

The Importance of Cultural Awareness in Global Health – Experiences from Botswana

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Botswana has been heavily impacted by the HIV/AIDS epidemic. Thus, HIV prevention and treatment have been built into national development policies. I travelled to Botswana to complete my practicum as a Master of Public Health student by working on HIV prevention and sexual/reproductive health education programs with Holy Cross Hospice (HCH), a local non-governmental organization. I quickly learned the importance of cross-cultural training in global health work. This training, and subsequent experiences on the job, led to an enhanced understanding of the challenges faced by health service organizations in developing countries and the various cultural factors that influence health outcomes of individuals and communities.

Botswana has one of the highest HIV prevalences in the world, with 17.6% of the population aged 18 months and above testing positive.¹ The prevalence has declined slowly in urban areas since 2000 but has remained stable in rural areas. The number of new adult infections has remained stable for several years at approximately 20,000 annually.² In the capital city of Gaborone, there are an estimated 33,588 persons living with HIV/AIDS and approximately 2113 orphans and vulnerable children.¹ The healthcare system in Botswana is stretched thin in physical and human resources due to HIV/AIDS. Between 1999 and 2005, country healthcare staff decreased by 17% due to the working-age population being infected and dying from HIV/AIDS. This problem has been exacerbated by the amount of hospital beds occupied by AIDS patients who are estimated to stay in hospital four times longer than other patients.¹

In order to advance the development of the nation, the Government of Botswana has created the Vision 2016 policy which includes seven key strategic goals, one of which is the development of “a compassionate and just, caring nation.”³ By 2016 the government aims to stop the spread of HIV and ensure that AIDS patients have access to quality care in health facilities, communities, and workplaces.³ My purpose in Botswana was to contribute to Vision 2016 by working at HCH for four months to develop and implement programs that increased the awareness of HIV/AIDS and related issues among adolescents in Botswana.

HCH is a community-based non-governmental organization in Gaborone that provides palliative care to terminally ill patients and also operates health education and psychosocial support programs for orphans and vulnerable children. At HCH I conducted school sensitizations to educate Standard 7 (similar to Grade 7

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in other countries) students on the topics of multi-drug resistant tuberculosis, H1N1 influenza, and the relationship between these infections and HIV/AIDS. Secondly, I assisted in the development of a Sexual and Reproductive Health manual for facilitators and peer educators to conduct workshops and activities. These workshops continue to encourage positive behavior change with regard to high-risk sexual activities as well as promote living positively with HIV. Finally, I conducted home visits to assess clients’ physical, emotional, and mental health status. These assessments were then used to make appropriate referrals to health and social services.

Cultural sensitivity training played an important role in enabling me to carry out these tasks successfully. This training drew interesting parallels between Canadian and Botswanian culture. During the training, a sociology professor from the University of Botswana, Professor Log, explored the rapid development of Botswana, especially in the capital city of Gaborone. He discussed the resulting tensions between traditional African and modern Western cultures. A key difference that emerged was that of societal organization: communalistic in Botswana vs. individualistic in the West. According to Professor Log, the communalistic culture in Botswana has translated into communal parenting of children where community members participate together in the discipline and care for all children in the community. Additionally, traditional Botswana custom has included boys being raised by men and girls being raised by women. Now, with the increasing number of female-headed households, mothers are experiencing challenges raising boys because historically this has not been a major part of their role.

Professor Log also mentioned that Botswana is currently undergoing a “masculinity crisis.” As women become aware of, and fight for, their rights, many men are feeling threatened. This has contributed to an increase in violence against women as men feel disempowered with the changing status of women in society. In addition, there has been a breakdown of the family structure as well as child neglect and abuse. This is a problem that is compounded by the lack of services for children. Professor Log noted that men

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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,