CFMS-GHP September 2009 Report

A Report on Activities from May - September, 2009

TABLE OF CONTENTS:

EXECUTIVE REPORT - VP GLOBAL HEALTH

Brianne Hudson, University of Alberta

I. DESCRIPTION OF POSITION:

The Vice President Global Health (VP-GH) provides guidance, leadership, and support to the GHP. The VP-GH is responsible for assuring that GHP follows the principles and procedures outlined in its operating policy. She/He represents the GHP to the CFMS executive and with external organizations such as the International Federation of Medical Students' Association (IFMSA). She/He is also responsible for managing the GHP budget, organizing GHP meetings, and maintaining communication between GHP members.

II. ACTIVITIES

Meetings Attended:

1. CFMS AGM, Halifax, NS, Sept 26-28, 2008
2. CFMS Exec Meeting, Ottawa, ON, Oct 17-19, 2008
3. CCIH, Ottawa, ON, Oct 26-28, 2008
4. CFMS Executive Teleconference, Dec 3, 2008
5. GHP National Officer Teleconference, Dec 10, 2008
6. CFMS Exec Meeting, Toronto, ON, Jan 16-18, 2009
5. IFMSA March Meeting, Hammamet, Tunisia, Mar 2-9, 2009
7. GHEC Conference, Seattle, WA, April 3-5, 2009
8. AM10 Organizing Committee Teleconference, May 30, 2009
9. GHP National Officer Teleconference, May 31, 2009
10. IFMSA August Meeting, Ohrid, Macedonia, Aug 5-11, 2009
11. CFMS Exec Meeting, Toronto, ON, Aug 15-16, 2009
12. GHP National Officer Teleconference, Sept 3, 2009

Portfolio Updates

The CFMS-GHP is now officially partnering with IFMSA-Quebec to organize the IFMSA August Meeting 2010 in Montreal. Currently, the VP-GH sits on the AM10 Organizing Committee Executive Board as one of the CFMS-GHP Representatives. However, because of the heavy workload involved with the VP-GH portfolio, I do not recommend that the incoming VP-GH fill this position. Nonetheless, the VP-GH should oversee and support CFMS-GHP involvement in this partnership.

Project Areas (Related Documents in AGM Meeting Package):

1. We're going to Montreal! IFMSA August Meeting 2010

At BAGM, CFMS reps approved CFMS-GHP's partnership with IFMSA-Quebec to jointly bid to host the IFMSA August Meeting 2010. In June and July, we finalized our MOU with IFMSA-Quebec to lay out the terms of our partnership. I was also heavily involved in laying the groundwork for fundraising for the meeting, and set up a CFMS-GHP sponsorship committee.

The presentation on our bid and the election for the host country of AM2010 took place at this year's IFMSA August Meeting 2009 in Ohrid, Macedonia. The CFMS-GHP brought 11 delegates, and the team did an incredible job promoting! We had amazing display banners for our booth, maple leaf cookies, red T-shirts for all, and a stellar presentation to over 500 medical students (special thanks to Alex Sigouin-Duquette and Sarah Fung). We won the bid with 70% of the vote.

The Montreal AM10 Organizing Committee (OC) is now in full swing. The OC is compromised of an executive board and a number of sub-committees. Our seven member Executive Board has now been finalized, and the CFMS-GHP hold three positions. Austin Gagne is Vice-President, and Sarah Fung and myself also hold positions as CFMS representatives. In addition, Sana Ghaznavi has recently taken on the role of Partnerships Committee Director, so will be responsible for fundraising initiatives for the meeting.

Related documents:
IFMSA Update – August 2009
Memorandum of Understanding between IFMSA-Qc and CFMS-GHP
Sponsorship Package for AM10

Also:
www.montrealam10.com

2. IFMSA August 2009 Meeting in Ohrid, Macedonia

In addition to winning our bid to host next August's meeting, our delegation had some other fantastic accomplishments. Over 50 exchange contracts for this year were signed (and more to come!), and the IFMSA accepted our policy statement on Aboriginal Health. One of our delegates conducted a survey of medical students at the meeting on their knowledge and beliefs on reproductive health issues. A number of our delegates also delivered presentations about local, as well as national, projects happening in Canada. Finally, this year, we were pleased to have a few members from outside the GHP attend the meeting, including another member of the CFMS executive.

Related documents:
IFMSA Update – August 2009

3. NEW Global Health List Serve – global@cfms.org
Two of our national officers (NOGHE & NOP) have set up a new global health list serve via our new website. It's a great way to stay up to speed on global health opportunities nationally and internationally. To join, visit global.cfms.org.

4. CFMS-GHP's website – global.cfms.org and www.healthforall.ca
We have been struggling with www.healthforall.ca for over one year now. We have recently decided to phase out www.healthforall.ca, and focus on developing global.cfms.org.

5. Pre-departure Training
Our National Officers of Global Health Education (NOGHEs) have done a fantastic job this year of promoting global health education, particular pre-departure training. Pre-departure training for students going on electives overseas is now taking place at all fourteen CFMS schools. In early 2008, only 6/14 CFMS schools offered pre-departure training.

6. Global Health Advocacy Program
The National Officer of Human Rights and Peace (NORP) runs this program. New this year, Global Health Advocates (GHAs) were elected at each school to carry out local and national advocacy initiatives surrounding a particular theme. The theme chosen for this year was Aboriginal Health. At the local level, advocacy was tailored to each school and included introducing Aboriginal Health interest groups, creating opportunities for Canadian medical students to learn more about Aboriginal Health, and lobbying for increased Aboriginal enrollment in Canadian medical schools. National advocacy efforts took place at the MonWHO Conference, Mar 6-8, 2009, in Montreal.

There was a lot of discussion in May at the BAGM, as well as over the summer, about how to move forward with the Global Health Advocacy Program in 2009-10. Last year was the first year for the program, and some schools selected GHAs fairly late in the year. Based on these discussions, the CFMS-GHP (CFMS Global Health Program) is encouraging schools to **select one GHA** this year, and continue with the advocacy theme of **aboriginal health** for a second year. Individual schools can decide how to select the GHA, but election is recommended. We will encourage GHAs from last year to mentor new GHAs for two months to facilitate the handover process.

7. MonWHO Conference
GHAs from 11 CFMS schools participated in this conference, and specifically represented the CFMS with three posters, as well as one presentation. Since the theme of the MonWHO was "Environmental Health", GHAs focused on issues that linked the GHAP's theme of Aboriginal Health with the MonWHO theme. Topics presented on included: Human Health Risk Assessment: Arsenic and the Northern Alberta Oil Sands; The Effect of Environmental Contamination on the Health of Aboriginal Populations; The Need for Safe Drinking Water in First Nations Communities; and Cultural Safety in Understanding Aboriginal Health and Environmental Health.

This academic year, the CFMS-GHP has been invited to hold a seat on the MonWHO Secretariat to further strengthen the partnership between our two organizations. The outgoing NORP will hold this seat.

Related documents:
MonWHO 2009 Update

8. CFMS International Exchange Program
The Jr & Sr National Exchange Officers (NEOs) coordinate this program. In 2009, the CFMS sent 101 students on clinical and research exchanges – more than ever before! Also this year, exchange participants are required to complete pre-departure training prior to going on their placements.

For this year, the NEO Sr is very committed to improving some administrative difficulties with the exchange program. He plans to compile a national training guide for LEOs. He is also interested in setting up a fund to purchase malpractice insurance for students from low income countries, and exploring funding for a social program for exchange students.

9. IFMSA March Meeting 2009
This year's March Meeting was held in Hammamet, Tunisia, from Mar 2-9, 2009. Five delegates from the CFMS attended.

Related documents:
IFMSA Update – March Meeting 2009

10. Give A Day Campaign 2009
With the support of the National Officer of Reproductive and Sexual Health (NORSH), GHLs at most CFMS schools participated in the Give A Day Campaign for World AIDS Day.

11. OMSW's Sexual and Reproductive Health Workshop
The NORSH put on a sexual and reproductive health workshop at OMSW (Ontario Medical Students' Workshop) in October. The session made use of plastic models to teach students how to do a pap smear and insert an IUD, and also provided information about major reproductive health issues in the global context. This initiative will be continued in 2009/10, and will also be held at Dal-MUN, and possibly AMSCAR.

12. Administration of the CFMS-GHP
The Jr & Sr National Exchange Officers (NEOs) are responsible for the administration of the CFMS International Exchange Program and coordinate activities at the local and regional levels through LEOs and REOs. The National Officer of Human Rights and Peace (NORP) is responsible for coordinating the Global Health Advocacy Program, and works with Global Health Advocates (GHAs) at each school towards this end, in addition to making necessary arrangements for the MonWHO. The VP-GH overseas the

CFMS' Global Health Program as a whole, and works directly with six National Officers, as well as Global Health Liaisons (GHLs) from each school. Responsibilities also include organizing CFMS-GHP participation at AGM and BAGM, as well as March and August IFMSA meetings.

III. FOLLOW-UP, VISION, GOALS AND RECOMMENDATIONS FOR THIS POSITION

1. IFMSA August Meeting 2010

This year, the CFMS-GHP bears the wonderful and monumental task of jointly organizing the IFMSA August Meeting 2010 in Montreal. I recommend the VP-GH assume a mainly supervisory role over CFMS involvement in this project. One recommendation would be for the VP-GH to request a progress update from one of the CFMS members of the AM10 Organizing Committee (OC) Executive *on a monthly basis* to remain up to speed with new developments.

2. Exchanges

It has recently been suggested that instead of having two National Exchange Officers (NEOs) and three Regional Exchange Officers (REOs), it would be more efficient to have two National Exchange Officers (NEOs) and two National Officers of Research Exchange (NOREs). Since our REOs and NEO Jr have not yet been hired, it would still be possible to make this change. The implication would be that we may have to fully fund extra people to attend the IFMSA meetings in March and August. The newly elected VP-GH should communicate with the past VP-GH and NEO Sr early in his/her tem regarding this to discuss further.

The NEO Sr also suggested that rather than bringing REOs to AGM for training, it would be better for the two NEOs and three REOs to meet separately, after the NEO Jr is hired. Since this can be accomplished without increasing costs, we are implementing this change this year.

3. Partnerships

I think a major goal for the CFMS-GHP this year is to develop internal operating guidelines and a terms of reference document regarding partnerships between CFMS-GHP and external organizations. Also, a manual for national officers/GHP members to maintain partnerships and recruit partners would also be invaluable to the GHP. This project falls in the National Officer of Partnership's (NOP) portfolio, but the VP-GH is encouraged to facilitate this process through regular communication and discussion with the NOP.

4. CFMS-GHP Website and List Serve

Another major focus for the year should be to develop our website global.cfms.org and increase membership of our list serve. Last year, our attention was divided between our CFMS website and www.healthforall.ca. We have now decided to phase out the latter website, and streamline its resources with the CFMS website. Developing forums for students to share information and discuss global health elective experiences should be a major goal for the year.

5. Global Health Advocacy Program (GHAP)
Last year was the GHAP's first year, and we're still experiencing growing pains. This year, we have already sent out a number of communications to ensure GHAs are selected early at each school. We have also developed a GHA manual. With an experienced National Officer of Human Rights and Peace (NORP) to lead this program this year, we are in good hands. The VP-GH should, however, communicate regularly with the NORP regarding this program and offer support where needed.

IV. SUGGESTIONS FOR IMPROVEMENT

1. Regular communication with NOs, past VP-GH, VP Finance and AM10 OC
Regular communication with different groups of people is so important for this position, but always a challenge. One strategy I think would be helpful is for the VP-GH to pick a *certain day of the week, once per month* (ex. the last Wednesday of every month) to:

1. host a national officer teleconference
2. talk to the past VP-GH
3. talk to the VP Finance
4. obtain a progress report from a CFMS rep on the IFMSA AM10 OC

To elaborate on point #3, I think that every month, the VP Finance should send a record of global health spending to the VP-GH to double check for any discrepancies. Perhaps a few days after the report is sent, the two could have a short meeting over the phone to discuss the record. Global health spending / budgeting can be complicated so regular communication between VP-GH and VP Finance is very important.

2. VP-GH Assistant from CFMS Exec
Next year, I strongly recommend that the VP-GH should have one of the regional reps on the CFMS Exec act as an assistant to help out with various administrative tasks.

3. GHP Working Groups
Last year, participation on small working groups was mandatory for all GHLs. However, because many GHLs had a lot of work to do locally and were not committed to the national working groups, many of the groups were quite inefficient. It is recommended that this year, working groups should be optional for GHLs.

* * *

NATIONAL OFFICER REPORT - National Exchange Officer, Sr (NEO)

Ken Mendoza, University of Manitoba

I. DESCRIPTION OF POSITION

As the National Exchange Officer Sr., I am responsible for coordinating the research and clinical exchanges within the International Federation of Medical Students Association (IFMSA). This includes coordinating the local committees in setting up incoming student placements, selecting outgoing participants, liasing with the elective coordinators at each Canadian university and communicating with exchange officers around the globe to improve the quality of the IFMSA exchange program.

II. ACTIVITIES

1. Meetings attended
   - IFMSA MM2009 – Tunisia
   - CFMS BAGM 2009 – Edmonton
   - IFMSA AM2009 - Macedonia

2. Portfolio changes
   - N/A

3. Completed Projects
   - 2008-2009 Outgoing Exchanges
   - Signed exchange contracts for 2010-2011 season

4. Current Activities
   - 2008-2009 Incoming Exchanges
   - 2009-2010 Outgoing Exchanges
   - 2009-2010 Incoming Exchanges
   - Hiring of new LEO/REO/NEOs

III. FUTURE GOALS

- Expand our exchange program (increasing the number of available spots)
- Assist students that have difficulty obtaining malpractice insurance
- Get a better idea of the Exchange budget
- Promote our exchange program to Deans/clerkship coordinators in St.Johns during or after the SGM/BAGM
- Establish a social program for incoming students
- Require students to evaluate their exchanges
- Ensure that LEO/REOs send out reimbursement forms promptly
- Clarify our exchange conditions

IV. RECOMMENDATIONS AND SUGGESTIONS FOR IMPROVEMENT

- Increased communication between the LEO/REO/NEOs and University officials
- Having a NEO assistant at the NEO's university
- Ask MedSocs to budget funding so LEO Seniors can attend the AGM
- Quebec now has 4 NEO/NOREs: NEO-in, NEO-out, NORE-in, and NORE-out. Most NMOs follow that format for their NEO structure. The REO system has only been in place for a year (developed when Jessie was VP-GHP and Mario was NEO, and first run this year with me and Fareen), but in my personal opinion it is not as effective as having 2 more NEO/NOREs rather than 3 REOs. It would be easier if each person has a dedicated role and a national overview. Realistically, last year, Fareen was the NEO-in and I was the NEO-out. Under the current system, I have to learn incoming as I go this year, while trying to teach outgoing to the new NEO Jr.
- LEOs need better training. Some LEOs have had poor handovers. I'll be working on a national training guide.

NATIONAL OFFICER REPORT - National Officer of Global Health Education (NOGHE)

Michael Slatnik, University of Western Ontario

I. DESCRIPTION OF POSITION

As National Officer of Global Health Education, my goals are to promote the incorporation and continual improvement of global health education and pre-departure training at all Canadian medical schools. I work closely with the Chairs of the Pre-departure Training and Global Health Curriculum working groups, as well as relevant external organizations such as the AFMC Global Health Resource Group, the Global Health Education Consortium and the Canadian Society for International Health.

II. ACTIVITIES

1. Meetings attended:

- Bethune Round Table, UofT International Surgery Conference (Toronto, May 2009)
- Refugee Health Conference (London, ON, Jun 2009)
- IFMSA August Meeting (Ohrid, Macedonia, Aug 2009)
- GHEC Student Advisory Committee meeting (Teleconference, Sep 2009)

2. Portfolio update

- No changes

3. Completed projects (over the last quarter, ie since BAGM)

- Creation of CFMS GHP Global Health Listserv
- Creation of first draft of Global Health Curriculum 'Advocacy Toolkit'
- Creation of medical student position on the CFPC Global Health Committee

4. Current activities

- Continuation of predeparture training advocacy and implementation.
- Conference call with Dr Nick Busing, AFMC CEO and President, regarding predeparture training national advocacy. Kelly Anderson and myself have drafted a paragraph for proposed implementation into the FMEC document (Future of Medical Education in Canada), and are working with AMSA and IFMSA-Qc to advocate for predeparture wording into the accreditation standards of US and Canadian medical schools.

- I am working with Laura Chng, our lovely NOP, on continued promotion of the CFMS GHP Global listserv, to increase membership and usage.
- I am continuing work with the CFPC Global Health Committee to define terms of reference for the medical student role.
- I am continuing work on the global health curriculum advocacy toolkit.
- I am chairing an IFMSA working group on the ‘Ethical guidelines for IFMSA clinical exchanges’.
- I have joined the GHEC Student Advisory Committee, and am actively participating in their work.

III. FUTURE GOALS

- Continued support for pre-departure training at every CFMS school, liaising with IFMSA-Quebec to coordinate pre-departure training at every Canadian medical school, and working on improving quality and structure of pre-departure training at all schools.
- Continued work on global health curriculum via committees and institutional partnerships.

IV. RECOMMENDATIONS AND SUGGESTIONS FOR IMPROVEMENT

None!

NATIONAL OFFICER REPORT - National Officer of Partnership (NOP)

Laura Chng, University of British Colombia

I. DESCRIPTION OF POSITION

The NOP is responsible for creating new and sustaining existing appropriate partnerships with external global health-related organizations, such as federal bodies, multilateral organizations and NGOs. This includes seeking out new and existing national global health projects that should be liaising with the CFMS GHP.

II. ACTIVITIES

1. Meetings attended:

- None since BAGM

2. Portfolio changes:

- Termination of healthforall.ca
- Responsible for transition, integration and restructuring of the CFMS-GHP domain within www.cfms.org/global

3. Completed Projects

- Creation of initial draft document on "Partnership Agreement and Guidelines" for introduction and consideration at the AGM with a view to incorporate into the IOGs.
- New partnership with SUNSIH. Collaboration on a half-day workshop at the upcoming CCIH that addresses issues of youth engagement in global health.
- Re-establishment of partnership with CSIH to build our overall continuity as a global health organization. Terms of partnership include the creation of dedicated poster space for Canadian medical students on the Sunday afternoon and future possibility for reduced conference registration rates.
- In collaboration with the NOGHE, the creation of global listserv to provide the latest global health opportunities to interested medical students.

4. Current Activities

- Creation of the Partnership Agreement and Guidelines Document and survey of the GHP to assess the number and nature of current partnerships within the organization
- Re-establishment of working partnership with CMAJ to improve academic engagement of Canadian medical students. Terms of partnership are pending but will most likely include dedicated research or editorial spaces for medical students in quarterly issues of the journal
- Establishing an alliance with CCGHR (Canadian Coalition for Global Health Research) with a view to create mentorship opportunities for all students in global

health; also to enhance research skills for young researchers through their summer institute that would be open for medical students.
- Promotion and Launching of the Global ListServ in Fall 2009
- Transition and restructuring of the old www.healthforall.ca site to a more streamlined and integrated version within global.cfms.org
- Poster Presentation at the upcoming CCIH to increase the profile of the CFMS-GHP and our ongoing programs and activities.

III. **FUTURE GOALS**

- Create a working framework and database of all external (local, national, and international) partners of the CFMS and contact information for purposes of transparency and resource sharing
- Conduct a survey interview with a representative from each medical school (most likely the GHL as they are elected) to investigate the perceived needs of Canadian medical students in terms of global health opportunities they feel are relevant and useful for their learning and career advancement
- Maintain current partnerships and explore working relationships with AMSA etc
- Increase Global listserv subscriber numbers to 1000
- Create a formal handover procedure/document to ensure smooth transition between NOPs in the future

IV. **RECOMMENDATIONS AND SUGGESTIONS FOR IMPROVEMENT**

- None!

NATIONAL OFFICER REPORT - National Officer of Human Rights and Peace (NORP)

Trisha Rys, Northern Ontario School of Medicine

I. DESCRIPTION OF POSITION

The role of the NORP is to create opportunities for Canadian medical students to learn more about issues related to Human Rights and Peace, and to act as advocates in this regard. The role of the NORP involves working with the GHP's Advocacy Working Group and Global Health Advocates (GHAs) to develop local and national advocacy initiatives. As well as supporting Global Health Liaisons (GHLs) to organize campaigns related to human rights and peace.

II. ACTIVITIES

1. Meetings attended:

- CFMS teleconferences
- GHA teleconferences
- Montreal World Health Organization Simulation (MonWHO)
- AGM (Sept 2009)

2. Portfolio update (list any changes to the nature of your portfolio, etc)
Not currently

3. Completed projects (over the last quarter, ie since AGM)

- GHA Manual
- Theme Proposal for the MonWHO
- Presentation to NOSMs first year students about the CFMS and positions available

4. Current activities

- Provide guidance to medical schools regarding the selection process of the 2009-2010 GHAs
- Attending MonWHO Secretariat teleconference every two weeks
- Theme proposal presentation to the MonWHO Secretariat next week
- Preparing for the CFMS conference (AGM) taking place in Thunder Bay
- Assistance in developing and eventually conducting GHA delegate training sessions
- Increasing student awareness of the MonWHO conference
- Working collaboratively with the MonWHO Secretariat to organize GHA workshop and poster presentations
- Reflecting on the GHA program and development of strategies to improve the program this year.

III. FUTURE GOALS

- Following the NORP position I would like to stay involved with the GHA program in some capacity
- To improve communication/ collaboration with the Advocacy working group
- Increase collaboration between GHLs and GHAs
- Select and Organize the 2009-2010 GHAs
- To attend AGM
- Submitting claims for the GHAs travel expenses
- Attendance/ Organization of the MonWHO
- Attendance/ Presentation at next IFMSA meeting

NATIONAL OFFICER REPORT - National Officer of Reproductive and Sexual Health

Sarah Fung, University of Alberta

I. DESCRIPTION OF POSITION

The goal of NORSH is to create educational and practical opportunities in the vast domain of sexual and reproductive health for Canadian medical students. In particular, NORSH is responsible for overseeing major international awareness days on a national level, including World AIDS Day and International Women's Day. In addition, NORSH organizes and implements workshops and conferences related to sexual and reproductive health. The above is achieved by close collaboration with other GHP members, national and international organizations and NGOs.

II. ACTIVITIES

1. Meetings attended

    i) CFMS BAGM, Edmonton, Alberta, May 1-2
    ii) IFMSA Macedonia AM09, August 5-11
    iii) NO conference calls, May 31 and September 6
    iv) MSFC conference call, June 4
    v) Montreal AM2010 conference calls, May 30 and September 8

2. Portfolio changes

- No changes to NORSH portfolio.
- As a CFMS GHP member and independent to the NORSH role, I am involved in the Montreal AM2010 Executive Board and Organizing Committee.

3. Completed Projects

Macedonia AM09:
- Facilitated session for the Standing Committee on Reproductive Health Including HIV/AIDS (SCORA) on the Greater Involvement of People Living with HIV/AIDS
- Delivered CFMS update to Pan-American Medical Students' Association at Regional Meeting
- Created display boards for Montreal AM2010 promotion
- Presented Montreal AM2010 bid to plenary

4. Current Activities

Regional workshops:
- Ontario Medical Student Weekend (OMSW), October 2009:
    Queens ob/gyn residents will assist in organizing and running workshop; tentatively, will cover deliveries and IUD insertion. OMSW willing to contribute funding.
- Alberta Medical Students' Conference and Retreat (AMSCAR), January/February 2010:
    Alberta College of Family Physicians may organize Women's Health workshop similar to last year; if not, will contact U of C ob/gyn residents.
- Dal-MUN, April 2010:
    Dal ob/gyn residents will assist in organizing and running workshop.

World AIDS Day and Give A Day:
- Continue last year's collaboration.
- Materials order form for WAD 2009 will be available for GHLs at AGM.
- Other WAD promotional materials available on World AIDS Campaign website.
- Update in progress of CFMS WAD Guide originally created by past NORSH.

Montreal AM2010:
- Sponsorship requests submitted to several organizations.
- Accepted offer to be one of two CFMS-GHP representatives on Montreal AM2010 Executive Board.

MSFC-CFMS collaboration:
- Exploring curriculum reform collaboration between CFMS and MSFC.
- May create curriculum reform how-to guide based on MSFC National Coordinator's project at UBC last year.

III. FUTURE GOALS

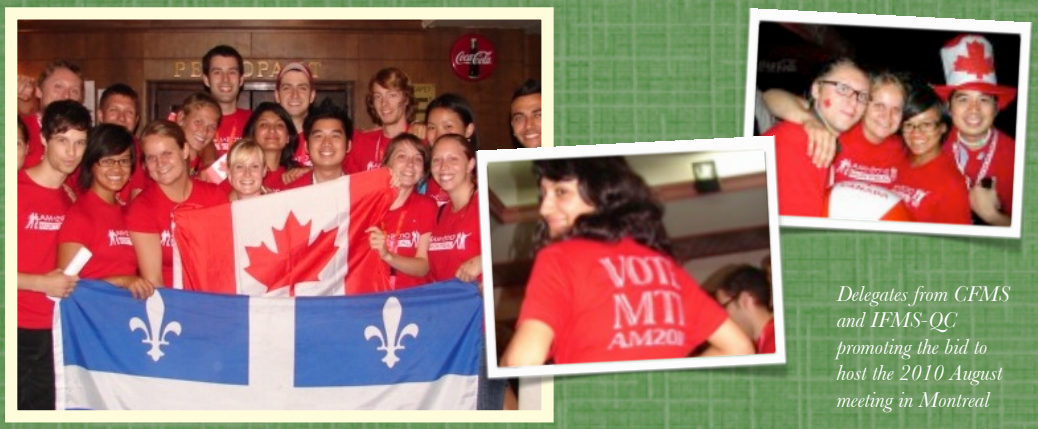
- Continue to work on current projects, as described above.
- Consider creation of nationwide project related to sexual and reproductive health.

IV. RECOMMENDATIONS AND SUGGESTIONS FOR IMPROVEMENT

- None presently.

IFMSA UPDATE

2009 August Meeting in Ohrid, Macedonia



Delegates from CFMS and IFMS-QC promoting the bid to host the 2010 August meeting in Montreal

What is the IFMSA General Assembly?

The Global Health Program of the CFMS represents its membership at the international level biannually at week-long IFMSA General Assemblies (GAs), which take place in March and August. The meetings are comprised of presidents' sessions, evening plenary sessions, standing committee meetings, regional meetings, project presentations and fairs, theme events, as well as lots of social programs.

Presidents' Sessions and Evening Plenary Sessions

At morning Presidents' Sessions, acting presidents meet to review and discuss reports, bylaw changes, policy statements, membership, elections, disciplinary measures, and other issues related to the general administration of the IFMSA. Time is allocated each afternoon for presidents to discuss decisions with their delegations, and motions are voted on during evening plenary sessions. Plenaries begin at 8:00pm and often continue until after midnight!

Standing Committee Meetings

There are six standing committees: medical education, public health, human rights and peace, reproductive health and HIV/AIDS, as well as professional (clinical) and research exchanges. Members of standing committees share ideas through presentations and small group work. In addition, the standing committees on professional and research exchange administrate the IFMSA Exchange Program. At General Assemblies, they exchange forms for program participants, sign new contracts, and review their

CFMS FEMC

IFMSA
International Federation of Medical Students' Associations

(Compiled by Bev Wudel, GHL, University of Saskatchewan)

Highlights

Our Delegation

Brianne Hudson, VP Global Health, U of A
Sarah Fung, NORSH, U of A
Ken Mendoza, NEO Jr., U of M
Michael Slatnik, NOGHE, Western
Shawn Mondoux, Ont. Regional Rep, U of O
Austin Gange, VP External Jr., U of O
Leslie Martin, GHL, U of O
Beverly Wudel, GHL, U of S
Leisha Hawker, GHA, Dalhousie
Sana Ghaznavi, U of A
Jacqueline Zhai, U of T

PAMSA Update

At the regional meetings of the Pan-American Medical Students' Associations (PAMSA), CFMS liaised with other members in the region. The next Regional Meeting in January 2010 will be held in Chile.

SCORA Update

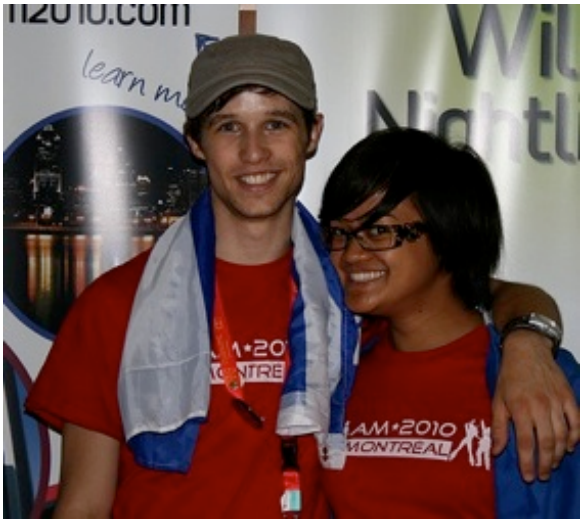
Several CFMS delegates attended the Standing Committee on Reproductive Health Including HIV/AIDS (SCORA). Sarah Fung facilitated a SCORA session on the Greater Involvement of People Living with HIV/AIDS, which encouraged participants to consider how they can include people living with HIV/AIDS in all stages of their programs.

New IFMSA Team of Officials

President: Silva Rukavina (Croatia)
Secretary General: Chantal Fenech (Malta)
VP External: Minke van Minde (Netherlands)
VP Internal: Chijioke Kaduru (Ghana)
Treasurer: vacant
SCOME Director: vacant
SCOPE Director: Ali Cankut Tatliparmak (Turkey)
SCOPH Director: Louise Mulcahy (UK)
SCORA Director: Branislay Chrenka (Slovakia)
SCORE Director: Federica Balzarini (Italy)
SCORP Director: Mori Mansouri (UK)
Region Rep (Americas): Fiorella Barbagelata (Peru)
LOME: Robbert Duvivier (Netherlands)
LOPH: Florian Stigler (Austria)
LORA: Imene Ben Ameur (Tunisia)
LORP: Diego Lemmi (Italy)
LOSO: Lucia Carratala Castro (Spain - Catalonia)
LORMA: vacant
LO UNESCO: Maxime Moulin (France)
LO WHO: Vesna Jugovec (Slovenia)

Montreal victorious in bid to host August 2010 meeting

Sarah Fung, NORSH & IFMSA bid co-presenter



If the sea of red Montreal t-shirts was any indication, delegates from nearly every country were enthusiastic about holding next August's IFMSA GA in Montreal, Quebec. One of the most highly-anticipated events at each GA is the bid promotion and presentations of the candidates to host next year's GA. The Canadian team, a partnership between the CFMS-GHP and its Quebecois equivalent, IFMSA-Quebec, have been working for a full year to put together a professional, comprehensive proposal to showcase what Montreal has to offer the world.

The entire week was marked by delegates from around the world sporting over 200 unmistakable, bright-red Montreal AM2010 t-shirts. The Montreal AM2010 booth featured banner displays, pins, stickers, temporary tattoos, promotional booklets, and countless maple leaf cookies, with CFMS and IFMSA-Qc delegates promoting the bid throughout the GA. Indonesia was also bidding to host. The Canadian bid presentation was very well-received and the team's hard work and dedication paid off with a decisive win (39/55), making the August Meeting 2010 in Montreal a reality.

Why Montreal? Montreal combines an inspirational setting, world-class facilities, professional organization, unforgettable nightlife, and a stimulating academic program. For more information, please visit http://www.montrealam2010.com.

Now that we have secured the GA for next August, the fun is only just beginning! CFMS and IFMSA-Qc are looking for enthusiastic, motivated people to join the team and help realize this vision. There are opportunities to get involved in sponsorship, theme development, logistics, greenification initiatives, and more. If you are interested in being involved in organizing this world-class event that will welcome approximately 700 medical students from around the world, please contact Brianne Hudson at brianne.hudson@cfms.org or Sarah Fung at norsh@cfms.org.

CFMS Exchange Program

Ken Mendoza, NEO

The CFMS Exchange Program is responsible for facilitating international clinical and research exchanges. At the August 2009 IFMSA meeting in Macedonia, we signed a total of 86 contracts with 30 different countries. Some of the new countries signed are Lithuania, Jordan, Greece, and Switzerland. There will more contracts signed between now and the 2010 March Meeting, especially with countries that were not able to send delegates to the 2009 August meeting.

Key developments produced by the exchange program are a student handbook and academic quality kits that will define what a good academic experience is and help to establish a standard for the exchanges. Students are required to fill out evaluation forms as part of their exchange and the statistical results will be used to improve our exchange program at both the local and international level.

Other notable successes from SCOPE/ SCORE sessions include the creation of the Liaison Officer to Research and Medical Associations position and a policy statement exchanges should not be used as a means of fundraising.

2010-2011 Signed Contracts:

Advocacy in the CFMS: the Canadian perspective on an international activity

Presentation to the Standing Committee on Medical Education (SCOME)
Shawn Mondoux, Ontario Regional Representative and PAC Chair

Advocacy is a funny thing. It's like being a child again. You whine and complain repeatedly to the people who have influence over what you want until you get what you've demanded of them. Only in our case we have good arguments and we can only hope that politicians are as ethical as our parents were. Here, in Canada, we have created a culture where this strategic whining is not only acceptable, but encouraged and necessary. After all, as the age old adage goes, «ask and thou shall eventually, after a long period of asking, receive. »

But, as I was both shocked and then pleased to find out, advocacy is a very new and relatively foreign concept to many National Medical Organizations (NMOs) from across the pond, both the Atlantic and Pacific. The beauty of this issue is that they have just recently realized the effectiveness of this strategy and are generally looking to establish advocacy programs of their own. Luckily, as chair of the CFMS' Political Advocacy Committee (PAC), I was able to sit in with a committee whose hot topic this year seemed to be advocacy and found that the CFMS had something to offer to everybody around the table.

The Standing Committee on Medical Education (SCOME) represents a unique committee on the IFMSA stage because its members deal almost exclusively with internal national medical issues, but seek advice on the world stage. These are motivated people who are seeking to change the educational experience of their students for the best.

As a CFMS member, I was able to deliver a session on the basics of advocacy; team building, formalizing issues, pertinent research, asking for help and knowing your government. The goal of the session to plant the idea of lobbying and get the ball rolling in other NMOs. The session was incredibly well received and much dialogue was conducted with nations such as Australia, Finland and Poland, who are all at various stages of starting their own programs. The CFMS is currently providing information and savoir-faire to Poland to increase their political awareness and provide an initial platform for advocacy. As we move forward with the IFMSA, the CFMS and I feel as though advocacy will become a more important issue for both SCOME and the IFMSA in general. We believe that the CFMS will have much to offer and look forward to continuing our relationships with other NMOs to improve advocacy efforts worldwide!

Reproductive Health Training at IFMSA Schools

Jacqueline Zhai, University of Toronto

At the IFMSA August meeting in Ohrid, Macedonia, I conducted a survey study to evaluate the reproductive health training medical students receive at their respective schools. All medical student representatives at the conference, including more than 800 delegates from 85 countries, were invited to participate by filling out a 3-page survey. The survey included questions on specific reproductive health topics covered in the student's curriculum, length and teaching format of each topic, and student demographic information. We had a total return of 324 completed surveys over the course of one week.

The data collected are now under analysis for an assessment the quality of reproductive health education in medical curricula in different IFMSA regions. Demographic information will be used to examine the geographical, religious, and cultural determinants of the quality of training in reproductive health. The training a student receives is, in turn, an important determinant of the student's competency in clinical settings. This competency is not only essential for dealing with intricate reproductive health issues in future clinical practice, but also in advocating on behalf of their patients in the society. Current literature indicates that sexual and reproductive heath care, especially topics like abortion and fertility, are significantly under-represented in the basic medical curriculum in both developing and developed countries alike. Therefore, an evaluation of current reproductive health curricula and their social contexts is essential in identifying issues and barriers that need to be addressed. The IFMSA meeting was a great forum to conduct this research.

The study was met with welcoming enthusiasm and helpful input from many students around the world. It was a great learning experience as well. Lastly, I would like to say a special thanks to everyone on the CFMS and IFMSA-Quebec team who have helped with survey distribution and recruitment for the study to make this work!

Policy Statement on Indigenous Health

Beverly Wudel, GHL

There are an estimated 370 million Indigenous people living in over 70 countries worldwide, many of whom are at risk for poor health as a result of factors such as poverty and social marginalization. Given the global implications of these facts, GHAs Jennifer Baxter and Leisha Hawker, and GHL Beverly Wudel saw a need for the IFMSA to adopt a policy statement on the health of Indigenous peoples.

The policy statement included seven recommendations addressing the following issues: development of a strategy for improving the health of Indigenous peoples; a focus on the upstream determinants of health; delivery of holistic healthcare in a culturally safe manner; cultural safety training in medical school curricula; inclusion of Indigenous perspectives on health in medical school curricula; development of strategies to achieve equitable representation of Indigenous people in medical schools; and that research on Indigenous populations follow the principles of ownership, control, access, and possession of health data.

The IFMSA policy statement on the health of Indigenous peoples was adopted by the IFMSA during the plenary sessions of the August 2009 meeting. Jennifer, Beverly and Leisha will be presenting a similar policy statement for adoption by the CFMS at the AGM in September 2009.

IFMSA Policy Statement on the Health of Indigenous Peoples

Contributors: Jennifer Baxter (Queens), Leisha Hawker (Dal), Bev Wudel (UofS)
July 1, 2009

(*This policy statement was adopted by the IFMSA in August 2009.)*

INTRODUCTION

There are an estimated 370 million Indigenous people living in over 70 countries worldwide. They represent a rich diversity of cultures, religions, traditions, languages and histories, yet they continue to be among the world's poorest and most marginalized populations.[1]

A history of colonization of Indigenous peoples with its resulting discrimination and marginalization continues to affect the health of Indigenous peoples. In both poor and industrialized countries in which they live, the health status of Indigenous peoples is invariably lower than that of the non-Indigenous population.[2] The health inequities that exist are due to a broad range of issues that are complex and interdependent.

The International Federation of Medical Students' Associations is the voice of medical students. As future physicians, it is our responsibility to advocate for the promotion and protection of health and human rights of all people. The IFMSA therefore makes the following recommendations:

1. That government collaborates with non-governmental organizations, universities and Indigenous communities to develop a comprehensive strategy for improving the health of Indigenous peoples.

2. That all stakeholders in member nations work to address the upstream determinants of health (income, education, employment, racism and marginalization, environment, housing, cultural identity, and self-determination).

3. That all stakeholders in member nations work to deliver holistic health care in a culturally safe manner.

4. That all medical schools include cultural safety training within their curricula.

5. That all stakeholders in member nations work to ensure the health needs and conceptualizations of health of their Indigenous populations are adequately and appropriately addressed in core medical training.

---

[1] World Health Organization. *Health of Indigenous Peoples*. Retrieved June 30, 2009 from http://www.who.int/mediacentre/factsheets/fs326/en/.

[2] World Health Organization. *Indigenous peoples' right to health.* Retrieved June 30, 2009 from http://www.who.int/hhr/activities/indigenous_peoples/en/index.html

6. That all medical schools and other stakeholders work to develop a strategy aimed at achieving equal representation of Indigenous peoples within medicine and the other health professions.

7. That all research on Indigenous health follow the principles of ownership, control, access, and possession of health data.

DISCUSSION OF RECOMMENDATIONS

1. That government collaborates with non-governmental organizations, universities and Indigenous communities to develop a comprehensive strategy for improving the health and self-determination of Indigenous peoples.

Article 23 of the UN Declaration on the Rights of Indigenous Peoples affirms the right of Indigenous peoples "to determine and develop priorities and strategies for exercising their right to development. In particular, Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programs affecting them and, as far as possible, to administer such programs through their own institutions".[3] Increased participation in and control over cultural, social, political and economic life has been shown to improve the health of Indigenous peoples. Community-directed models of health services are more responsive to the culture and needs of individual communities. Given that a transfer of control requires significant resources, we advocate that self-governance be associated with a fair redistribution of lands and resources.[4] In the past, governments and universities have conducted research and developed programs without consulting the Indigenous people affected. Indigenous peoples can best determine their needs and how to address those needs. Governments and universities should thus collaborate with Indigenous peoples with the aim of building capacity and improving health.

2. That all stakeholders in member nations work to address the upstream determinants of health (income, education, employment, racism and marginalization, environment, housing, cultural identity, and self-determination).

The IFMSA recognizes that the health of Indigenous people and communities is influenced by a number of complex and interrelated factors. The health of individuals and communities is

---

[3] United Nations. United Nations Declaration on the Rights of Indigenous Peoples. Geneva: Office of the United Nations High Commissioner for Human Rights, 2008.

[4] Royal Commission on Aboriginal Peoples. Highlights from the Report of Royal Commission on Aboriginal Peoples. Ottawa:Ministry of Supply and Services, 1996.

influenced by more than just biology and access to health services; it depends on the social, political, and economic environment in which people live.[5]

Research shows that Indigenous people tend to attain a lower level of education, are more likely to be unemployed or underemployed, and have a lower mean income when compared to their non-Indigenous counterparts.[6] Furthermore, historical policies of assimilation have contributed to a loss of cultural identity among many Indigenous groups. This loss of identity, further complicated by a long history of racism and marginalization of Indigenous people, continues to negatively influence the health of these groups.[7]

The IFMSA, recognizing the powerful influence of these upstream determinants on the health of Indigenous people, recommends that member nations advocate for the development and implementation of policies that work towards a social, political, and economic environment that supports and promotes the health of Indigenous peoples.

3. That all stakeholders in member nations work to deliver holistic health care in a culturally safe manner.

Based on a globally-shared Indigenous paradigm that is both holistic and spiritual, as well as strongly tied to traditional lands and the environment as a living entity, Indigenous peoples have a much more inclusive conceptualization of health and healing than is allowed for by the biomedical model of health.[8] Indigenous populations who are forced to minimize health to physical ailments or disease states thus face barriers to accessing health services and achieving positive health outcomes. When physicians ignore these interrelated aspects of health they fail to meet the health needs of their Indigenous patients and thus perpetuate a cycle of inadequate health services and poor health.

Recognizing health in its cultural context and providing holistic health care is essential for the improved health of Indigenous persons and communities. This includes recognizing and

---

[5] World Health Organization. *The determinants of health.* Retrieved June 30, 2009, from http://www.who.int/hia/evidence/doh/en/print.html.

[6] World Health Organization (2007). *Social determinants and Indigenous health: The International experience and its policy implications.* Retrieved June 30, 2009 from http://www.who.int/social_determinants/resources/indigenous_health_adelaide_report_07.pdf.

[7] World Health Organization (2007). *Social determinants and Indigenous health: The International experience and its policy implications.* Retrieved June 30, 2009 from http://www.who.int/social_determinants/resources/indigenous_health_adelaide_report_07.pdf.

[8] Wilson, D. (2006). *The practice and politics of Indigenous health nursing.* Contemporary Nurse, *22*(2). Retrieved June 30, 2009, from http://www.contemporarynurse.com/archives/vol/22/issue/2/article/725/the-practice-and-politics-of-indigenous-health

respecting traditional healers and health practices as a valued part of the healing process and working with such practitioners to maximize Indigenous health.

Implicit in delivering holistic health care to Indigenous peoples is practicing in a culturally safe manner. Cultural safety extends beyond cultural competency, which entails skills, knowledge and attitudes, to include self-reflection on one's attitudes, biases, and prejudices.[9] By understanding that Indigenous people's paradigms may differ from one's own, and the potential negative effect one's beliefs and actions regarding culture can have on physician-patient relationships, physicians can move towards seeing the strengths and capabilities of Indigenous peoples and populations.[10] It is only with this positive outlook - moving past negative stereotypes and misconceptions - that the strong physician-patient relationships required for positive changes in Indigenous health and health service provision can be fostered. In this appreciation for differences, allowing their patients to define culturally safe services, physicians can understand how best they can provide truly holistic health care.

4. That all medical schools include cultural safety training within their curricula.

The IFMSA recommends that core medical education include the skills necessary for self reflection in cultural understanding including personal attitudes, biases and prejudices, such that future physicians are trained to be culturally safe care providers.[11] Inherent in this cultural safety training is cultural competence (skills, knowledge and attitudes), an understanding of cultural heterogeneity (particularly applied to Indigenous peoples) and the dynamic nature of culture, and the skills needed to recognize one's lack of knowledge of the individual perception of health.[12]

---

[9] IPAC-AFMC (2009). *First Nations, Inuit, Métis health core competencies: A curriculum framework for undergraduate medical education.* Retrieved June 19, 2009, from http://www.afmc.ca/social-aboriginal-health-e.php

[10] Wilson, D. (2006). *The practice and politics of Indigenous health nursing.* Contemporary Nurse, *22*(2). Retrieved June 30, 2009, from http://www.contemporarynurse.com/archives/vol/22/issue/2/article/725/the-practice-and-politics-of-indigenous-health

[11] IPAC-AFMC (2009). *First Nations, Inuit, Métis health core competencies: A curriculum framework for undergraduate medical education.* Retrieved June 19, 2009, from http://www.afmc.ca/social-aboriginal-health-e.php

[12] Towle, A., Godolphin, W., & Alexander, T. (2006). Doctor-patient communications in the Aboriginal community: Towards the development of educational programs. *Patient Education and Counseling, 62.* Retrieved June 20, 2009, from the Elsevier database.

Cultural safety also empowers physicians to interrupt unequal power relationships, which can be significant barriers for Indigenous patients.[13,14] By allowing the patient to define a "safe service", the patient-centered model of care is emphasized, benefiting patients of all cultural origins.[15]

The IFMSA believes medical school curricula can serve as a starting point in developing background knowledge and fundamental skills required for the evolution in communication of non-Indigenous physicians working with Indigenous patients.[16] With a strong introduction, it is possible that greater numbers of future physicians will develop an interest in continuing this development process, thus increasing access to culturally safe care for Indigenous populations worldwide. This would not only serve to benefit Indigenous patients, but would open doors for better understanding of communication complexities with patients of other marginalized and disenfranchised populations.[17]

5. That all stakeholders in member nations work to ensure the health needs and conceptualizations of health of their Indigenous populations are adequately and appropriately addressed in core medical training.

For countries in which disparities exist between the health of Indigenous and non-Indigenous populations, and/or where Indigenous conceptualizations of health differ from the mainstream medical model, it is important that these concepts are addressed in medical education, such that future physicians are a part of positive changes in Indigenous health care and health outcomes.

---

[13] IPAC-AFMC (2009). *First Nations, Inuit, Métis health core competencies: A curriculum framework for undergraduate medical education.* Retrieved June 19, 2009, from http://www.afmc.ca/social-aboriginal-health-e.php

[14] Towle, A., Godolphin, W., & Alexander, T. (2006). Doctor-patient communications in the Aboriginal community: Towards the development of educational programs. *Patient Education and Counseling, 62.* Retrieved June 20, 2009, from the Elsevier database.

[15] IPAC-AFMC (2009). *First Nations, Inuit, Métis health core competencies: A curriculum framework for undergraduate medical education.* Retrieved June 19, 2009, from http://www.afmc.ca/social-aboriginal-health-e.php

[16] Towle, A., Godolphin, W., & Alexander, T. (2006). Doctor-patient communications in the Aboriginal community: Towards the development of educational programs. *Patient Education and Counseling, 62.* Retrieved June 20, 2009, from the Elsevier database.

[17] Peachy, L.G., McBain, K.E., & Armstrong, R.M. (2006). Indigenous health: burden or opportunity? *eMJA, 184*(10). Retrieved June 26, 2009, from http://www.mja.com.au/public/issues/184_10_150506/pea10434_fm.html

In Canada[18], as well as Australia and New Zealand,[19] curriculum frameworks — to be implemented in medical schools nation-wide — have been developed outlining key objectives addressing Indigenous health issues in an effort to minimize health disparities in Indigenous populations and promote access to culturally safe and appropriate health care.

The IFMSA recommends that all member nations evaluate the education currently provided to their medical students regarding Indigenous health practices, health needs, and culturally safe care for their Indigenous populations to identify any gaps that may exist. Based on these gaps, learning objectives can be created in partnership with key faculty and Indigenous stakeholders to provide an overarching framework for comprehensive Indigenous health education, the specifics of which can be implemented based on regional differences in Indigenous populations and practices.

The IFMSA further recommends that diverse teaching methods be considered that go beyond didactic lectures, as simple awareness is not enough to effect changes in attitudes, physician-patient relationships, or community health outcomes. Teaching methods should ensure students have the opportunity to apply and incorporate what they have learned into patient care situations and settings. Ideally, this would include an experiential component, as evidence suggests that medical students participating in clinical placements in Indigenous communities are more likely to practice in such locations.[20]

6. That all medical schools and other stakeholders work to develop a strategy aimed at achieving equitable representation of Indigenous peoples within medicine and the other health professions.

---

[18] IPAC-AFMC (2009). *First Nations, Inuit, Métis health core competencies: A curriculum framework for undergraduate medical education.* Retrieved June 19, 2009, from http://www.afmc.ca/social-aboriginal-health-e.php

[19] CDAMS (2004). *CDAMS indigenous health curriculum framework.* Retrieved June 21, 2009 from http://www.medicaldeans.org.au/pdf/CDAMS%20Indigenous%20Health%20Curriculum%20Framework.pdf

[20] Medical News Today (April 23, 2008). Indigenous health education essential to close the gap, Australian Medical Students' Association. *Medical News Today.* Retrieved June 21, 2009, from http://www.medicalnewstoday.com/articles/104958.php

Despite increasing concern regarding the health of Indigenous people, they continue to be underrepresented in medical schools.[21,22, 23,24] The need to increase the number of Indigenous physicians extends beyond simply achieving equality. Lack of access to health care, including primary care physicians, is contributing to inequality in the health of Indigenous people.[25] Increasing Indigenous representation in medicine has the potential to improve access to health care. Furthermore, access of Indigenous peoples to physicians who share their culture and language may reduce barriers to health by providing culturally safe medical care and improving self-determination of Indigenous communities.

Many medical schools in Canada, the United States, Australia, and New Zealand have developed strategies to increase enrollment of Indigenous students in medical school. Despite these efforts, only a modest increase in Indigenous physicians and medical students has been achieved.[26] This can be attributed, in part, to an applicant pool that is underrepresentative of the Indigenous population,[27] suggesting that the strategies employed have not addressed many of the barriers preventing Indigenous students from applying for admission.

Further strategies are needed to achieve a representative physician population. While more research is needed to identify best-practice strategies necessary to achieve optimal Indigenous representation in medicine, proposed suggestions for removing barriers include:

- Development of alternative admissions pathways for schools which do not currently have a formal policy
- Innovative use of resources and technology to provide distributive medical education, allowing students to study in or near their hometown (recognizing that inherent in this is improved access to technology for many Indigenous populations)
- Providing opportunities for clinical placement in communities and facilities that serve Indigenous peoples

---

[21] Spencer A, Young T, et al. (2005). Survey on Aboriginal issues within Canadian medical programmes. *Medical Education* 39:1101-09.

[22] Lawson KA, Armstrong RM & Van der Weyden MB (2007). Training Indigenous doctors for Australia: shooting for a goal. *Medical Journal of Australia* 186(10).

[23] Butts G (2008). Diversity in academic medicine: Call to action. *Mount Sinai Journal of Medicine*. 75:489-90.

[24] Dhalla IA, Kwong JC et al. (2002). Characteristics of first-year students in Canadian medical schools. *CMAJ* 166 (8).

[25] Lawson KA, Armstrong RM & Van der Weyden MB (2007). Training Indigenous doctors for Australia: shooting for a goal. *Medical Journal of Australia* 186(10).

[26] International Network on Indigenous Health Knowledge and Development (2003). Knowledge translation to improve the health of Indigenous Peoples. Retrieved June 20, 2009 from http://www.inihkd.org/INIHKD_Discussion_Document%20_March_2003.pdf

[27] Collishaw NE. Canadian medical student selection and some characteristics of applicants. J Med Educ. 1972;47:254-62.

- Development of programs that provide cultural and social support in post-secondary institutions that currently lack these; facilitation of contact between students and existing Indigenous support services where available
- Providing educational support for students who do not meet requirements for admission, but would be suitable applicants if knowledge gaps were addressed
- Encouraging high school students to consider medicine as a career; ensuring career counselors are informed on medical admission requirements and able to provide early support to high school students considering medicine as a potential career
- Establishment of mentorship programs linking Indigenous students considering a career in medicine with Indigenous physicians[28]

The IFMSA believes that achieving a representative population of Indigenous physicians is a necessary step to realizing the goal of Indigenous health. Medical schools in member nations with Indigenous populations must work with local Indigenous stakeholders to develop strategies to increase Indigenous representation in medicine.

7. That all research on Indigenous health follows the principles of ownership, control, access, and possession of health data.

Information about the health status of Indigenous peoples is essential for advocacy and development of initiatives to address their individual health needs. However, research methods are based on a western European value system that is different from the values of many Indigenous peoples. Research - including program evaluation, surveillance, and uses of health data- should derive from Indigenous values, culture, and traditional knowledge. Indigenous communities should play a directing role in the research and should be involved in all stages from conception to completion. In the past, research has excluded and further marginalized

[28] International Network on Indigenous Health Knowledge and Development (2003). Knowledge translation to improve the health of Indigenous Peoples. Retrieved June 20, 2009 from http://www.inihkd.org/INIHKD_Discussion_Document%20_March_2003.pdf

Indigenous peoples. Following the principles of ownership, control, access, and possession will diminish harmful research and improve research relevance.[29]

7.1 The principle of ownership states that a community or group owns information collectively in the same way that an individual owns their personal information. It is distinct from possession. [xxix]

7.2 The principle of control asserts that Indigenous peoples are within their rights in seeking to control all aspects of research and information management processes which impact them. The principle extends to the control of all stages of research, from conception to completion. [xxix]

7.3 The principle of access refers to the right of Indigenous peoples to have access to information and data about themselves and make decisions regarding access to their collective information.[xxix]

7.4 While ownership identifies the relationship between a people and their data in principle, possession or stewardship is more literal. Although not a condition of

---

[29] First Nations Centre. 2007. OCAP: Ownership, Control, Access and Possession. Sanctioned by the First Nations Information Governance Committee, Assembly of First Nations. Ottawa: National Aboriginal Health Organization.
[xxx] WHO Indigenous health fact sheet. Retrieved June 30, 2009 from www.who.int.
[xxxi] NAHO fact sheet on cultural safety. Retrieved June 30, 2009 from www.naho.org.
[xxxii] International Work Group for Indigenous Affairs. Retrieved June 30, 2009 from www.iwgia.org.

ownership per se, possession (of data) is a mechanism by which ownership can be asserted and protected. [xxix]

CONCLUSION

The IFMSA recognizes the existence of significant disparities in the health of Indigenous peoples around the world and acknowledges the need for policies and strategies directed at reducing health inequalities. With the implementation of these recommendations, the IFMSA affirms the need for, and possibility of, improvements in the health of Indigenous peoples worldwide.

Appendix

Indigenous- An official definition of Indigenous has not been adopted by the UN system due to the diversity of the world's Indigenous peoples. Instead, a modern, inclusive understanding of Indigenous has been developed and includes peoples who:

- identify themselves and are recognized by their community as Indigenous
- demonstrate historical continuity with precolonial and/or presettler societies
- have strong links to territories and surrounding natural resources
- have a distinct social, economic, or political systems
- maintain distinct culture, language, and beliefs
- form nondominant groups of society
- resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities. [xxx]

Holistic health- includes physical, mental, emotional, and spiritual well-being as well as harmony existing between individuals, communities and the universe.[xxx]

Cultural Safety- is an evolving term and a definition has not yet been finalized. Cultural safety moves beyond the concept of cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization, and relationships with colonizers, as they apply to health care. [xxxi]

Self-determination is the right for all peoples to determine their own economic, social, and cultural development. [xxxii]