport with the patient eliciting information about the nature of the health problem facing the patient
- carrying out a physical examination
- arriving at a diagnosis, communicating it and discussing its implications



*Adolescents have special needs but often are reluctant to utilise health services.*

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- providing information on the pros and cons of available treatment options and helping the patient reach a decision

- providing appropriate treatment and making an effort to respond to the patients psychological needs and helping him/her deal with the social implications of the health problem

- making arrangements for ensuring continuity of contact and/or referral to other appropriate services, in consultation with the patient

- providing the patient with the information, skills and supplies that he/she needs to prevent an occurrence/recurrence of this and other related health problems

## Overall strategy

Participatory development workshop was held in Uganda in February last year. The feedback that we received from the health care providers and other youth serving professionals (such as social workers) was very positive indeed. It confirmed that

such a 'product' was vitally and urgently needed. The orientation course was held later on in Zambia and Malaysia and will be conducted in Caribbean countries towards the end of the year.

We recognise that if the orientation programme is to have a realistic chance of changing the way in which health workers interact with and deliver services to adolescents, it will need to be used as part of an overall strategy (involving some fairly substantial preparatory and follow-up work). Practical guidelines for this are being developed as part and parcel of the orientation programme package.

In the future perspective, as a collaborative action with medical faculties and medical students' organisations, the new orientation programs for medical students - the future of health care - will be developed to strengthen the capacity of health care providers to meet the needs of adolescents, effectively and with sensitivity.

Table 1: The basic structure of the orientation programme

- Introduction to adolescence and adolescent health issues and problems
- Reproductive health issues and problems:
  1. Early, unwanted pregnancy
  2. Unsafe abortion
  3. Care during the ante-natal period, during delivery and during the post-natal period
  4. Sexually transmitted diseases (including HIV/AIDS)
- Other health issues and problems:
  1. Tobacco, alcohol and substance use
  2. Mental health issues and problems
  3. Nutritional disorders
  4. Endemic diseases
  5. Intentional and accidental violence
- Personal agenda settings

## Abortion is not method of contraception

CLEMENTINE MADDOCK (c.maddock@umds.ac.uk)  
MEDICAL STUDENT, UMDS, UK

*The alarming figures of the high abortion rates in South London have led Clementine Maddock to examine the issues surrounding in order to attempt to explain the background of it*

### How many women are affected?

Lambeth, Southwark, and Lewisham Health Authority (LSL) is responsible for the health of the population residing in these three boroughs of London. LSL has higher abortion rates for women across all age groups than England and Wales collectively. The figures range from nearly double to nearly triple the national rates within each age band. The number of abortions per 1,000 live births is 238 in England and Wales, compared with 553 in LSL. For every 100 women of childbearing age in this area, 108 abortions will be performed.

As shown in Table1, the 20-24 year old age group has the highest incidence of terminations of pregnancy (TOP) in LSL and nationally.

Some of the factors resulting in unwanted pregnancies in the United Kingdom:

- Failure to use contraception
- Failure of the contraceptive method used
- Poor social circumstances that may render the woman or couple unable to cope with a child
- The detection of potentially handicapping conditions in the fetus (small number of terminations)

### Contraception and contraceptive services

The most commonly cited reasons given for not using contraception included abstinence or no sexual partner (15%), pregnancy (3%), or trying to get pregnant (5%). Amongst the users of contraception, the pill was the preferred method (41%), followed by the condom (25%), and sterilisation (14%). The reasons given for using a particular method were ease of use, lack of side effects, availability on the NHS, and the ease of obtaining supplies.

There are no specific data available for LSL, concerning the percentage of women using contraception, and the methods

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chosen. However, it is noted that the pill, IUD, and female sterilisation are more commonly used among lower social classes, while condoms and male sterilisation are more frequently chosen with increasing social class. As LSL is an area of high social deprivation, it is possible that the pill and IUD are more commonly used than national figures would suggest.

Approximately one third of women of all ages who have an unplanned or unwanted pregnancy did not use contraception at the time of conception. This statistic rises to 50% for teenagers. This suggests that about two-thirds of women who have an unplanned pregnancy have experienced contraceptive failure.

In all studies, the condom was the most frequently cited method used which failed. A very high failure rate for the pill can also be observed; approximately one-fifth of unplanned conceptions occurred while women stated that they were using this method.

Common reasons for contraceptive failure include split condoms, not using a condom every time, forgetting to take the pill, vomiting and diarrhoea while taking the pill, and interactions of antibiotics and the pill.

There is a lack of awareness of emergency contraception amongst both the general public and health professionals. While surveys have shown that women are aware of the existence of emergency contraception, very few know how long after sexual intercourse the post coital pill and IUD can be used. The traditional name "morning after pill" may have contributed to the confusion as it implies the need to start treatment immediately,

rather than up to 72 hours for oral contraception or 5 days for IUD insertion.

Free contraception services are provided by family doctors (GPs) and family planning clinics. LSL ranks highly compared with the other London boroughs in regard to family planning clinic service coverage. But it is obvious from the high conception rates in the area that there are many women using no or inadequate methods of family planning. This suggests that there are still elements of unmet need.

### Why do women have abortions?

Poor social circumstances are identified as a key factor in unwanted pregnancy. Most terminations are carried out on single women. A Swedish study identified a number of motives of women seeking abortion aged between 20-29 years. The most commonly cited reason was bad relationship with a partner. Other factors were immaturity, interference with work or studies, and unsuitable life situation for having a child. Less common motives were economy, dwelling, and medical and health factors.

Within LSL, it is possible that economy may be a more common reason, although there is no research as to the motives for women seeking abortion in this region. LSL is the second or third most deprived health authority area in the country. There are also a high proportion of minority ethnic groups in LSL. Although all family planning clinics in LSL provide interpreting services, and written materials in other languages, services provided do not have a specific strategy for minority ethnic groups, and do not have female doctors. Further research aimed at determining any ethnic differences in abortion rates in LSL should be considered. A number of other factors may be contributing to the high abortion rates in Lambeth, Southwark, and Lewisham: contraception non-use and failure, non-use of emergency contraception as well lack of a supportive partner.

### Conclusion

Effective contraceptive use relies on educating the user. Publicity campaigns explaining emergency contraception may

be of use. Combination of two/more different contraceptive methods should be suggested. GPs and family planning clinics, when providing emergency contraception, can take the opportunity to discuss future contraceptive requirements and explain the consequences of unwanted pregnancies and abortions. This may prove difficult if there are language difficulties. Any differences between ethnic groups may be due to a number of factors including cultural beliefs, access to services, and appropriate family planning provision. By identifying such factors, the health needs of those populations may be better addressed.

The example of South London is unfortunately not unique. In many Eastern European countries the incidence of the TOP is even higher. As proved by this study main reasons for unwanted pregnancies and abortions to happen are either ignorance or lack of responsibility of both partners. The pregnancy is not something that happens accidentally. It should be properly planned and fortunately, the time we are living in, offers us the variety of solutions for that. Abortion is definitely not the method of the birth control and should be

Table 1: Abortion rate by maternal age, 1995

AGE OF WOMEN	ENGLAND & WALES	LSL
11 to 15	2.1	3.5
16 to 19	21.7	48.4
20 to 24	25.5	68.1
25 to 34	15.5	39.0
35 and over	3.7	10.2
All ages	11.2	30.7

(abortions per 1,000 women residents within age band).

Table 2: Why do women risk unwanted pregnancy?

A number of studies have questioned women seeking abortion about their reasons for not using contraception. Reasons given by teenagers:

- Previous side effects from oral contraception
- Fear of side effects from oral contraception
- Waiting for next cycle to start on a different pill
- Had sex before getting contraceptive advice
- Condom not available during sex/intercourse occurring unexpectedly
- Too embarrassed to see doctor/buy condoms/ talk to parents about contraception

The reasons given by women of all ages included:

- Relationship finished
- Side effects of method
- Ran out of supplies
- Partner unhappy with method
- Trusted to luck

# The health of refugee youth

NIKOLA JAGODIC (m2jagodi@rcub.rcub.bg.ac.yu), NATIONAL FRIENDSHIP CLUB COORDINATOR, YUGOSLAVIA  
TIGRAN VILOTIJEVIC (tigran@EUnet.yu), SCORP DIRECTOR, YUGOSLAVIA

*The displacement of youth is a traumatic experience and the problems do not stop there. Ensuring a healthy environment for the youth of refugee communities to develop is only one of the next steps*

The health of women and children are the main objectives of today's reproductive health care. This should cover both their biological and psychological. Sometimes, the psychological aspects can be more influential—biological problems are more or less easy to solve. But the future for reproductive health lies in taking care of future parents—today's adolescents. Unfortunately, they are often the most vulnerable part of the population. Sometimes, like during a war for example, their problems may be so bad that they are forced into exile, itself.

Exile is the most dramatic stress that children can experience. The sudden removal of a person from his/her familiar environment (Tellenbach) leaves a developing individual without landmarks for orientation when making ethical and moral decisions. As well as their family identity, adolescents also long for group identity. This longing is a powerful tool in our work with adolescent refugees. It is the only way of awakening interpersonal relationships, thereby aiding resocialisation into their new environment.

In psychiatry, social therapy helps an individual to adapt to life in the community while preparing their sur-

roundings to facilitate these aims. It uses a variety of psychotherapeutic techniques, including group therapy as this reproduces the community atmosphere that may be missing from their lives. Social group therapy is important and requires well led, structured activities which aim to socialise the individual. These include working therapy, occupational therapy and recreational activities. This sociotherapeutic method also involves healthy members of society as well as disturbed ones.

## What are „clubs“?

„Clubs“ are ideal when it comes to the prevention of psychosocial disorders among adolescents as they provide a place where they can meet and participate in various activities. Clubs were first introduced in the social psychiatry of Serbian adolescents in 1964. The aim back then was to resocialise adolescents experiencing acute crisis of mental disorders. The inspiration for the clubs came from research performed by Serbian experts in London. Later, this method was applied to preventing psycho-social disorders in adolescents that were coming from the provinces to study in Belgrade.

In accordance to this research, and with the guidance of child psychiatrists from the Institute of Mental Health in Belgrade, we organised „Friendship clubs“ for refugee adolescents in the Federal Republic of Yugoslavia.

The structure of a club session (the agenda, lectures, requirements of certain forms of behaviour) is structured and it encourages the participants to follow such a structured existence in their lives. This is important as life in refugee accommodation is often unstructured, making it difficult for inhabitants, especially children, to adapt to a normal way of life. We rely

on certain characteristics of our adolescents for our work in preventing psychosocial disorders. They should:

- long to meet with others
- want to create an atmosphere of togetherness and a feeling of group belonging
- tend to express creativity in everyday activities, sports, art or scientific work
- be curious about the unknown in life. The sooner they grasp cultural and intellectual values, the sooner we will manage to save them from becoming accustomed to pure sensual satisfaction, which impoverishes life and prevents development and maturity.

This last point is essential in terms of reproductive health. Without positive, moral, and ethical role models for what is healthy sexual behaviour, the youth in refugee accommodations may find themselves struggling with sexually transmitted diseases and unplanned pregnancies. The club provides a friendly atmosphere, where we hope they will discuss such issues, and perhaps approach the club organisers with their questions, hopes and fears. Having youth from a variety of backgrounds also helps as they will each bring a different amount on knowledge (and misconceptions), and through their conversations they will educate each other—as is the normal process of discovery in childhood.

The club has positions for international medical students. As well as being an interesting experience, being at the club will also teach them how to deal with exiled youth, the problems they face, and the circumstances they live in. They learn how to communicate with people of completely different life experiences and how to recognise their needs and fears.



IFMSA

Club provides a friendly atmosphere.

# Focus

## An experience from the Uganda refugee project

MEIKE NITSCHKE (meike.nitschke@lrz.uni-muenchen.de)  
INTERNATIONAL COORDINATOR OF THE URP, GERMANY

*There are specific problems with maintaining reproductive health in a refugee camp. Meike Nitschke gives some examples*

In a refugee camp, medical treatment is limited to very urgent cases. Priorities are given to life threatening diseases such as outbreaks of diarrhoea, severe malnutrition or accidents. But there is also need for preventative health measures to avoid the development of epidemics that will affect both the refugees and the local, surrounding population.

Preventive health is based mainly on the pillars of primary health care, and includes the supplying of drinking water, sanitation, and ensuring the health of mother and child. Since many refugee camps serve as temporary home for people who have had to flee from their homes, life goes on, hence, so does reproduction. Children become adolescents, women become pregnant and babies are born.

### Pregnancy problems

Since conditions in a camp are normally poor, counselling about sexual issues, pregnancy, and prenatal care is extremely important to avoid later complications.

This is especially the case as many female refugees are under extreme psychological stress and this has to be considered in their treatment. The women are often so exhausted from when they had to fled their homes, that any ideas of having children has to be forgotten. Therefore, any pregnancies that occur often lead to abortions.

The health centres of the camps in Orukinga and Nakivale, where the Uganda refugee projects are, provide as many services of reproductive health care as the over worked staff can offer. At least once a week a coun-

selling afternoon for pregnant women takes place. Their weight is taken, they are offered to talk about problems of their pregnancy or to ask questions if something is unclear to them. Afterwards, they are examined by the experienced midwives of the centre. Additionally seminars and group discussions with traditional birth attendants among the refugee population take place to ensure good co-operation.

### Opportunities to educate

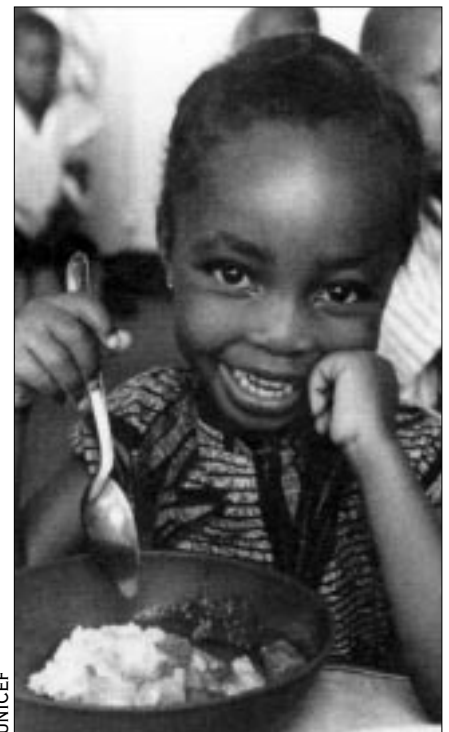
When pregnant mothers visit the health centre they usually bring their children. The staff take this opportunity to check their weights as well as screen for malnutrition.

To fight malnutrition and to teach parents how a balanced food composition for children should look like, all mothers are brought together and a big meal is cooked twice a week. This is funny but it gives an opportunity to ask questions and to exchange experiences about how the limited food items in the refugee camp can be used for a healthy nutrition of the family. At the daily outpatient department, young women and those who do not want to get pregnant have the chance to discuss contraception with the medical assistant.

At the OPD cases of sexually transmitted diseases are often observed—they can be the causes of pain and infertility. Treatment of reproductive tract infections at the health centres of Orukinga and Nakivale is very difficult as most of the required drugs are not available. This underlines the importance of the health education sessions as preventative measures, that are car-

ried out daily before the out-patient clinic starts. During home visits in the afternoons, the health centre staff offer more personal discussions about these sensitive issues.

This can only be a short overview of the activities in reproductive health care at the Orukinga and Nakivale refugee camps. However, I have tried to point out that, especially in refugee camps, a



*Improvement of nutrition - a major goal for children.*

lot of attention has to be paid to reproductive health. The need for physical love or the „responsibility“ for replacing the part of the population that was lost in the war often leads to a high level of sexual activity among refugees. Reproductive Health Care therefore is essential for keeping refugees healthy.

## Problems in a Sudanese camp

ELSKE HOORNENBORG (elskehoornenborg@hotmail.com)  
THE NETHERLANDS

*In 1996, Donna and Elske went to a refugee camp in Sudan. Here they describe some of the reproductive health problems they saw*

The people who live in UmSagata refugee camp have been there for more than ten years. The camp is in the north east of Sudan and the people are mostly from Eritrea. They are still afraid to return to their homes. The camp looks more like a small village and the people work in the surrounding fields. The large number of cows in the camp mean that the people are generally well fed, but the health care in the camp is bad. There is only one health assistant who distributes medicines for malaria and cleans wounds, but that is all. There is no doctor and the nearest hospital is 4 hours drive away. Some times, in the rainy season, it can take up to four days.

### Antenatal care

Many of the girls marry young. This combined with the fact that there is no contraception available (and even if there were it would not be allowed) means that the often become pregnant while they are still young themselves. Although, the people are not starving, the food situation is not optimal and the young mothers can become very weak. Because of this we gave lectures and held discussions on „mother care.“

### Paediatric problems

Superstition is also a problem. For example, mothers believe that if their baby gets diarrhoea, they should stop feeding it, because everything they give will come out the other end. However, if the baby that gets nothing to drink, especially in that hot climate, he/she will die within days. We saw many dehydrated children and distributed a lot of oral rehydration therapy. We also taught the mothers how to make the preparation used in ORS



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*Many girls marry and often become pregnant while they are still young themselves.*

using salt and sugar. However, at times, our cultural differences were just too big: „Those white doctors from Holland were very interesting, but why should they stop us doing something we have been doing for years?“ I suppose I would have thought the same if I were in their situation.

Sometimes we saw children with many small scars on their skin. This was because of another superstition—they believe that burning a child can take away the pain. What can you say to a parent who believes this? Perhaps we should say, „Please do not do that, it is of no use, it only harms the child“? We tried, but it was so difficult. There is much work to do on the field of child care.

### Female circumcision

The biggest problem is female circumcision. At the age of four, the girls have a big party and after that they are circumcised. In the past, and still today in the small villages, this meant cutting everything away, including the clitoris, labia majora and labia minora,

and then sealing most of it, leaving only a small hole to make it possible to urinate. I shall leave it to you to imagine what happens when they lose their virginity, which is usually on the night of marriage. The circumcision usually does not occur under sterile conditions. Infections are common both during the procedure and when the girl goes on to give birth at a later date.

These days, circumcision usually means only the removal of the clitoris. In the more educated families, the girls sometimes do not get circumcised at all. These girls often feel „different,“ and they are teased at school for not being circumcised. Today, over 95 % of the girls is still circumcised. It is so difficult to change things, and any changes will happen slowly. We talked about this subject with the Sudanese girls, many of whom are very against circumcision. However, any changes will start in towns, among the more educated people, and it will take a lot of effort to pass these ideas to those living in small villages and refugee camps. There is a lot of work to do.

# Shakespeare wanted



IFMSA / TIGRAN VILOTUEVIC

Are you waiting to amaze the world (or at least the world's medical students) with your writing? Do you have something to say? Can you prove that the pen is mightier than the sword? The next Medical Student International (MSI) is about Africa. Got something to say, then contact the editors.

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IFMSA General secretariat  
c/o Mrs. Mia Hilhorst  
Division of Social Medicine  
University of Amsterdam  
Academic Medical Center  
PO Box 22700  
NL-1100 DE Amsterdam  
The Netherlands

# Coming soon

## A workshop on refugees and reproductive health

MARIA RYDEVİK ([scoasd@ifmsa.org](mailto:scoasd@ifmsa.org))

DIRECTOR OF THE STANDING COMMITTEE ON AIDS AND STD'S (SCOAS), SWEDEN

TIGRAN VILOTIJEVIĆ ([scorpd@ifmsa.org](mailto:scorpd@ifmsa.org))

DIRECTOR OF THE STANDING COMMITTEE ON REFUGEES AND PEACE (SCORP), YUGOSLAVIA

*It is time to meet the new workshop run by both SCORP and SCOAS to be held before this year's general assembly*

It is now customary to hold an event before the IFMSA general assembly. The event, usually a workshop, is linked to one of the six standing committees but this year the Standing Committee on Refugees and Peace (SCORP) and the Standing Committee on AIDS and STD's (SCOAS) have come together to discuss a common theme: refugees and reproductive health, with a particular focus on women, youth and children.

There are specific problems with reproductive health care in a refugee population:

- Pregnancy and delivery complications are prevalent and these lead to death and disease among refugee women
- Malnutrition and epidemics can reduce physiological reserves of pregnant or lactating women which can further endanger the health of mother and child
  - Violation of the human rights of refugee women such as rape, sexual abuse and involuntary prostitution
  - Prevention and care of sexually transmitted diseases, including HIV/AIDS becomes increasingly difficult
  - Family planning plays a crucial role in helping a population to maintain its size within its capabilities
  - Complications with unsafe abortion
  - Educating adolescents on sex and cultural issues and guiding them on their way from childhood to adulthood
  - The problems of child abuse and exploitation
  - Birth registration and immunisation procedures

The workshop will be held in the same city as the general assembly and around 70 participants from all over the world will participate, contributing their

experiences and knowledge. It is hoped they will return home and continue to develop the working plans founded during the workshop. In this way they will share their gained knowledge with students and others in their home countries.

### Project outline

There will be two major themes:

- The psychological effects on refugees' reproductive health
- The biological side effects and the health services provided

*Aims:*

- To produce an IFMSA statement, regarding both reproductive health and refugees
- To develop new projects
- To hold round table discussion with a view to changing curricula to include reproductive health and rights issues

*Preliminary working schedule:*

Each day will have a specific topic, illustrated by the lectures given by the invited guest speakers and the poster presentations of the participants, followed by discussions and working groups.

Day 1 Refugees and Reproductive Health; introduction to the topics.

Day 2 Youth

Day 3 Women

Day 4 Children

*Methodology:*

Guest speakers will be invited. They will either be professionals working in that specific field or people with personal experiences to share. These may include people from UNFPA, UNHCR, WHO, UNESCO, UNICEF, child psychiatrists, women organisations, sexually abused women, and youth refugee.

Thematic poster sessions where the

participants present scientific data or projects from their home country. Discussions will be held on the topics that are introduced through the lectures and presentations of the day. The focus group discussions in the smaller working groups should concentrate on different subjects, for example:

- What we can do, as medical students, and what future IFMSA projects can we develop
- Formulating a statement representing the opinion of the medical students on reproductive health rights
- The changes that could be made to the medical curriculum—the results should be sent to the relevant conference on medical education

The results and projects that arise from this workshop will be published and distributed world-wide, among IFMSA members and their collaborative agencies. This will be used to make people aware of the problems facing refugees, what can be done, and what is currently being done by IFMSA projects.

Table 1: International workshop coordinators

Maria Rydevik ( <a href="mailto:scoasd@ifmsa.org">scoasd@ifmsa.org</a> ) SCOAS director Dag Hammarskjöldsv 4, A:317 224 64 Lund, Sweden Phone: +46 46 150553 Fax: +46 46 222 0562
Tigran Vilotijevic ( <a href="mailto:scorpd@ifmsa.org">scorpd@ifmsa.org</a> ) SCORP director Knjeginje Zorke 16a 11000 Belgrade Yugoslavia Phone: +381 11 435 373 Fax: +381 11 185 425

# Coming soon

## The Kawempe community health project (1997-2000)

MUSANA BAZIL (mbazil@uga.healthnet.org), UMSA COORDINATOR

AGNES ANYAIT (agnes@uga.healthnet.org), MAKERERE MEDICAL SCHOOL, KAMPALA UGANDA

*The new project run by both SCOPH and SCOAS is about to start its first international rotation*

### Issues and activities

The Kawempe Community Health Project is a collaborative effort between the Uganda Medical Students Association (UMSA), the University Partnership for Essential National Health Research (UPENHR), St. Stephen's Hospital, Kawempe, and the Netherlands Medical Students International Committee (NeMSIC). It is based in the Kawempe division of Kampala district, Uganda. Under this project, medical students from Uganda and their counterparts from other parts of the world will participate in community activities, on rotational basis, aimed at improving health conditions in the area. The project is run under the Standing Committee on Public Health (SCOPH) and the Standing committee on AIDS and STDs (SCOAS), both committees of the International Federation of Medical Students Associations (IFMSA) to which UMSA and the NeMSIC are full members.

The project has the following objectives:

- To create awareness among the youth, both school going and non-school going, about HIV/AIDS and STDs and support the community's efforts towards behaviour change as a mode of prevention of their transmission

- To expand the maternal and child health (MCH) services at the St Stephen's hospital, Kawempe in an attempt to lower the morbidity and mortality rates in the area

- To improve the water and sanitation situation in the Kawempe area by conducting health education and protecting spring wells

- To promote good working relations between Ugandan and foreign medical students as an avenue for future professional exchanges

To meet these objectives, the students will carry out the following community based activities:

- Education on HIV/AIDS and STDs in primary and secondary schools in the area

- Training of community peer group counsellors

- Setting up drama/music clubs with educative messages on prevention of HIV/AIDS and STDs

- Education on the various aspects of reproductive health including, among others, adolescence and related problems of sexuality at that stage, the prevention of teenage pregnancies, abortion and its associated problems, fertility and its control, including

information on contraceptives, and the concept of family planning, its benefits, where and when to obtain services from

- Running antenatal and immunization clinics at the St Stephen's hospital including outreach programmes to increase coverage

- Provision of counselling services to mothers at the St Stephen's hospital concerning the various methods of family planning

- Improvement of diagnostic and curative services at the St Stephen's hospital through provision of medical equipment

- Health education concerning the sanitation situation in Kawempe

- Protection of spring wells

- Carrying out specific disease surveys in the area and compiling this information to form a database for future references

### Objectively verifiable indicators

Following a baseline survey carried out by Ugandan medical students and community members in the Kawempe Division in 1992 and on which this project is based, some of the findings included;

- 60% of the household members interviewed were below the age of 20 years hence a predominantly young population

- The general morbidity rate was 43% with malaria, upper respiratory infections and diarrhoeal diseases being the most common complaints

- 62% of pregnant mothers under the age of 19 years



WHO/H. ANENDEN

*Educating on HIV/AIDS and STDs - training of community counsellors*

# Coming soon

did not attend antenatal clinics. These are known to contribute greatly to the high maternal mortality rate in Uganda of about 500/100,000 (1997)

- About 90% of the households knew how AIDS is transmitted and how it can be prevented. However, there were gross misconceptions such as transmission through mosquito bites, sharing of utensils and toilets amongst others

- 29% of households obtained their water from unprotected wells

- 56% of households were sharing latrines and in some cases as many as 15 households shared one latrine

- 24% of children in school-going age (5-19years) were out of school

## Means of verification

This will be through:

- Administration of questionnaires at the end of each rotation to students and the community and subsequently a report for that rotation

- Community seminars to get opinions of the community members

- A mid-term report

- A final report at the end of the three year period

## Key assumptions

1. That there will be ample cooperation between the students and the community

2. That funds will be procured to run the project

We therefore appeal for any kind of support to run this project. For further information, contact either us at the addresses in table 1.

Table 1: Addresses of coordinators

Musana Bazil  
(mbazil@uga.healthnet.org)  
Local coordinator, UMSA  
Makerere University  
Nkrumah Hall  
PO Box 16010  
Kampala  
Uganda  
Phone: +256 41 543042  
Fax: +256 41 530412

Sabina de Weerd  
(s\_de\_weerd@hotmail.com)  
International coordinator, NeMSIC  
Gerard Noodtstraat 129  
6511 ST Nijmegen  
The Netherlands  
Phone: +31 24 322 54 21  
Fax: +31 24 361 35 86 (office)

## Right to health care

ELLEN-ANN ANTAL (e.a.antal@ioks.uio.no) NORWAY  
INTERNATIONAL WORKSHOP COORDINATOR

### *SCORP is inviting you to the second international training workshop on human rights*

Knowledge of human rights and relevant laws is essential for health professionals. Physicians have a special responsibility as observers of human rights violations. However, human rights education is not included in the medical curricula of most countries. It is obvious that human rights and fundamental freedoms can only be observed and fought for, when they are generally known. Medical professionals have a collective responsibility to fight for the promotion and provision of the right to health care.

The participants of the first IFMSA training workshop on human rights and medicine, held in August 1997 in Uganda, expressed the need for having better education of medical students on the human rights. This alarmed organisers and here it is: the second training workshop is approaching in August 1998, Harare, Zimbabwe on the theme „Right to health care! Health care should be available for all, but is this true in practice?“. IFMSA,

Federation of African Medical Students' Association (FAMSA), International Physicians for the Prevention of Nuclear War (IPPNW) and Human Rights Union for Medical Action in Africa (HURUMA) joined their efforts to organise this event.

The workshop aims to teach participants about health care law. It is also important to motivate them to advocate for the implementation of the universal right to health care. The workshop gives the opportunity to meet with people that are already working in the human rights field and to get to know their projects like HURUMA, the Prison project, refugee projects and the project that aims to include education on human rights in the medical curricula. It offers the field for international exchange, discussion and possible cooperation on this important issue. This gives the opportunity to create firm and solid network in Africa with strong connections established with Europe, that is sup-

posed to advocate for human rights. The workshop also tends to train students to set up projects on human rights in their home countries.

The participation of both medical and law students from all over the world is welcomed. This valuable share of knowledge and skills is meant to enable strong and successful advocacy for human rights to health care for all.

Table 1: Workshop coordinators

Nuyen Ganga Raju  
(ngangaraju@healthnet.zw)  
Box. A178 Avondale  
Harare, Zimbabwe  
Phone: +263 4 791631 ext 300  
Fax: +263 4 724912

Ellen-Ann Antal  
(e.a.antal@ioks.uio.no)  
Arnulf Overlandsvei 115  
0764 Oslo, Norway  
Phone: +47 22 493096  
Fax: +47 22 118908

# Calendar 1998

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
M	5 12 19 26	2 9 16 23	2 9 16 <sup>23</sup> <sub>30</sub>	6 13 20 27	4 11 18 25	1 8 15 22 29	6 13 20 27	3 10 17 <sup>24</sup> <sub>31</sub>	7 14 21 28	5 12 19 26	2 9 16 <sup>23</sup> <sub>30</sub>	7 14 21 28
T	6 13 20 27	3 10 17 24	3 10 17 <sup>24</sup> <sub>31</sub>	7 14 21 28	5 12 19 26	2 9 16 23 30	7 14 21 28	4 11 18 25	1 8 15 22 29	6 13 20 27	3 10 17 24	1 8 15 22 29
W	7 14 21 28	4 11 18 25	4 11 18 25	1 8 15 22 29	6 13 20 27	3 10 17 24	1 8 15 22 29	5 12 19 26	2 9 16 23 30	7 14 21 28	4 11 18 25	2 9 16 23 30
T	1 8 15 22 29	5 12 19 26	5 12 19 26	2 9 16 23 30	7 14 21 28	4 11 18 25	2 9 16 23 30	6 13 20 27	3 10 17 24	1 8 15 22 29	5 12 19 26	3 10 17 24 31
F	2 9 16 23 30	6 13 20 27	6 13 20 27	3 10 17 24	1 8 15 22 29	5 12 19 26	3 10 17 24 31	7 14 21 28	4 11 18 25	2 9 16 23 30	6 13 20 27	4 11 18 25
S	3 10 17 24 31	7 14 21 28	7 14 21 28	4 11 18 25	2 9 16 23 30	6 13 20 27	4 11 18 25	1 8 15 22 29	5 12 19 26	3 10 17 24 31	7 14 21 28	5 12 19 26
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DATE	TITLE	VENUE	CONTACT & INFO
5-10 Mar	93rd Exchange officers' meeting of IFMSA	Athens, Greece	IFMSA/HelMSIC secgen@ifmsa.org <a href="http://www.helmsic.gr/eom98">http://www.helmsic.gr/eom98</a>
10-12 Mar	IFMSA Leadership training programme (LTP)	Athens, Greece	IFMSA/HelMSIC ltpd@ifmsa.org
4-8 Mar	7th Annual IHMEC conference	San Jose, Costa Rica	IHMEC vgj@med.unc.edu
14-21 Mar	First IFMSA winter games	Kopaonik, Yugoslavia	YuMSIC yumsic@eunet.yu
10-14 Apr	The 1st youth international conference on AIDS/SDDs in Africa	Kampala, Uganda	Uganda youth anti AIDS association nilestar@starcom.co.ug
27-29 Apr	2nd International medical congress (IMC '98)	Izhevsk, Russia	RMSA asmi@igma.udm.ru
Apr	International university congress on medicine and sports applied sciences	Cadiz, Spain	Delegacion de Alumnos Facultad de Medicina (AIEME) secgen@ifmsa.org
6-9 May	14th International medical students' scientific congress (IMSSC)	Istanbul, Turkey	Research club of Istanbul University, Medical faculty secgen@ifmsa.org
15-19 May	Workshop on medicine and internet/computers	Belgrade, Yugoslavia	YuMSIC yumsic@eunet.yu
28 Jun-3 Jul	12 <sup>th</sup> World AIDS conference	Geneva, Switzerland	aids98@congreg.se scoasd@ifmsa.org
3-14 Jul	4th International summer school STOP AIDS	Bled, Slovenia	IFMSA/SloMSIC scoasd@ifmsa.org
6-17 Jul	9th Utrecht emergency medicine summer school	Utrecht, The Netherlands	NeMSIC/Utrecht medical school <a href="http://www.med.ruu.nl">http://www.med.ruu.nl</a>
28 Jul-2 Aug	IFMSA workshop: Refugees and reproductive health with special focus on children, adolescents and women	Egypt	Egypt/IFMSA scorpd@ifmsa.org scoasd@ifmsa.org
2-8 Aug	47th IFMSA General assembly	Safaga, Egypt	IFMSA/EMSA secgen@ifmsa.org
2-6 Aug	World youth forum of the United Nations system	Braga, Portugal	The Portuguese national youth concil (CNJ) UN Youth Unit cnj@mail.telepac.pt
Aug 1998	2nd Workshop on human rights and health: „Right to health care“	Harare, Zimbabwe	IFMSA lippnw@ifmsa.org luhoafro@ifmsa.org
23 Aug-4 Sep	International medical congress	Grado, Italy	pad272@padovanet.it
22-23 Oct	International conference on adolescent and health	London, U.K.	The Forum on adolescent health secgen@ifmsa.org

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# UNFPA

## United Nations Population Fund

### Autonomy & empowerment of women

UNFPA is guided by, and promotes, the principles of the Programme of Action of the International Conference on Population and Development (1994). In particular, UNFPA affirms its commitment to reproductive rights, gender equality and male responsibility, and to the autonomy and empowerment of women everywhere. UNFPA believes that safeguarding and promoting these rights, and promoting the well-being of children, especially girl children, and development goals themselves. All couples and individuals have the right to decide freely and responsibly the number and spacing of their children as well as the right to the information and means to do so.

### Leadership Partnership

UNFPA, as the lead United Nations organisation for the follow-up and implementation of the Programme of Action of the International Conference on Population and Development, is fully committed to working in partnership with governments, all parts of the United Nations system, development banks, bilateral aid agencies, non-governmental organisations and civil society. UNFPA strongly supports the United Nations Resident Co-ordinator system and the Implementation of all relevant United Nations decisions.

### Reproductive health

UNFPA's three main areas of work are: to help ensure universal access to reproductive health, including family planning and sexual health, to all couples and individuals by the year 2015; to support population and development strategies that enable capacity-building in population programming; to promote awareness of population and development issues and to advocate for the mobilisation of the resources and political will necessary to accomplish its work.

### Mobilization of resources

UNFPA will assist in the mobilisation of resources from both developed and developing countries following the commitments made by all countries in the Programme of Action to ensure that the goals of the International Conference on Population and Development are met.

### Assistance

UNFPA extends assistance to the developing countries, countries with economies in transition and other countries at their request to help them address reproductive health and population issues, and raises awareness of these issues in all countries, as it has since its inception.

### Stabilizing world population

#### Quality of life

UNFPA is convinced that meeting these goals will contribute to improving the quality of life and to the universally accepted aim of stabilising world population. We also believe that these goals are an integral part of all efforts to achieve sustained and sustainable social and economic development that meets human needs, ensures well-being and protects the natural resources on which all life depends.

### Human rights

UNFPA recognises that all human rights, including the right to development, are universal, indivisible, interdependent and interrelated, as expressed in the Programme of Action of the International Conference on Population and Development, the Vienna Declaration and the Programme of Action adopted by the World Conference on Human Rights, the Convention on Elimination of All Forms of Discrimination Against Women, the Programme of Action of the World Summit for Social Development, the Platform for Action of the Fourth World Conference on Women and in other internationally agreed instruments.