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are not being educated about the women's rights movements and thus are getting left behind as gender relations moves forward in Botswana. With rapid economic development made possible by the diamond mining industry, as well as the influence of Western culture, Botswana has accepted many Western values without fully understanding them. This has contributed to the challenges discussed above.

Working in this cultural context was both unique and challenging. Some experiences were more difficult than others. For example, I attended the funeral of a hospice client who had died of AIDS. Here I saw firsthand the stigma associated with the disease. In this case the family firmly believed that their loved one had died due to low blood pressure even though she had been clinically diagnosed with AIDS.

During the HIV prevention education sessions, I witnessed many male participants who were not open to the idea of using condoms. They would claim, "You can't taste the sweet with its wrapper on." Understanding these underlying ideologies was useful in enabling me to be culturally sensitive in my work. I focused on engaging participants in discussion about condoms to dispel myths and provide accurate information.

Another major challenge was the lack of resources, particularly the lack of adequate transportation. I conducted home visits on foot and was restricted to one catchment area. Unfortunately, this meant that few visits were conducted in the other areas of operation. It also created tension between individual program staff as they often competed for resources. It is hoped that a new integrated service model, which will recruit clients as family units rather than individual children or adults, will increase collaboration among staff and allow for more efficient use of resources.

As a whole, my time at HCH was a positive learning experience. I witnessed the struggles that people living with HIV face on a daily basis. At the same time, I worked with a wonderfully compassionate staff that genuinely cared about their clients despite resource challenges. Despite the occasional frustrations, I am grateful for all of this.

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Mental Health Considerations in Refugee Populations

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ABSTRACT

The needs of refugees are increasingly being recognized within Canadian society, including the unique mental health needs they possess. Refugees face a host of stressors before, during, and after migration that can influence their mental health. To advance health equity, practitioners must move beyond a biomedical model of care when working with refugees. In making sense of their symptoms, their resilience, subjective experiences, and cultural differences in the expression of symptoms must not be neglected. When addressing their mental health needs, a Social Determinants of Health approach, which acknowledges the importance of addressing social and economic stressors, should be adopted.

KEYWORDS: *mental health, refugees, migration and health, psychiatry*

INTRODUCTION

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Refugees are "persons who have fled their countries of origin due to a well-founded fear of being persecuted for reasons of race, religion, nationality, or membership in a particular social group, or political opinion".[1] By the year 2007,

the number of refugees and asylum seekers neared 14 million,[2] with Canada resettling between 10 to 12 thousand annually.[3] Refugees constitute a significant group in Canadian society, and in order to promote health equity within our country, we must have a thorough understanding of the specific health needs of this population and how to address them in a comprehensive manner.

One of the most important issues that health care practitioners will face when working with refugee populations is that of mental health because of the nature of the experiences refugees have endured. This article will explore the mental health challenges faced by this group, including the various stressors influencing their mental health and the most common manifestations of mental illness among refugees. The article will also explore different approaches to successfully addressing their mental health needs.

FACTORS INFLUENCING THE MENTAL HEALTH OF REFUGEES

Refugees face a variety of pre-migratory, migratory, and post-migratory stressors that can have lasting impacts on their mental health. While most practitioners recognize the significance of stressors endured in their home countries, many do not fully understand the challenges they encounter after arrival, which are often equally powerful in influencing mental health.[4]

Pre-migratory stressors are events experienced in the home country that forced people to flee. These include civil conflict, persecution for being in a particular group, exposure to physical or emotional torture, the loss of family members, and exposure to famine and disease.[4] Migratory stressors are events endured during escape. Refugees are exposed to a variety of stressors during their journey because of dangerous modes of transport, the crossing of insecure borders, and the potential for being detained.[4,5]

Post-migratory stressors, including the process of cultural transition (learning to function in a new language and culture), are often endured long after migration. It is during this phase of adjustment where the greatest risk of mental health challenges lies. Post-migratory factors include the realization of the loss of possessions, family, and culture that have ensued.[4] Stressors include the fear of being sent home, discrimination by the host culture, and coping with abrupt changes in socioeconomic status, including poverty, unemployment, underemployment, and unsafe housing conditions.[6]

MANIFESTATIONS OF MENTAL HEALTH ISSUES IN REFUGEES

The type and prevalence of mental health disorders among refugees are highly contested topics. Several meta-analyses have been conducted with refugees in Western cultures which show that the most common disorders faced by refugees are posttraumatic stress disorder, depression, anxiety, and dissociation.[3,4]

However, critics of this research have pointed to the overemphasis on the biomedical model of care when diagnosing and treating refugees. The focus tends to be on ascribing pathological diagnoses based on defined criteria. This approach carries with it the danger of characterizing all refugees as a homogenous group that experiences trauma in set ways. It ignores the resilience of refugees and fails to consider what the meaning of the trauma and settlement is to the individual refugee being cared for.[6]

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More recently, the concept of cultural bereavement has been developed which suggests that mental health symptoms in refugees, while they may complement diagnostic categories, may represent a “normal and constructive process of rehabilitation from traumatic experiences”.[1] It encourages professionals to explore symptoms in terms of the subjective experience of the individual person.[1]

A range of mental health symptoms may manifest in refugee populations depending on cultural factors, and not all may be pathological. The focus should be shifted away from a purely biomedical model when trying to establish the meaning of mental health symptoms in this group.

TREATMENT APPROACHES TO THE MENTAL HEALTH NEEDS OF REFUGEES

Similarly, the treatment of refugees warrants a broadening of our current biomedical approach. The WHO Commission on Social Determinants of Health (SDH) describes a hierarchy of factors shaping health and well-being, the majority of which extend beyond the health sector. The model encourages us to consider factors such as income, education, social support, and access to safe housing and water in influencing health.[7]

Nowhere is the importance of considering a SDH approach to treatment more pertinent than in this population. Studies have shown that when asked what will help their situation, refugees cite social and economic factors far more commonly than psychiatric or medical assistance.[6] Thus, when clinically assessing a new refugee patient, it is important not only to ask about their migration history, losses, feelings of guilt, grief, and nightmares, but also ability to find work and the presence of social networks.[4] In evaluating a new refugee for treatment, one must keep in mind the variation in cultural norms and seek the assistance of local community translators or cultural consultants when required. This can be helpful in distinguishing normal cultural expressions from pathological symptoms. In many communities, psychological distress often manifests as somatic complaints, and this should be considered when deciding upon further work up of these symptoms.[4]

Upon their arrival, refugees often suffer from cognitive disorganization. Thus, as the first point of contact, physicians should refer patients to local governmental and community-based organizations. These organizations can provide structure to their

> ...we must move beyond a biomedical approach in diagnosing and treating refugees.

day, help organize their time, orient them to the language and culture, as well as assist them in finding housing and employment.[4] Citizenship and Immigration Canada (CIC) funds settlement and community centres across the country where new immigrants and refugees can gain access to counselors, social workers, and community volunteers trained to assist newcomers in this way. As well, CIC provides free French and English language classes across the country through a program called Language Instruction for Newcomers to Canada (LINC).[8] Finally, physicians may want to refer appropriate individuals to the Canadian Centre for Victims of Torture, based in Toronto, where refugee victims can gain access to peer support groups, social workers, psychiatrists, and counselors to assist them in navigating through the legal system as well as finding housing, finances, employment, and educational opportunities.[9]

Once these basic needs are secured, physicians can begin to revisit traumatic events and assess the patient's reaction and coping mechanisms. Treatment approaches must consider the notion of cultural bereavement and allow for refugees to make sense of their symptoms in their own terms. In addition to offering counseling and potentially pharmacotherapy, practitioners should acknowledge and build on traditional community-based methods of healing that undoubtedly contribute to resilience and encourage participation in community groups.[4,5]

CONCLUSION

Refugees face a host of different stressors as a result of the forced migration process that may influence their mental health. As health care practitioners engaging with this growing population, we must move beyond a biomedical approach in diagnosing and treating refugees. A consideration of cultural differences, subjective experiences, and individual resilience will help both health care provider and refugee make sense of their mental health symptoms. In treating refugees, we must build on community methods of healing, focus on factors the refugee identifies as crucial to their well being, and improve their social and economic conditions.

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Dispatch: Cuban Health – A Public Matter

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During the summer of 2010, I was part of a group of six Canadian medical students transplanted from Vancouver to Santa Clara, Cuba for the purpose of observing the operations of the Cuban public health system, renowned to be one of the most comprehensive in the world.[1] This article describes a single day and acts as a window into that three week visit.

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> The heat was stifling, my white lab coat sticking to my back, each blast of cool air from a small electric fan triggering a fleeting euphoria.