DISCUSSION SUMMARY

Discussion began with a strong repudiation of assistance modes that create passivity and dependency among Central American refugee and internally displaced populations. In light of the fact that return and reintegration present the assistance communities with a new opportunity to serve vulnerable populations, many stressed that we must learn from our past mistakes with internally and externally displaced populations. They advised the replacement of the dependency mode with another that emphasizes participation by the returnees in decision-making and implementation of programs. They also called for respect for, and protection of, the leadership and organizations returnees may bring back to their home communities.

While most of the participants agreed that assistance agencies in both host and home countries must find ways of sustaining or building such leadership and collective participation on the part of refugees and displaced, several acknowledged that governments may not welcome such an active role and presence for these populations. Indeed, one individual cited the following paradox: while collective organization and autonomy may be attributes that contribute to successful mass repatriation and reintegration, these very same attributes may be interpreted by home governments as threatening--i.e., signs of subversion.

Returning to the need to avoid policies and programs that instill passivity and dependency within refugee and displaced populations, one individual lamented the policy of bringing in experts to solve problems which the refugees and internally displaced are often more adept and organized to resolve if they are given the necessary information and resources. Another participant seconded this point and added that income generating projects for refugees have often failed because the "experts" have been unfamiliar with the demographic composition and cultural practices of the target population. He cited such failures as the Los Angeles project in Costa Rica which foundered due to the

lack of men to carry out several phases of farm production and an employment scheme in Limon, Costa Rica that overestimated the willingness of Nicaraguan refugees from the Atlantic Coast, who are habituated to a fishing economy, to adjust to employment in the fields of the banana industry.

While agreeing with the general stance that refugees, internally displaced, and returnees must help design and implement projects that will impact upon them, one participant, nonetheless, warned that following "folk wisdom" may result in dire ecological consequences. He voiced concern over practices (such as replacing food crops with grazing land and cattle) which contribute to land erosion and leaching of the thin topsoil. With these problems in mind, he urged policymakers and assistance agencies to consider environmental impacts and recovery when formulating development projects.

Another potential danger raised by several participants is the hostility that agencies may unintentionally unleash in neighboring communities if they chanel aid solely to the reintegrated population. Rather, assistance should be made available to all marginal groups within targeted areas, observed one participant.

Finally, one participant stressed that the region needs a legal model for the integration and reintegration of all displaced populations. Such a model would draw upon already existing accords and would provide guidelines for establishing and guaranteeing rights to protection, legal status, employment, economic security and health.

MENTAL HEALTH IN REFUGEE COMMUNITIES: A PROPOSAL WITHIN THE FRAMEWORK OF PRIMARY HEALTH CARE STRATEGY

Armando Campos Santelices

The author analyzes the integral relationship between mental and physical health and social welfare. He proposes integration of a community-based mental health component into basic health care programs for refugees and also details specific steps to illustrate the process. The author suggests that these activities would not only improve current health and social conditions but allow participants to educate and prepare themselves for a less dependent future.

I. Introduction

This article examines the issue of mental health in refugee settlements.

Despite important advances in the general perception of mental health, there is tendency to limit study and action to mental disorders and to divorce the focus from historical and social determinants of mental health. Such difficulties in focus are exacerbated when discussion turns to refugees because complex and polemical issues, often cloud our perspective. For these reasons, the present discussion is not limited to operational questions. The task at hand is to contribute to a general understanding of the problem.

In undertaking this, it is necessary to develop a frame of reference based on three key concepts and their corresponding relationships: Mental Health, Primary Health Care, and Community.

Mental Health

The constitution of the World Health Organization (WHO) proclaims health to be not the mere absence of sickness, but rather a state of complete physical, mental, and social welfare. This statement marks an extremely important doctrinal advance in that it establishes the global and indissoluble nature of the process. At the same time, however, it brings forth a decisive problem with enormous practical consequences: What is human health if it is not the mere absence of sickness and suffering?

The notion of welfare, at first blush so clear, does not answer the problem; its concrete definition will always depend on the degree of inequality existing in each society. As we well know, human needs are recognized and addressed in a discriminatory fashion. When applied to some social groups, the notion of welfare normally entails "the satisfaction of basic needs," which in itself is difficult to define and implies the mutilation of the human condition. For other groups, welfare may be associated with a well-balanced diet or the possession of artistic objects. So, too, the term "health" has become too ideologically charged to allow us to arrive at a clear definition.

For us, Health, as a social process, product, and goal, represents the development of the potential of the human being in three inseparable dimensions:

-as a complex biological system;

-in the psychic attributes that throughout history have distinguished the human being as a species (abstract thought and complex emotions); and

-as the purveyor of a system of social relations that determine the objective and subjective existence that the human being actively constructs.

Certainly, these dimensions can be affected to a greater or lesser degree by a variety of sicknesses and antisocial patterns. But, as the WHO has declared, the hypothetical absence of such problems will not make us sound.

Health, as a fundamentally historical task, unites the true possibilities that a society builds in order to fulfill its potential, with all its attendant determinants, contradictions, and deficiencies. To speak, however, about "human potential" may lead us to an extremely idealized abstraction. We must invest the term with realistic content. To speak, however, about "human potential may lead us to an extremely idealized abstraction. We must invest the term with realistic content. In establishing our definition of mental health, we should remember that our psychological processes condense our biological evolution, especially of our nervous system, as well as our activity within a social context.

Both the biological and social dimensions spring from one historical root. If this is evident in the social aspect, we should not forget that the development of our nervous system is not the direct product of a purely morphological evolution. The brain of present-day homosapiens differs quite little in its broad structure from the brain of Cro-Magnon man; however, the changes in the fine histological structure and its functions, generated through the realization of creative praxis, are enormous.

Our psychological development is a product of the historic dimensions of our biological and social spheres. Thus, we should understand the way in which the mental development of a people or social group is arrested by acute health deficiencies and the impoverishment of their culture. Such a condition runs counter to human nature and affects millions of people, and it should not be obscured in the debate on refugee affairs, given the socioeconomic position of most refugees and the marginality and domination that frequently arrests their lives.

In the first place, mental health--health as an entity--is always identified with an integrated project of social development. However, this need not undercut the specificity of corresponding actions. Let us consider the following:

Just what are we talking about when we consider the "mental health" of people? Not, in principle, a state or balance between the "absence or presence" of psychopathological disorders.

Mental Health defines an active orientation of the personality toward the world and toward "one's self," in which, given the infinite personal variations in the process, there prevails the development of a critical and creative thought process of positive emotions and of a disposition toward personal growth associated with a coherent sense of self-esteem.

Conceived as such, mental health is a never-ending process; in which the personality is organized on its own terms in order to entertain the emotional and intellectual possibilities that distinguish us as human beings.

If--due to their relevance for our topic--we refer specifically to the different kinds of suffering that can affect us, we will see that the main result of mental health as social action is not to mitigate suffering or modify its effects; rather, it is to stimulate the willingness of individuals to confront the conditions and situations that cause them suffering and lead them to make others suffer.

This is not to understate the importance of psychological disorders or psychiatric or neurological problems in the field. The WHO calculates that there are 300 million people worldwide who need help to overcome these kinds of problems. These disorders cause two-fifths of all the cases of incapacity registered worldwide and are the cause of one-fourth of all the contacts between the world population and existing health services. Nevertheless, at least half these cases of disorders could be prevented; to do that, however, action is essential.[1]

Without question, there is a multiplicity of relationships among physical, mental, and social health problems. Physical illnesses may bring anguish, depression, deterioration of productive capacity, and difficulties in social ties. Like-wise, many behavioral patterns are extremely harmful to physical and social health.

By characterizing healthy psychological development as a process of developing different areas of human endeavor, we attempt only to identify the essential sphere of action for mental health care and each individual's responsibility within it.

Primary Health Care

Ten years ago, the countries of the world committed themselves to "Universal Health in the Year 2000," and to a basic strategy to fulfill this goal--Primary Health Care (PHC). This objective contemplated the global reorientation of the social practice of health, and here we should emphasize the fundamental feature of delivering health services to homes, communities, schools, and factories.

PHC is a strategy aimed at increasing equity, effectiveness, and efficiency in health services through different courses of action. At present we are concerned with three in particular:

a) The strengthening of the first level of care; that is, the first contact between the health services and the individual, family, or community. Implicit in this is the restructuring of all three levels of care, not just an isolated reinforcement of the first level.

b) The reinforcement of primary prevention; that is, of all those activities that are effective in developing health and preventing specific disorders and diseases.

c) Community participation conducive to individual responsibility and the direction of social energy toward health education and activities needed to improve living conditions.

In the field of mental health, "promoting health" becomes the process through which conditions conducive to personal health are produced, improved, and preserved.

This process is an end in itself; what is indispensable is a preventative base for most mental disorders.

Community

Communities are collective organizations whose members carry out an exchange of direct, ongoing psychosocial activity and who share common problems, or

at least can recognize them as such. For these reasons, they have the potential to raise the level of consciousness, organization, and mobilization.

In this scheme, a high level of consciousness or organization is a worthy attribute and a community goal, but there are no criteria by which to define it. Even though the prototype of this community may be found in collectives which confront their own problems of socioeconomic marginality, other types of structures and community dynamics may exist.

With these conceptual elements laid out, we can develop a point of departure:

We must undertake community mental health programs, guided by a strategy of primary health care, among refugee populations who live in camps or maintain cooperative relations with urban areas.

II. Mental Health Problems in Refugee Communities

The huge worldwide phenomenon of the forced displacement of hundreds of thousands of people from their own countries has resulted in a wealth of important psychological research. In terms of volume and depth, the majority of work has likely been dedicated to research on the issue of the exile and return of families, with relatively high socioeconomic and educational levels, who migrated to industrialized countries. Less research has focussed on the mental health problems of migrants from rural areas who generally have been displaced to neighboring or nearby countries where they either live in camps or become absorbed into the urban underclass.

Be that as it may, the extreme gravity and the human costs of mental health problems stemming from the process of exile, refuge, and return must not be ignored.

The circumstances of expulsion are normally determined by intense social violence and often by psychological warfare. Several traumatic events characterize the departure, displacement, and arrival--the break with a way of life, the uprooting, the incessant fear, the forced concentration, the present and future insecurity, even the return itself with its burden

of readjustment. These events, inter alia, all form part of an experience that assaults the health of the individual.

Moreover, mental health problems are the most specific of all the serious problems affecting the refugees; they are related most directly to the migrants' own experiences. Many of these migrants have known only critical poverty, and the traumatic events they experience have a great potential for destabilization, particularly among those groups of people whose traditional way of life knows little variation.

In the opinion of many observers, social life in the camps under conditions of forced concentration creates highly intense psychopathogenic conditions. In 1983, while working on a study at the behest of the United Nations High Commissioner for Refugees (UNHCR), I had the opportunity to examine these problems briefly at camps located in Honduras. It is worth noting that much of the original interest in the UNHCR study originated among the medical care personnel, who witnessed a level of psychosomatic disorders among the refugees they attended. The study undertaken by Pacheco, et al., on Nicaraguan refugees in Costa Rica does much to illuminate this issue.[2]

Although different in certain respects, the mental health problems of refugee families residing in densely populated urban centers are no less serious, and in this regard, the research carried out by Bottinelli et al. on Guatemalan and Salvadoran families living in Mexico City provides eloquent findings.[3]

Whereas few would question the seriousness of the mental health problems among refugee groups, there have nevertheless arisen many erroneous interpretations and much confusion leading to serious errors in strategy.

The most serious source of errors arises from the position, commonly taken, that mental health programs for refugees should receive low priority. Countless times we have heard that "first" come other health objectives, such as vaccinations and treatment for parasites and their attendant diseases; or that mental health programs are overprotective and may discourage return or exacerbate the isolation of individuals or families.

Such objections stem from a radical misunderstanding of the nature and significance of mental health.

To begin with, mental health cannot be treated as an alternative matter unrelated to physical health problems. In a successful program to combat fleas and mites, for example, participants need to learn which conditions lead to these problems in order to eradicate them and prevent their recurrence. Such understanding is a mental as well as physical health improvement.

Moreover, the only mental health program that can be considered "over-protective" is one that confuses community mental health activities with the work of a paternalistic psychiatrist interested only in isolated personal problems.

What is most important and difficult, however, is to make people aware that mental health is not a dimension of reality that can be recognized or ignored according to the interests of the observer. It is a process inherent to human nature and concerns us all. A community may have no established program to improve mental health conditions, but the deficiency will never overcome the problem.

In other words, the lack of programmed action to improve mental health conditions in high-risk communities such as those of the refugees only exacerbates existing problems at the expense of the social and economic welfare of the community itself.

As we well know, the situation of people in refugee camps is defined as temporary. It is understood as a preparatory phase prior to either voluntary return, the incorporation into the receiving society, or transfer to a third country. Any one of these alternatives will demand the strengthening of the individual's sense of responsibility, and once again, this translates into mental health work.

Finally, looking at the issue in cost-benefit terms, we might ask: Were initiatives taken in this area, what improvements would be seen in productive projects involving refugees and in rational resource management for their assistance? One often hears that the main stumbling block in organizing productive work projects among refugees stems from certain defective attitudes toward working in groups. Overcoming this barrier should be an important mental health goal.

III. Methodology

Mental health activities in refugee communities should be based on two principles: coordination of the three preventative levels, with emphasis on the first, and broad participation within the community itself.

To guide these activities, we may wish to refer to research on refugees and reports on community mental health carried out in many countries. Great value can be derived from studies and assistance, education, and planning activities carried out with regard to the social and psychological consequences of natural disasters, in particular the 1972 earthquake in Managua, Nicaragua and the 1985 Nevado del Ruíz volcano that wiped out the city of Armero, Colombia.[4]

Below we examine potential courses of action in refugee communities within the context of the three levels of preventative health care traditional in the field of public health.

Primary Prevention

A unique feature of refugee camps is that they concentrate people who have recently undergone highly psychopathological experiences and are confined within a situational framework that features other psychosocial factors of maladjustment.

There are those who believe that this is inevitable and that, in any case, refugees are in a better situation than they would be in had they remained in the zone from which they were expelled. Others take the extreme and--for the time being, at least--unrealistic position that "the refugee camps must be abolished."

From our viewpoint the basic question is: What can be done to reverse the destructive potential of the refugee camps? That is, what possibilities are there to transform the camps into places conducive to promoting the physical, social, and mental health of the people dwelling there?

There is no easy answer. We cannot ignore the numerous obstacles that exist. The very existence of the

refugees, however, poses a difficult problem, so there are no simple solutions.

At the psychosocial level, virtually all the alterations typically detected in individuals and families, to a greater or lesser degree, present difficulties for constructive relations in the areas of interaction. These phenomena include all the various symptoms of anguish as well as other problems that investigators have found, such as "disconfirmation and frozen propositive grief," deterioration of self-esteem, and rigid adhesion to certain social habits that comprised a previous normality and which now become factors of maladjustment.[5]

So varied and serious are the problems that anyone who interprets mental health as "the elimination of symptoms" will become convinced that treatment is impossible. Our key argument, nevertheless, is that the promotion of mental health in refugee communities should stimulate positive or healthy forms of psychosocial interaction, primarily those that already exist in the heart of the community.

At the level of primary prevention the mental health activities need not require new programs. The issue is to strengthen the content of group activities already under way, including those which are spontaneous. The goal will be to strengthen solidarity, critical thinking, and cultural identity.

Only these community forms of social interaction, especially those which are self-generated and participatory, can generate feelings of mutual support and a greater awareness of constructive relations and the process of exile itself. In terms of mental health, these are goals in themselves, however, the process also creates a medium of collective defense against anguish, suffering, and the destabilizing effects of exile--disorientation, demoralization, passivity, overdependence, and aggressive resignation. In other words, no human being, much less someone who is dissociated and threatened, can develop on his or her own either the solid, active disposition that can confront present and future problems or the strength to withstand psychological disorders.

In operative terms, the greatest importance lies in the participation of agency personnel, refugee leaders, and basic health workers in both popular education

activities and other efforts to enrich the cognoscitive, participatory, and affective content of programs developed in fields such as production, education, housing, environmental health, health care, nutrition, recreation, and child-rearing. At the same time, it is important to consider the possibilities offered by "participatory research-action," which in recent years has become one of the most important means of developing community participation in health.

The methodology, which of course must be adapted to the concrete conditions of each group and camp, is not complicated. It has to be based on the participation of the refugees and trained personnel in a constant process of "reflective action" on their everyday lives and on the concrete problems experienced, among them the psychosocial problems of uprootedness, insecurity, demobilizing nostalgia, refusal to interact integrated with other migrants, negative individualism, and other problems of previous origin that may have been modified by recent experiences, e.g. fatalism, superstition, and machismo.

This process may also be the most appropriate framework for informing the group about duties, rights, and opportunities. The participatory approach might resolve problems of poor communication and mistrust that are generated by hierarchical communication procedures. It is worth emphasizing that lack of information exacerbates the psychosocial problems of the refugees.

For all of these tasks, it is necessary to resort to the participatory structures and forms that have naturally developed in these communities as well as to the popular culture itself. In this regard there are clear precedents in the educational and participatory activities that have been carried out in the camps, even when there has been no awareness of their significance for mental health.

It is important that the facilitators who work in this field--social workers, educators, health promoters, and others --consider the importance of their work in promoting mental health and in coordinating their efforts.

Secondary Preventative Care

The participant-investigation process that we find at the first level of preventative care also fulfills objectives at the secondary level. Participatory research-action also includes the problematic issues of community mental health and the origin of and attention to mental disorders that affect it.

Nevertheless, since this process takes time to consolidate, organization of participant activities geared toward problem management need to be undertaken without delay. The following points are just some that merit consideration:

a) Training refugees to become basic mental health workers who can help prioritize the psychopathological problems in terms of prevalence and negative consequences for community relations.

These workers may later play important roles in their home communities, should they return to them, or in other settlements.

b) The introduction of a mental health component in the formation and training of primary health personnel who work in the camps or will do so in the future.[6]

c) Educational programs, especially those aimed at mothers and heads of households and those which address the necessities of the elderly and the handicapped.

d) Help for families at high risk, such as those who suffer severe dissociation or have undergone other highly traumatic experiences such as torture, the death of one or more family members, and sexual abuse.

e) Psychotherapeutic group activities for which some Latin American experiences in "therapeutic community" could be serve as guides.

For this purpose, the work of psychologists in camp health centers should prove useful, at a minimum to assist in training other personnel and basic health workers.

The basic health workers can acquire rudimentary knowledge of psychopathology and psychiatry. They can

also acquire the abilities and skills that contribute to the recognition and control of acute mental disorders.

The workers can also offer indispensable cognoscitive elements to learn how the community interprets the origin of its mental health problems and what possibilities exist to overcome them. It is important in this respect to develop a layman's terminology to facilitate communication.

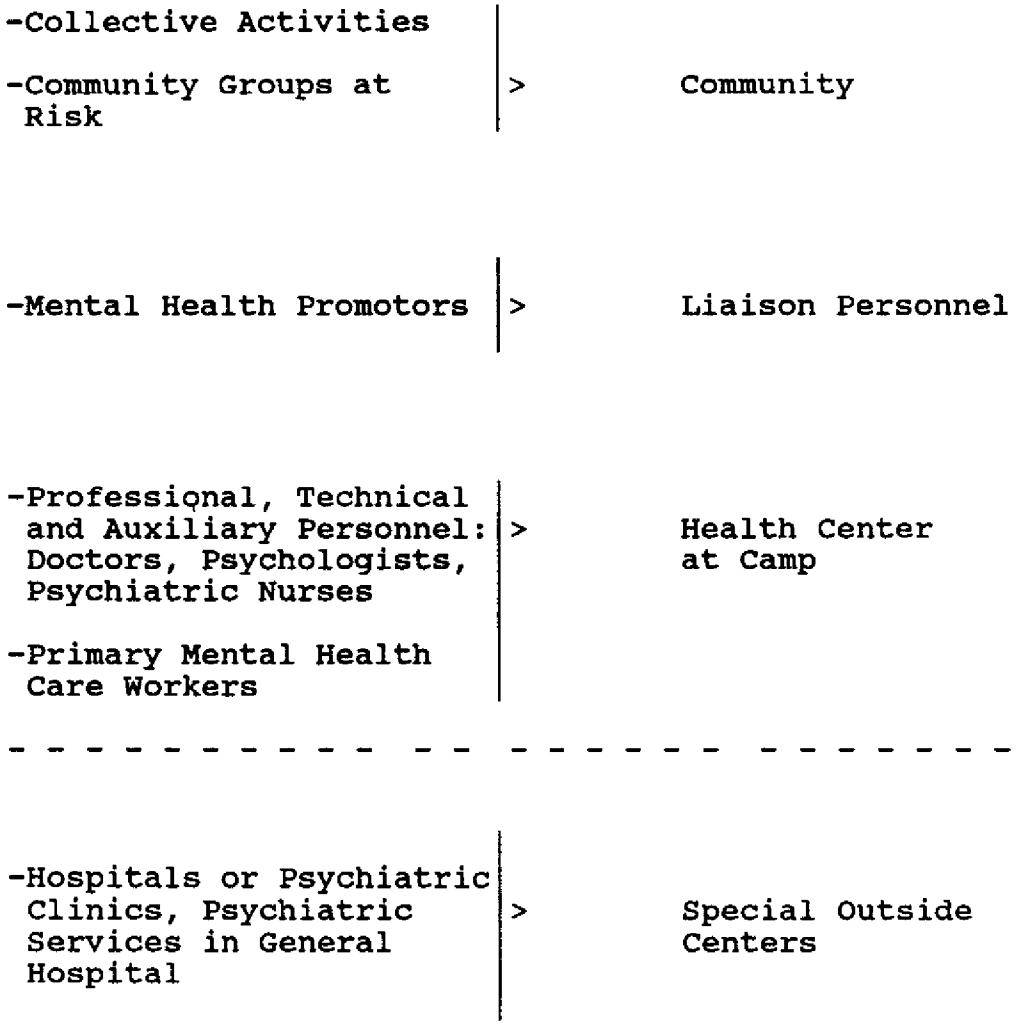
Terciary Preventative Care

Two fundamental problems appear at the third level. The first concerns the community's ability to offer emergency neuropsychiatric care. There are many cases in which communities have become capable of dealing with these experiences, at least, to the extent of avoiding serious consequences and protecting those affected. It is important to take proper measures in the health centers themselves as well as to train individuals who can be responsible for different subdivisions in each camp.

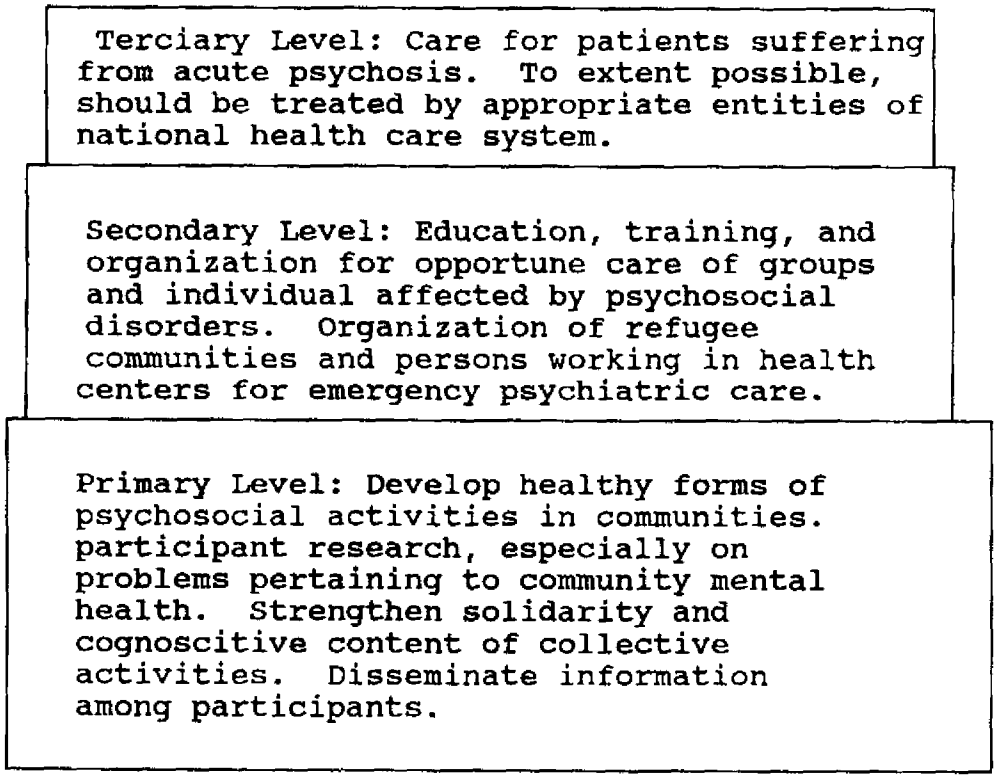
The second fundamental problem concerns care for chronic psychiatric disorder. Care for many, if not all, patients usually takes place in the camps themselves both because of the advantages of community options over the institutionalization of those with mental problems and because of the physical conditions within the camps themselves. Thus, systems for training and delegating responsibilities tailored to the size and experience of human resources found in the camps need to be developed.

Consistent with the strategy of primary health care, patients would ideally be sent to special centers in the receiving country or to appropriate units included as part of the technical assistance offered by international and national organizations.

Below is a framework that could be helpful in coordinating secondary and terciary mental health care:


-Collective Activities
-Community Groups at Risk
Community
-Mental Health Promotors
Liaison Personnel
-Professional, Technical and Auxiliary Personnel: Doctors, Psychologists, Psychiatric Nurses
-Primary Mental Health Care Workers
Health Center at Camp
-Hospitals or Psychiatric Clinics, Psychiatric Services in General Hospital
Special Outside Centers

CONTENT OF THE THREE LEVELS OF PREVENTATIVE MENTAL HEALTH CARE



IV. Conclusions

With forthright support from governments and international organizations, the provision of mental health care experience based on primary health care strategy has shown increasing promise throughout the world.

Is there any reason to exclude such care from refugee communities?

Is there any justification for limiting access to activities aimed at "Universal Health by the Year 2000," a position subscribed to by all the member nations of the World Health Organization?

Due to the size of the population affected by mental health problems worldwide and the severity of the problems, there is urgent need to establish a policy in this regard. Only an erroneous understanding--to which professionals in the field may themselves have contributed--could lead to the rejection of such a strategy or to its subordination in favor of supposed "alternative priorities."

Plans for mental health action, based on the recuperation of constructive strength in affected communities, may significantly reduce the high human and economic costs of forced migrations, while at the same time facilitate essential goals in the handling of such refugee problems as voluntary repatriation and incorporation into the local community under responsible conditions and with a sense of social commitment.

These plans also require the support of research that can orient the relevant activities and contribute to greater public awareness of the delicate nature of the problem.

NOTES

1. World Health Organization. "Four Decades of Achievement: Highlights of the Work of WHO." Geneva, 1988.

2. Pacheco, Gilda, et al. "Psychosocial Issues Concerning Nicaraguan Refugees of Rural Origin." Forthcoming, CIPRA.

3. Bottinelli, Cristina, et al. "Guatemalan and Salvadoran Families Living in Mexico City: The Process of Migration and Refuge and Future Alternatives." Forthcoming, CIPRA.

4. Ahearn, Federico, and Simeon Rizo. "Problemas de salud mental después de una situación de desastre." Boletín de la Oficina Sanitaria Panamericana 85 (1), 1978. Lima Bruno, et al. Atención en salud mental para victimas de desastres: Actividades desarrolladas en Armero, Colombia. Boletín de la Oficina Sanitaria Panamericana 104 (6), 1988.

5. Disconfirmation (Bottinelli, et al.) is the experience by the individual that he/she simply does not "exist," as a result of a specific social situation such as frequently occurs among individuals with illegal status in receiving countries.

Frozen propositive grief, as opposed to "melancholic grief" in which one gives him- or herself up as lost, is characterized by an experience in which time appears slowed down or dilated and the individual lacks goals or direction. Consciously or unconsciously, the condition results from the attempt to "keep alive" lost people or objects.

6. Climent, C.E., et al. "Mental Health and Primary Health Care," Chronicle of the World Health Organization 34:249-245 (1980).

This WHO guide for primary health care personnel includes a chapter on promoting mental health, the treatment of acute psychotic states, convulsions, chronic psychosis, and mental retardation.