Letter from the Editors

Welcome members,

Thank you for your unwavering support of the MWIA Young Forum Bulletin. We hope that you will continue to support this work by submitting your articles, reading the latest issues, and encouraging your friends and colleagues to get involved.

The MWIA Membership has been very active in the past few months. The theme of our 2013-2016 triennium is Prevention and Elimination of Domestic and Sexual Violence. There are two main initiatives that we would like to share updates on.

The first is the development of the Violence Training Manual, led by Dr Bettina Pfleiderer in Germany. Thank you to everyone who has submitted cases. The revisions of the training manual are currently underway and we look forward to the final product!

The second is an exciting partnership with Zonta International to distribute Birthing Kits to areas of high need. Currently we are exploring partnerships in regions such as the Middle East and Africa. Our goal is to help address Millennium Development Goals 4 and 5 - towards the health of mothers and their children. More updates to follow from these preliminary meetings!

In new year, look forward to updates from the MWIA Delegation that will be attending the United Nations Commission on the Status of Women, which takes place in March, focused around International Women’s Day.

If you haven’t already please join our Facebook group, search “Young MWIA-The Medical Women’s International Association”. Thank you to those members who have: our Facebook group has grown from 100 to over 650 since 2010. Our goal is to increase this to 1000 before Vienna 2016. Get your friends to join!

Previous issues of the newsletter are available there and on the MWIA Website:

We look forward to your continued support and are happy to discuss article ideas with you.

Charlotte Rohrborn and Pamela Liao
Medical Women International Association – Young Forum
Newsletter Editors
International Experiences and the Voluntourism World

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Medical students, residents and staff physicians alike learn and practice medicine not only in their local communities but also abroad, through Global Health Experiences (GHE’s) or voluntourism: a provision of volunteer services where one is visiting or travelling. Many in the medical profession and even those planning to apply may consider international experiences as an opportunity to develop skills and competencies while benefitting from the cultural exchange that travel provides. On the other hand, many have questioned the ethics around provision of care in these settings, and the impact of such programs on the international communities. Medical voluntourism by pre-medical students, medical students, and even physicians deserves a thorough evaluation, with those participating or abstaining from participation requiring a deep understanding of both sides of the situation if they ever hope to engender sustainable change.

So what are we accomplishing for ourselves and for communities when we work on foreign soil? Educators have noted that the experience is life-changing, enabling us to develop a sense of empathy that would not otherwise have been cultivated, with students “no longer able to watch disaster unfold in another country without thinking how they might help”.[1] Some believe that the purpose of voluntourism needs clarification, that it is truly a vehicle of cultural exchange as opposed to long-term or sustainable development.[1] Dr Patrik, Deputy Editor of the Canadian Medical Association Journal, notes that physicians who travel overseas are more likely to work in under-served areas once back home, a clear benefit, though not to the host country itself in terms of local impacts.[2]

Furthermore, students note that their help is needed in under-staffed areas with overly-full waiting rooms: “when the choice is between me and no one, there are different standards because there have to be different standards”.[3] Given some of the debilitating shortages of health professionals in developing regions, one can imagine that well-intentioned volunteers simply wish to support the over-worked staff and to add to the clinic’s efficiency and ability to serve patients.[3] Lastly, one can consider that developing nations are not providing adequate exposure for interested students, and with our shortage of physicians and lengthening educational requirements, experiences to help solidify a commitment to the journey in medicine can be integral.
If nothing else, some believe that one manifestation of our collective social responsibility as physicians is an obligation to respond to inequities in health services and their accessibility and provision, not only in our own backyards but in our global backyard. Physicians have duties to their patients, to each other, and to the general public to safeguard health systems so that they are effective, efficient, equitable and sustainable.[4]

Though we may have large hopes for what medical voluntourism can accomplish, we need to examine the costs we are incurring, and if these are justified. Often, projects are found to be exclusively charity-based approaches to providing medical care as opposed to enabling an equal and collaborative community partnership that has promise for lasting sustainability. This approach is almost impossible to sustain, and does nothing to address the structural or institutional factors that effectively created the medical inequity. In these regards, many GHEs miss the mark.[4]

While students believe that their assistance is better than having none at all, we must also consider that their enthusiasm for early clinical exposure, combined with the pressure to help busy clinics, may result in performing clinical tasks that they are not trained to complete. It is these ethically problematic clinical situations that not only can harm patients, but also leave volunteers in potentially psychologically damaging circumstances. One also has to consider the compromise to patient autonomy in these settings, as they may be unaware of the student’s level of clinical education or, if aware and properly consented, be unable to demand or access better care.[3]

As Dr Patrick points out, is an unfortunate fact that “one thing we do know for sure is that there is always some harm that comes from even the most well-intentioned of humanitarian missions”, so the overall message is “don’t go”. A well-known JAMA article in 2008 outlines some of the larger issues with academic global health programs, with the CMAJ noting that there is no clear evidence that such activities are “beneficial in an enduring way to the host country”. [2]

Overall, there are several factors to consider when embarking on an international medical experience including the impact it will have on the community and on the care-provider. To help ensure a positive experience for both participants in the exchange, several institutions have developed resources to help prepare medical personnel to deliver a positive and sustainable program, which are provided for readers below. Ultimately, we aim to ensure our international programs address ethical concerns, possibly high risk situations, and educate those involved to create a sustainable and locally sourced program that fits with cultural practices in conjunction with medical best practice.

1) The Johns Hopkins Berman Institute of Bioethics collaborated with the Stanford Center for Innovation in Global Health to produce an excellent
case based online course on Ethical Challenges in Short-Term Global Health Training.

2) **HumEthNet**, a website that developed out of empirical research on the ethical dilemmas faced by humanitarian healthcare professionals working in humanitarian crises, disasters or areas of extreme poverty

3) The **McGill Humanitarian Studies initiative**, which offers the Canadian Disaster and Humanitarian Response Training Programs that range from an introductory course to an advanced program that includes simulation training.

Works Cited


A Call to Action on Violence Against Women

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On 21st November I attended the launch of The Lancet Series on Violence against women and girls, held at the London School of Hygiene and Tropical Medicine. This series presents a vital collection of papers that, for the first time, gathers the existing evidence on key interventions for the prevention of violence against women and girls.

Grievously, at least one in three women will experience physical and/or sexual violence from a partner, or sexual violence from someone other than a partner, in her lifetime. Globally, women experience countless acts of violence because of their gender, as well as other forms of discrimination including their race, class, sexuality, ethnicity, disability, caste, HIV status - the list is simply endless.

This Lancet series raises awareness of the poor response that the health sector has made to this critical issue. However, it also recognizes the pivotal role that health practitioners can play in primary, secondary, and tertiary prevention of acts of violence against women and girls. Evidence-based interventions include a) training in violence prevention, which encompasses the identification of intimate partner violence and how to provide comprehensive first-line support and referral to the required services; b) establishing protocols, referral networks, and capacity building; c) ensuring the adequate training of health care workers in violence prevention; d) showing leadership in raising the profile of this endemic issue for women amongst colleagues and the wider public; and e) addressing the underlying drivers of violence such as alcohol abuse. The scope of the work we have to do is expansive, but imperative.

I urge you all to take the opportunity to read this series and become advocates for the improvement of the conditions of women and girls experiencing violence in society today: in your public, professional and personal realms. I call you to action.
Abstract

Sexual Violence and Women’s Health: Educating Future Clinicians
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Editors Note: This abstract has been published for member awareness but has not been formally peer-reviewed.

Background: Sexual violence (SV) against women is common in Australia and worldwide with lifetime prevalence in Australia estimated between one in five and one in three women. Its health impacts, particularly on young women are well documented. Despite growing evidence, SV appears to be an under-taught health issue with limited attention in medical school. The best way to teach medical students about the sensitive subject of SV is unknown.

Aims: This study aims to explore whether undergraduate SV education is necessary. It also aims to gain professional insight into how SV education in medical schools could be best delivered to students and examine what content is required to be taught at the undergraduate student level.

Methods: 44 practicing medical doctors were recruited to partake in individual semi-structured interviews. The data was managed in NVivo 10. A thematic analysis was applied to the data, coding it into themes.

Results: Participants identified a common need for SV education at the undergraduate level, given most participants had experiences with patients who were victims of SV, particularly at a junior level. They believed content should cover four key areas: awareness and epidemiology of SV, health outcomes of SV, a trauma sensitive model for history taking, and management and referral processes for SV.

In terms of delivery, there was a general consensus on small group tutorials for skills acquisition, and lectures or online modules for the delivery of knowledge content. They also called for SV to be integrated into the curriculum both horizontally and vertically.
Conclusion: This study suggests SV education should be a core component of the undergraduate medical curriculum because doctors reported encountering SV victims early in their careers. Ideally the curriculum should allow students to reach a level where they feel they could competently recognise and manage a patient who had experienced SV and refer them appropriately.

Reaching out to school children and youths
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INTRODUCTION
No one can really say when the art of tribal marks began (1). It is used to identify each family to be easily recognised on the basis of tribal marks worn (1). Several ethnic groups in developing countries wear facial marks.

CASE SUMMARY
A four year old boy was brought to an outreach organised by a non-government organization. As the mother removed the dress of the boy to be examined by the medical doctor, there were numbers engraved on the chest of the boy separated by dots. As the medical doctor inquired, the mother said it is the date of birth. The child was born in a village different from that of the parents but it was the custom of the village where the child was born to inscribe and write the date of birth on the chest of the child. This is done with special dyes and needle in place.

DISCUSSION
Body adornment is a significant cultural activity which is widely practised by the many ethnic groups which are found in the vast continent of Africa (2). Some of these decorations are made in form of temporary body designs while others are permanent body designs (2). Most tribal marks are made on the face. This is a different one as it is done on the chest. Because it is a permanent mark,
it remains as the child grows. In Nigeria, the many reasons for wearing facial marks include identification or royal lineage or ethnic origin, enhancement of beauty and as component of ritual enhancement to ward off evil spirits. In parts of southern Nigeria, facial marks are engraved for identification of persons is often elaborate. Some tribal marks run as parallel grooves from the forehead through the temple and cheek to the chin and complimented with accessory marks from the medial canthus of the eyes downward to join the mainstream facial marks. Generally people want to be associated with accepted norms and practices in their society for the purpose of identification, enhancement of beauty or other reasons (3).

CONCLUSION
There are different forms of tribal marks, in this modern day of HIV/AIDS scourge, tribal marks should be discouraged.

REFERENCES

Upcoming Events

For details please visit MWIA website.

March 4-7, 2015, Sao Paulo – Brazil: Latin America MWIA Regional Meeting

March 9-21, 2015, New York, NY, USA
The Commission on the Status of Women, United Nations New York
Beijing + 20
http://www.unwomen.org/co/csw/csw59-2015

April 24-25, 2015, Taiwan, Western Pacific Regional MWIA Meeting
Evergreen International Convention Centre.
The main theme is “Juggling and Balancing,” with the sub-theme “Prevention and Elimination of Domestic and Sexual Violence.”

www.mwia.net
The major focus of the conference will include abstracts on above mentioned topics. We encourage all participants, who have an interest in these areas to submit abstracts for consideration before December 31, 2014. This is a great opportunity to present your advances to a supportive audience of professionals. Abstracts are invited in a range of topics related to the theme. For more information on the conference and the procedures for submitting an abstract, please visit: [http://www.tmwa.com.tw/2015mwia-wprm](http://www.tmwa.com.tw/2015mwia-wprm)

April 24-27, 2015, Chicago, Illinois, USA - The American Medical Women’s Association - Centennial Celebration

July 8-10, 2015, Accra, Ghana, Africa and Near East MWIA Regional Meeting
Theme: The Obesity Pandemic & Helping the woman and her family with the sub-theme of Domestic and Sexual Violence

November 2015, 3rd World conference of Women’s Shelters. [Information see here.](#)

December 13-14 2015, Calcutta, India, Central Asia MWIA Regional Meeting

**International MWIA congress 2016**
Vienna, Austria
Theme “Generation Y”
July 28-31, 2016
Registration Opens Jan 2015
Make a difference   - Exchange Ideas

Dear Members, we are asking for submissions for the next issue of our newsletter. We are looking for updates on interesting projects, clinical experiences, personal experiences, and other activities in all regions of MWIA from our young members. Max 500 words.

For examples, please see our previous issues.

For more information, and link to our facebook group:

http://mwia.net/young-mwia/