The Dr. Yuk Chan Ma and Dr. Yuen Kok Chan Prize in Multicultural and International Medicine

Applicants 2011-12

WINNER: Niall Filewod
East Africa

Of the many challenges of medical school, one of the most rewarding was my decision to complete my Family Medicine rotation in East Africa. The need to meet faculty requirements, in combination with my own desire for a challenging and immersive experience, resulted in a far-ranging adventure that profoundly changed my understanding of how social, cultural, and economic problems underpin illness and disease. I learned a great deal – each experience provided both positive and negative examples of medical intervention in the developing world.

In Moshi, Tanzania, I was able to participate in a 'health caravan' run by CACHA, a Canadian organization. Each day we would drive out to a rural village, set up a mobile clinic, and see as many patients as we could before dusk and exhaustion drove us home. The program was a wonderful example of how an overseas group could achieve some kind of continuity of care – the clinics were organized in association with a local women's centre, and many of the villages had received clinic visits on an annual basis for several years. The clinics also illustrated the challenges of practicing medicine with profound linguistic and cultural barriers, as well as the difficulties entailed by recruiting Canadian clinicians to work in a foreign country for a two-week stretch—a doctor counseling her patient on abortion was shocked to discover that it was illegal. How should you treat lifestyle diseases when the realities of life are so profoundly different?

In Nairobi, Kenya, I worked in a set of sexual health clinics that targeted sex-workers in the urban slums. Here again the effects of continuity were visible – STIs that had once been rampant were well controlled amongst the clinics' clientele, although the incidence of HIV was still depressingly high. In interviews I learned about the economics of sex-work, which offered fallback employment to many of the women, as a way of making ends meet when their small businesses couldn't generate enough income. I talked with workers in the clinics about the politics of prostitution, and learned that in Kenya, much as at home, a tacit acceptance of the status quo limits efforts to improve the situation of sex-workers.

My adventure ended in Siaya, western Kenya, where I was able to join rounds at the district hospital. I saw innumerable cases of malaria and sickle-cell disease, as well as the effects both of HIV and HIV therapy – one patient, suffering from toxic epidermal necrolysis, was losing patches of skin the size of dinner-plates. Over beers with Kenyan researchers, I learned how tribal politics informed health-care delivery, and how cultural conflicts conflated health-care challenges.

My two months in East Africa were transformative. As I continue on in medicine, the lessons I learned will continue to inform my practice and my life.

Adrienne Boon
Inuvik, NWT, Canada

I spent eight weeks working in the Inuvik hospital, the northernmost hospital in Canada. North of the Arctic circle and serving outlying communities accessible only by iceroad, boat or plane, depending on the season, Inuvik provides the opportunity to see the full scope of family practice in rural Canada. Obstetrics, ER, clinics, surgeries and anesthesia are all run by family doctors, and I had the opportunity to work in all of these areas, as well as visiting the smaller communities. However, the region has an extraordinary amount of difficulty in retaining physicians. There is currently just one permanent doctor living in Inuvik, while the rest are locums, mostly either semi-retired doctors from the south or young career locums. There is a striking difference in the relationships maintained by the one permanent doctor, who knows everyone in town, their families, and their stories, and by the locums who tend to be excellent doctors but are not part of the community in the same way, and do not necessarily know the system, the culture, or the challenges for the local population.

Inuvik is made up of roughly one third Inuvialuit, one third Gwich'in First Nations, and one third southerners and immigrant Canadians. The local population has been heavily affected by the residential school system, and nearly all the Aboriginal people over the age of 50, and even some of the younger adults, grew up in the system. Although most people still spend a substantial amount of time hunting and fishing on the land, the local languages have been lost. The effects of the separation of families, physical, sexual and emotional abuse, and loss of language and culture are evident in the rates of alcohol abuse and violence. However, a strong sense of community and family remains. Children are welcomed and loved by everyone they know without the possessiveness of southern families. They walk in and out of every home and are fed wherever they are with a generosity of spirit that is almost disarming when it turns out that the child in question is the woman’s sister’s ex-husband’s niece. The resilience of the communities, despite a history of such concerted efforts by the Canadian government and the churches to destroy their identities and traditional ways of life, is remarkable.

Adrienne Boon
Addis Ababa, Ethiopia

Ethiopia tends to hold a mythical status in the minds of Canadians, most of whom think primarily of the pervasive images of starving children in the desert from the 1980's. However, I found Ethiopia to be a lush agricultural country of welcoming people with rich cultural traditions. I had also heard that it had the dubious distinction of medical training good enough for western countries to poach their doctors, leaving the country tragically short of physicians, and resulting in the oft-repeated quip that there are more Ethiopian doctors in Chicago than in Ethiopia. I spent my four week pediatric elective at Black Lion Hospital, the largest teaching hospital affiliated with Addis Ababa University, and it was clear that the medical education was indeed excellent, although crowded now due to the government's efforts to dramatically increase the number of trainees. The residents are knowledgeable, both in terms of what the ideal care would be, and of what is possible and realistic in the context of the family's and the hospital's resources.

Children from all over the country come to Black Lion for treatment, and between three wards, a pediatric ICU, and a neonatal ICU with up to four babies per incubator, the pediatric teams look after about 140 patients. Malnutrition, tuberculosis, and pediatric cancers are routine diagnoses, as are infections of every organ system: pericarditis, pneumonia, osteomyelitis, meningitis, AIDS, sepsis. Some children arrive with very advanced disease. There are no physicians in many rural regions, and so families go to traditional healers, who burn the skin in the painful area, and bring the child to hospital only after she fails to improve. Sometimes there are still effective treatments to be had at that point, but sometimes all the doctors can offer is palliative care. Some families then choose to take the child home to die, partly because they cannot afford the expense of private transport to bring the body back to their village for the important burial rituals, and so prefer to take the inexpensive public bus with a sick child. The challenges facing Ethiopia remind me of how lucky we are in Canada for the care we can provide, the resources available, and the low incidence of many diseases that are so often fatal in less developed countries.

Estelle Chétrit
Beersheva, Israel

I chose to pursue an internship in Beersheva - Israel's southernmost desert region called the Negev. Its historical richness is omnipresent: from the Israelite era to the Ottoman Empire, the arid desert climate embraces its heritage. The vast landscape is populated with Israeli Jews, Arabs and Bedouins – a multicultural crossroad of modern and traditional, urban and rural life. The transition from nomadic to sedentary lifestyle within a relatively new State has left many Bedouins without official civil status. The rural localities of their settlements and uncertain livelihood have led to unreliable access to water and electricity.

In May 2011, I enrolled in the medical school exchange program of Ben-Gurion University of the Negev where I had the opportunity to work with local nurses, physicians and translators. Through a network of clinics we served the region's population of 100,000 Bedouins. The clinic infrastructure and services offered varied based on the locations. In the larger Bedouin cities such as Rahat, the clinics were staffed with numerous healthcare professionals and were connected to the electronic health system of Soroka, the third largest hospital in Israel. Bedouins navigated the unmarked paths and sand hills in order to meet us. I was invited to join the mobile unit for house calls and experienced firsthand their hospitality and warmth.

One of my most memorable experiences was when we visited a family who was mourning the loss of their daughter. She had recently lost a battle to a rare genetic condition – a situation which is all too common in the Bedouin population. An emphasis on the tribe as a source of political power and pride led to a tenfold increase in the Bedouin population since the creation of the State of Israel with a resulting increase in the number of children born with genetic conditions. From congenital deafness to cardiac abnormalities and inborn errors of metabolism, each tribal name brings pride as well as a potential diagnosis.

The cultural differences were accentuated by my limited knowledge of the regional dialect. I was privileged to work with a physician who provided an unparalleled cultural translation through her vast local experience. The perspective I gained has inspired me to continue to seek an understanding of the cultural, religious, ethnic and lingual differences that merge in Montreal. This experience reinforced the importance of ensuring access to proper healthcare regardless of gender, religion or geographical location both at home and abroad.

Milena Garofalo
Bluefields, Nicaragua

Two years ago, I volunteered in a mobile clinic in Nicaragua with Global Medical Training, where I had the opportunity to meet a number of physicians. I decided to return to Nicaragua, this time visiting Bluefields, a small island of approximately 49 000 people on the Caribbean coast, the hometown of one of the physicians I had previously met. I would be doing a four week elective in Women's Health, an area of medicine of particular interest to me.

I worked mainly in the city's only hospital, with a few days set aside for primary care. My first impression of the hospital was that it did not look like a hospital at all. The level of hygiene in the hospital was nothing like back home: soap was hard to find, unlike the numerous antibacterial soaps we find at every corner in Montreal hospitals. My responsibilities as a fourth year international medical student consisted of both clinical and surgical work. I attended the obstetrical/gynecological rounds in the morning and then proceeded on helping discharge patients as well physically examining those who required it. My ability to communicate and write Spanish improved a lot. Even though I had the opportunity to attend a few deliveries, most of the clinical experience that I gained was surgical. I was given the chance to assist a number of surgeries, improving my suturing technique substantially.

More important than the clinical knowledge gained was the immense cultural and social experience that I was submerged in. Medicine is still disease-centered rather than patient-centered in Nicaragua, just as it was once here, many years ago. There is also a certain cultural belief in witchcraft and "witch doctors", making it difficult to understand and treat certain patients. Their way of practicing medicine seemed rather primitive at times, not because of choice, but due to the lack of resources available. For example, I was astonished at the fact that women crowded the rooms on the maternity ward, their beds almost touching, with absolutely no privacy. I, like the other health-care workers, had to learn to rely mainly on my history and physical exam skills to make my diagnoses because other imaging and laboratory investigations were either too expensive or unavailable. I realize that we live in a privileged society, and many times we take what we have for granted, using our resources sometimes unnecessarily, simply because we can. It was definitely an eye-opening experience.

Lauren Hamlin-Douglas
Butare, Rwanda

Rwanda is a small land-locked country in East Africa known for a mountainous countryside, expansive tea plantations, and the Virunga volcano chain, home to the rare mountain gorillas. Sadly, a gruesome recent history has also put Rwanda on the map. In particular, conflict between Hutus and Tutsis, culminating in the 1994 genocide, led to the deaths of 10% of the Rwandan population. These events have touched each and every Rwandan in some way.

Though I first traveled to Rwanda in 2006 and returned in 2009 for an internship, my four-week family medicine rotation at Centre Hospitalier Universitaire de Butare in August 2010 solidified my understanding of the social and cultural factors impacting healthcare in Rwanda. I already knew basic facts: Rwanda's healthcare system was rebuilt from essentially nothing post-genocide, having lost important infrastructure and all but a few healthcare workers. Specialists are still few and far between, and a lack of reliable medical supply sourcing often causes services to grind to a frustrating halt, even when personnel are available.

I had found it more difficult, however, to develop an understanding of Rwandans' attitudes and beliefs towards health issues, especially when genocide entered the conversation. Working in outpatient clinics and on internal medicine wards with Rwandan medical students seemed to open the channels of communication through our shared training experience. As patients presented complaining of chronic pain or PTSD flashbacks, we discussed the paucity of mental health training in medical school and questioned the appropriateness of the application of Western diagnostic criteria. As we wandered by benches outside the TB clinic lined with prisoners in their brightly coloured uniforms, we examined the challenges of overcrowding in prisons and weighed the benefits of gacaca traditional justice.

After establishing trusting relationships with my colleagues, I asked about other issues: the approach to traditional healers and why so many young Rwandans develop congestive heart failure from untreated streptococcal infections. We also discussed the challenges of medical trainees in Rwanda – a lack of teaching resources and limited access to equipment including such basics as penlights and reflex hammers. Training with Rwandan medical students not only taught me about the social and cultural context of health issues in Rwanda, but also the need for innovative and culturally-appropriate solutions developed on the ground, which these future leaders will develop. I look forward to partnering with my colleagues in such endeavours over the course of our careers.

Daniel Jones
Ottawa, Canada

Jamie sees the net…and chooses to pass to Paul. Paul takes one look at the goalie and fires a shot. Top right corner…goal! The team converges and exchanges hugs and high fives.

This seemingly ordinary scenario played out on many fields across the world, was, for me as the coach of Ottawa's homeless soccer team, both extraordinary and magical. Jamie and Paul (not their real names) had complicated histories of mental illness, drug abuse, and violence. I remembered how 3 months ago these same young men were on the street, in trouble with the law, psychologically unwell and doing drugs. They seemed surprised when I invited them to participate in a street (homeless) soccer team I co-founded with a friend in December 2010. Our practices were weekly, and over a period of 7 months, our team grew to twenty-five regular players. We entered a 2nd division (co-recreational) team, and we subsequently won the league! I organized focus group discussions to deal with issues that had arisen, and players were free to come and go as they choose. Many players would tell me how good they felt, how their self-confidence was rising, and how the shelter life had made them forget how to 'have fun' and 'let go'. The umbrella organization, Street Soccer Canada, works to help homeless people off the streets, and to promote physical and mental health. The initiative continues to grow and develop in the Ottawa area.

This experience was truly inspiring for me; I could see how the sport that I had always loved functioned as a vehicle for social inclusion and justice. In my work with homeless people, I learned that issues of self-esteem are critical to the health and well-being of marginalized persons. I believe the street soccer team gave homeless individuals the chance to see themselves in a different light: to re-image themselves as people capable of mastering skills, discipline, and interacting positively with others. All of which had a tremendous impact of their sense of self worth.

The fundamental insight I have had was that poverty is not just a lack of money. Poverty has an enormous social dimension, in which impoverished people do not feel part of a community. The extraordinary aspect of this initiative was that in many ways the participating individuals were healing themselves and also helping to heal others around them. Soccer was a means by which they could enter into community, and hence satisfy the basic human need to belong. The team's collective sense of wellbeing was heightened through the medium of soccer, and I feel privileged to have been a part of this important community-based project.

Samantha Liauw
Yogyakarta, Indonesia

Health Promotion through Teaching English in Yogyakarta, Indonesia

Yogyakarta, Indonesia is a dynamic city where modernization and globalization meets religion and Indonesian tradition. It's a mix of air-conditioned shopping malls and traditional, bustling markets. It's home to both Gadjah Mada, the nation's largest university and Borobudur, the world famous ancient Buddhist temple. In Yogyakarta, I could hear the Islamic call to prayer while I watched a transgender cabaret show at a rooftop restaurant.

Last year, I spent one month (April-May 2011) at Teruna Bangsa, an elementary school in Yogyakarta. For a school of 150 students, there were only two washrooms and the classrooms were just big enough for everyone to have a desk and chair. Despite these minimal physical resources, the level of English at Teruna Bangsa was higher than any other school in the city. When I asked the students what their favourite subject was, all of the students said English. They were very proud to communicate in this foreign language. Consequentially, knowing English will be instrumental in securing employment in the future.

My role at the school was to contribute to the development of the English curriculum. To this end, I recorded over twenty hours of English audio exercises for the students. I also taught English to the students as well as the teachers. In the evenings, I led an extracurricular program at an orphanage, where some of the students live.

One of the reasons the students are so advanced is because they have two local, dedicated, teachers, Esfie and Santi. They encourage their students through extracurricular activities and a challenging English curriculum tailored to the students' needs. For example, Esfie recognized that the learning material issued by the Ministry of Education was not relevant to Indonesian culture, and unsuitable for her students' level. Therefore, over the past few years, she has spent countless hours creating specialized English workbooks with more suitable topics.

Health is not only about disease and the body. Health is also about well-being; having a sense of self, purpose, and confidence. Over the summer, I witnessed health promotion through local commitment to teaching English in an Indonesian urban setting. As I described, the culture and society of Yogyakarta are diverse and dynamic. Empowering and preparing these students will ultimately help them to adapt, thrive and contribute to this changing environment. The commitment to empowerment of children of the lowest socioeconomic strata should be a model of health and development in globalizing communities.

Joshua Ng
South Africa and Madagascar

Crossing the Mozambique Channel

"There is nothing like returning to a place that remains unchanged to find the ways in which you yourself have altered". Nelson Mandela's wisdom rang true long after I returned from Southern Africa. I had spent five weeks in Johannesburg, working in the trauma department at the Chris Hani-Baragwanath (CHB) hospital, followed by nine weeks in Northern Madagascar on a family medicine rotation at a rural hospital. I have been altered by the people whom I had met, their struggles, the complexity of their communities, and the profound tragedy of their unmet health needs.

As a rotating elective student in Johannesburg, I saw firsthand the kind of violence from which the city garners its nefarious reputation. In addition to the high incidence of blunt and penetrating trauma, what rocked me emotionally was the lack of legal recourse which victims of violence were provided. Delays in hospital paperwork made it near-imposisble to file timely police reports, and thus victims often left the hospital with no legal protection from their aggressors. Anecdotally, the likelihood of an arrest being made after an attack was slim. But despite the lens through which I viewed the city in the trauma bay of its "black hospital", I also discovered a city which has in many ways thrown off the cloak of its past, with a culturally proud Soweto and a thriving downtown core.

Madagascar, while less violent, has no less desperate health needs. I worked at the Hopitaly Vaovao Mahafaly, 200km from the nearest equivalent facility, serving a population of 170,000. At this hospital, I met a woman who had walked for four days with a prolapsed umbilical cord because her village was inaccessible by oxcart. I saw a 14-year-old girl die because of a lack of basic monitoring technology. I travelled with the community health team on vaccination missions, twice bringing acutely unwell children back to the hospital. In completing a hospital mortality audit for 2010, I discovered two things—that schistosomiasis, a preventable parasitic infection, was a contributor to far more deaths than one would have imagined, and that the tragedy of untimely death was directly correlated to access to care.

Both hospitals faced unique challenges in treating the ill—one suffered from overwhelming clinical volume, the other from systemic infrastructural deficits. But the dedicated staff at each challenged me to reconsider the manner in which I am called to serve the sick.

Kirsten Niles
Nalerigu, Ghana

Every community has a unique aura that is the culmination of culture, environment, resources and beliefs. These qualities are critical in every aspect of life including health and medicine. I had an opportunity to experience this interaction during a two month family medicine rotation at the Baptist Medical Centre in Nalerigu, Ghana, a small community located in the East Mamprusi region of Ghana. The hospital serves the many surrounding villages and more distant locations including the neighbouring countries. With 126 patient beds, it accommodates nearly 10,000 in-patients and over 60,000 out-patients per year.

Northern Ghana is filled with diverse cultures and beliefs including traditional African traditions (including witch craft and healers), Christianity, and Islam. Additionally, it is a patriarchal society with the man supporting his occasionally multiple wives and certainly many children and the woman involved in delivery of children and home life. Access to money presents a significant challenge limiting access to nutrition, healthy living conditions, and consistent medical care.

I started this rotation with trepidation as I knew I would be working in a culture that differed from many that I had experienced and that this may change my ability to provide adequate health care. Additionally, I was aware that resources were limited and my clinical skills would be put to the test daily. My nervousness diminished each week, however, as I developed the clinical skills that assist in diagnosis when lab tests are not available, X-ray film has run out, and the key tools of history and physical exam must suffice.

More than my clinical growth, I learned about the cultural aspects of medicine in Nalerigu and the pervasiveness of illness and death in life. I spent hours in the pediatric ward where children arrived daily with malaria, gastroenteritis and pneumonia. Depending on the financial situation, belief structure and distance to the hospital, children would be admitted with varying severity of their illness, frequently following days of severe febrile seizures, lengthy journeys or unsuccessful treatment by local medicines. These delays meant that some of the children would barely arrive at the ward before passing. Upon examination other children would have signs of local treatments including ink on skin wounds and raw garlic on the chest. Finally, the majority of the children had malnutrition symptoms including the bloated belly of kwashikor limiting their strength.

I faced the intensity of grieving mothers as their children succumbed to illness with the knowledge that had the child arrived sooner, death may have been prevented. The recovery of other children in the ward provided solace and an opportunity to educate families regarding ways in which their culture and medicine could coexist. I learned that medicine cannot stand alone and must collaborate within the local culture to be successful.

Hélène Retrouvey
Peru

The Hogar San Pedro: My Second Home

Medical practice beyond the borders of my community has always fascinated me. When I enrolled in medical school, I learned about a great project in Peru: volunteering at the Hogar San Pedro, in Ricardo Palma, Peru. My goal was to participate in a medically oriented mission to provide quality care. This experience was also an opportunity to discover a new culture and increase my awareness of the challenges faced by people living in developing countries.

On June 27, after six months of intensive Spanish lessons, four of my colleges and I left for Peru with a willingness to help, learn and immerse ourselves in a foreign culture. We arrived at the Hogar, a remote health care facility focusing on treatment of sensitive and multidrug resistant tuberculosis patients, on June 28. The Hogar welcomes patients from all ages including orphan children, abandoned because of the stigma associated with their medical conditions, as well as adolescents and adults without families. Our roles at this institution were both medical and social. On the medical level, we helped the pharmacist, nurses and physician in their daily tasks which included cleaning and dressing wounds, preparing and distributing medication, as well as organizing and preparing health campaigns. We organized many social activities such as bingos, Olympic days, outings into the city, craft, drawing, cooking activities in order to entertain patients.

The community treated us as though we were family. They immediately integrated us and shared their homes, invited us to meals and welcomed us to visit at any time. They also shared their culture by inviting us to village festivities and to ceremonies at the Hogar.

We slowly built strong bonds with patients. They taught us the importance of trust by sharing their worries and pains, allowing us to better appreciate the challenges they faced. The kindness and confidence shown by these ill and underprivileged people deeply humbled us and emphasized the importance of human interactions and relationships in medicine.

After a few days at the Hogar, my initial goal of self-improvement through acquisition of new clinical experience and skills was altered. I realized my main role at the Hogar was to improve the quality of life of the patients by providing support and understanding in addition to primary care. I now appreciate that global health partnerships not only provide quality compassionate care, but also care consistent with the host population's cultural beliefs in order to provide a positive impact.

Mélissa Roy
Ecuador

It was in the small Andean community of Chilcapamba, Ecuador, that I spent seven weeks of the summer of 2011. Hosted by the family of my playful and helpful (almost) siblings, Tupak, Consuelo and Victor, I felt well integrated within the community's traditions and customs. The purpose of my visit was to take part in the ongoing McGill to Chilcapamba Research Partnership that started in the summer 2008 in collaboration with the PRAM (Participatory Research at McGill). The community had expressed the desire to explore more deeply the theme of women's reproductive health that had been started the year before. Following this interest, a qualitative protocol about the use of contraception by the women of the community of Chilcapamba was approved by the McGill Department of Medicine IRB.

Once in Ecuador, I had the privilege of organizing voluntary focus groups (eight) with women of the community in order to identify the perceived barriers in accessing contraceptive means. Individual, voluntary and confidential interviews (eight) were performed with women using different modern methods of contraception to gain a more detailed understanding of the women's experiences and expectations about contraception use. Five (Gynecologist and Obstetricians) medical professionals of the Asdrubal de la Torre hospital, where I was doing field work and observation, enthusiastically agreed to participate in individual interviews. In these encounters, possible culturally sensitive solutions to the barriers of contraception use and accessibility were explored and discussed. The leader of the community, a dedicated and determined woman, was without a doubt a key player to the success of the project.

Although I was working in the sometimes rigid context of a research project's protocol and methodology, I was able to build a unique alliance with the women I interviewed and spoke with. Women opened up to me about their marital, social and medical contexts in a way I could never have imagined. The medical professionals were not only open but also willing to discuss with me the issues faced by the communities visiting the hospital. These physicians expressed to me their willingness to improve health care services and to better understand and consider patients' needs.

In brief, my experience consisted of an exceptional opportunity to witness the tangible impact of culture on health. I felt integrated within the community and came home with a new perspective; one of patients, of women, and of indigenous members of a small community in Ecuador.

Phil Vourtzoumis
Nalerigu, Ghana

The Baptist Medical Center is a 123 bed mission hospital, in Northern Ghana. I was excited at the prospect of experiencing an entirely foreign culture and felt I would be exposed to so many challenges and problems that I would likely rarely see in Canada. I knew that I would grow from the experience but at the time I could never have imagine how profoundly and deeply this experience will have made me appreciate the strength of the human spirit.

The hospital is well organized, during clinic days, we would see up to 500 patients per day. Patients who require observation or surgery are admitted to hospital and attended to on daily rounds. Tuesday and Thursday is procedure day, where a good portion of the complaints involved wound debridement, dressing changes, c-sections and any other emergent surgeries. We were able to only perform a minimal of diagnostic evaluations; blood tests for malaria, infections, anemia, as well as stool cultures and lumbar punctures. Many of the cases presented virtually textbook. One of the greatest frustrations for me was my inability to communicate without a translator. Beyond our medical knowledge, intuition was key.

During my time at the BMC, I encountered many situations that I believe would have had a very different outcome in a hospital in Canada. Very frustrated at the lack of resources, medications and equipment that limited our ability to make a more accurate diagnosis. All the medical training in the world cannot prepare you to watch helplessly as a child dies in your arms. What struck me even more was the resilience of the people who, even through their pain and sadness, accepted their fate with dignity. They were sincere in their appreciation for any help we could provide them.

Over the course of the month, I made it a point to visit the village and interact with the people in their environment. There is a very strong sense of family and they are supportive of each other. When compared to the insignificant material possessions we take for granted at home, these people have so very little, yet they are always smiling.

I will draw on these moments next time I stress out about clothing, traffic or the latest iPhone gadget. In the end, probably the greatest operation that was performed was on me. I had my eyes and my heart opened just a little bit wider.

(Julian) Zhunping Xue
Belize

I went to Belize in July 2009, July 2010, and April 2011, as a member of the Montreal WHO-PAHO (Pan American Health Organization) Center's collaboration with the Belizean Ministry of health to improve mental health in that country. I was deeply involved since the beginning: in 2009, I explored what contributions we could make and helped define our goals. In 2010, I worked with two McGill physicians to present the latest research to psychiatric nurse practitioners, who form the backbone of mental healthcare in Belize. I returned with the same physicians in 2011 to help train general practitioners so that mental health care would become an integral part of their local practice. Throughout these trips, I helped with communication, produced documentation, organized feedback, provided logistical support, and gave peer-reviewed presentations. In between trips, I built, disseminated and analyzed online surveys that evaluated this project's success. In November 2011, I presented a poster at the 2011 Global Health Conference in Montreal outlining this project as a model for approaching mental health in that region.

For all of my devotion to this project, I gained far more from Belize than I could ever give to it. The importance of social and cultural factors in shaping mental health care is widely known, but to witness this in person is transforming. The nurses, for example, bike through the streets of Belize City, finding homeless people whom they know to be mentally ill. They then administer, not only food and water, but also long-acting antipsychotics. The nurses confidently assured me that there has been a dramatic decrease in street violence since this intervention. The cultural milieu in Belize makes something unthinkable in Montreal plausible and effective. I also saw psychosocial counselling that differed greatly from "back home". The nurses did not hesitate to advise, even to admonish, at levels that would be considered inappropriate here. However, their patients do not become defensive, indeed, they nod vigorously in agreement, often through tears, and I feel they have been given extra strength in their ordeal.

I was astonished in Belize by the many illiterate villagers who understood mental illness and its symptoms. From them, I realized that good mental health care is possible even in limited conditions. I look forward to renewing the many friendships and professional bonds that I formed in Belize, from them I have gained both refreshing perspectives as well as a sustaining hope.

Eric Zhang
Nalerigu, Ghana

Nalerigu is a small dusty village nestled amidst the rolling grasslands and the stout baobab trees of north-east Ghana. It is a rural place, relatively untouched by the industrialization of the south. A place of extremes, the area knows only two seasons; wet and dry. The dry spell lasts for months on end, with the hot Harmattan wind blowing harshly upon the land.

Recently, I had the privilege of working at the Baptist Medical Centre in Nalerigu, an organization dedicated to providing primary health care, surgery and women's care to the rural hamlets of northern Ghana. People travel for hours to reach the hospital, some from as far as Togo to the east and Burkina Faso to the north. During my eight weeks at the hospital, I worked with an international team of American and Dutch physicians, and local Ghanaian translators and nurses. I saw and treated a wide range of pathologies, with limited resources at hand. The substantial amount of patients each day made for an intense but enriching learning experience.

Besides the clinical exposure, I have also learned a lot about Ghanaian culture and how locals deal with health and the realities of a harsh life. A child growing up in rural Ghana is faced with many obstacles varying from a lack of nutrition, to snakebites, to motor vehicle accidents. Yet, despite these realities, which are many times fatal, Ghanaians are a joyous people, who place much emphasis on family and community. Laughter and the willingness to share joy with others is a major way in which the locals deal with the pain of seeing their loved ones in hospital. Often while rounding through sick children in Pediatrics ward, I would see mothers coming together for a good laugh, or sharing a meal. Other times, I have witnessed fellow villagers visiting a patient to donate one or two cedis to help fund the expenses of a surgery or blood transfusion. The way the community comes together for a sick member and together helps him/her towards good health is truly admirable.

Funerals in northern Ghana are not times of hushed words and black clothing, but a time of fire, song and dance for days on end amongst family and friends- a celebration of good health and life, in the face of death. Here in the west, I think there is a lesson to be learned for all.