Public Mental Health Volunteering in Egypt and the Making of a Psychiatric Career: A Reflective Essay

Introduction

This essay is an exploration of my experiences in volunteering in the public mental health sector in Cairo, Egypt during the years of 2014/5 and a reflection on how those experiences have shaped my career choices and my ideas about what kind of psychiatrist I would like to be. My experience involved volunteering at different levels of the global health machine: I spent four months at the Mental Health Unit of the World Health Organisation's (WHO) Eastern Mediterranean Regional Office (EMRO) in Cairo, followed by four months with the Cairo office of the international humanitarian NGO Médecins du Monde/Doctors of the World, culminating in my involvement in a local, trauma-focused community mental health intervention for Sudanese refugees in Nasr City, Cairo. These experiences influenced my outlook on mental health and illness and cultivated in me an appreciation of the importance of developing partnerships with communities and building local capacity in order for change to be sustainable.

I graduated from medical school with two major interests: public health and psychiatry. The volunteering experiences I discuss here were my attempt at marrying the two. My interest in community and public health was first kindled during my fourth year of medical school at Alexandria University. The public health curriculum I was exposed to focused on 'traditional' arenas of public health involvement in the Global South: maternal and child health, family planning, infectious diseases, and nutrition. Mental health was not a feature. I did not know it at the time, but the public mental health policy landscape was undergoing a major overhaul: in 2009, the 1940s era mental health policy of the Egyptian government was replaced with a new policy, and a new General Secretariat for Mental Health was established under the leadership of psychiatrist Nasser Loza, current President of the World Federation for Mental Health.[1] The change being advocated by Loza and similar minded psychiatrists mirrored the global changes taking place in mental health policy: a move from institutional to community treatment, integration of mental health services into primary care, and greater legal safeguards and protections for the rights of people with mental illness, particularly in reference to involuntary hospitalization.

Psychiatry was not a subject given much attention during medical school, playing second fiddle to the more prestigious neurology. To my colleagues, the word 'psychiatry' often conjured images of lucrative addiction treatments in the private sector. The public perception of mental health and illness in Egypt would change forever with an event that coincided with my final year of medical school: the Revolution of January 25th, 2011 and, more broadly, the events of socio-political unrest that swept the Arab world and came to be known as the 'Arab Spring'. Aided by social media platforms, a new space for conversations about mental health was carved into public discourse. Greater mental health literacy ensued. These conversations often revolved around trauma and post-traumatic stress disorder (PTSD), aided in no small part by the security vacuum and increase in violent crime that are often part and parcel of revolutionary unrest. As it became clear that the Revolution was not going in the direction hoped for and the military regime was doubling down on its repressive tactics,

---

[1] Mental health legislation in Egypt - PMC (nih.gov)

another kind of trauma was called into being: that of a 'revolution denied', as Egyptian psychiatrist Sally Toma has written.[2] The pervasive sense of loss and trauma has been compared to that experienced by Chileans following the coup that toppled the democratically elected socialist Salvador Allende and ushered in the fascist military dictatorship of Pinochet in 1973.[3]

There was yet another focal point for trauma in public discourse in the years following 2011, and it was this one that piqued my interest in humanitarianism and volunteering. As Syria's own version of the Arab Spring got underway and the country descended into civil war, Egypt played host to hundreds of thousands of Syrian refugees. Reports of the psychological trauma they were carrying filled the airwaves.[4] The well-off among them were able to start their own businesses, and soon restaurants serving Syrian food began to proliferate. The less fortunate ended up on the caseloads of NGOs like Caritas. One could be forgiven for assuming that this was the first sizeable refugee population to seek asylum in Egypt, but there was another long-established refugee population in Egypt that was not getting a tenth of the media attention: Sudanese refugees had been in Egypt for decades and, prior to the arrival of Syrians, were the largest refugee group in Egypt.[5] It was within this context of refugee trauma and differential access to health services and media airtime that I identified the first inklings of my career in public mental health.

The WHO experience

My first experience as a volunteer was at the WHO-EMRO headquarters in Cairo. There, I was an intern tasked with developing the curriculum for what would be the region's first Leadership in Mental Health course.[6] Now in its ninth consecutive year, the course aims to equip those working in mental health services in both patient facing and managerial roles with the leadership skills and public health competencies necessary to effect meaningful change in mental health policies. Undertaking this work involved reading widely and familiarizing myself on topics as varied as deinstitutionalization, the recovery movement, community approaches to the treatment of mental illness, the integration of mental health care into primary care, and the adaptation of global health strategies that had proven successful in the fight against HIV/AIDS to the mental health context. It also involved scrutinizing the curricula of existing Leadership in Mental Health (LMH) courses, liaising with their faculty, and presenting the draft curriculum to a meeting of stakeholders.

For reasons ranging from colonialism and arbitrary lines on maps, to repressive regimes, to economies subservient to Global North-dominated financial institutions, the Middle East North Africa (MENA) and Eastern Mediterranean regions are home to chronic refugee crises. A unique feature of the curriculum I was designing that had not been a part of

---

[2] Egypt, The Collective Trauma Of A Revolution Denied - Worldcrunch

[3] Exile as bereavement: Socio-psychological manifestations of Chilean exiles in Great Britain - Munoz - 1980 - British Journal of Medical Psychology - Wiley Online Library

[4] UNHCR - Doctors face uphill task to treat Syria's mental wounds

[5] Refugee Context in Egypt – UNHCR Egypt

[6] A preliminary evaluation of the delivery of the "Leadership in Mental Health, Eastern Mediterranean Region" course | Middle East Current Psychiatry | Full Text (springeropen.com)

other LMH courses was a specific module on Mental Health and Psychosocial Support (MHPSS).[7] This was all the more apposite with the rising refugee numbers in Egypt and the ongoing socio-political turmoil of the Arab Spring. MHPSS in emergency and humanitarian settings thus became a cornerstone of the Cairo-based LMH course. It also kindled my interest in medical humanitarianism and the place of mental health in it.

The major learning point from my experience with WHO which was formative to my professional development was that I developed an understanding of the nuances and intricacies of mental health policies. I learned how policy is formulated, how it should – ideally - function as a guide to local practices rather than a rigid prescription, and how it is translated into programmes and action plans. For policy to be effective and impactful, it needs to be developed in consultation and partnership with the communities it is supposed to benefit. This, however, is necessary but not sufficient. Building political will to enact policy change is crucial if a policy is to become more than a document. This involves rubbing shoulders with policymakers and politicians and convincing them that mental health is both a priority and that it can be studied and intervened on successfully in a manner that is both measurable and scientific. This involves providing evidence that mental health interventions can be cost effective and economically sound. This, in turn, places demands on the kinds of mental health interventions that governments will fund: They need to be easily replicable and amenable to up-scaling after an initial successful pilot. A sustainable mental health intervention is thus ideally one that is integrated into primary care, can be performed by rapidly trained workers, and needs specialist input on a supervisory rather than operational level. All this was on my mind in seeking subsequent volunteering opportunities.

Though my volunteering experience at WHO was informative and educational, it left much to be desired. Because it was based at EMRO headquarters, I spent most of my time sat at a computer or attending meetings with other professionals. My work did not involve any community based work and was far removed from the communities its work was intended to benefit. Though I read and wrote much about grassroots organization, 'barefoot doctors', and the involvement of Non-Specialist Health Workers (NSHWs) in the delivery of mental health services, I did not meet any people who would actually be involved in these roles.[8] The stakeholders I liaised with were all professionals within my network rather than community representatives and leaders. Eager to learn how the knowledge and expertise I had gained could be applied, I resolved to take it directly to the communities who were expected to benefit from them. Volunteering with a humanitarian NGO seemed the natural next step.

The Médecins du Monde/Doctors of the World experience

In 2013, in response to the influx of refugees to Egypt, MdM-Egypt commenced a project entitled 'Barriers to access to mental health services for at-risk populations in Greater Cairo'. I volunteered in 2014 as a research assistant and participant observer. This was an opportunity to engage communities in a way that had not been possible during my involvement with WHO. It was also a chance to observe first-hand how the principles of mental health policy and planning that were elaborated in the LMH curriculum could be

---

[7] Mental health and psychosocial support in humanitarian settings: linking practice and research - ScienceDirect

[8] Barefoot doctors in China - PubMed (nih.gov)

translated into action in the 'field'. The at-risk populations in question were refugees and asylum seekers; children in street situations and those deprived of parental care; and children and adults with intellectual disabilities. MdM implemented its vision through partnerships with local NGOs: Caritas in the case of refugees, the Banati ('My Girls') charitable foundation and orphanage in cases of disadvantaged children, and Basmat Amal ('Smile of Hope') in the case of children with intellectual disabilities.[9]

My work involved research interviews with service providers, participant observation at community events, and report writing. Through interviews with the front line providers – teachers, social workers, psychologists, volunteers - at each of these organisations, I was able to gain a sense of the barriers and facilitators to their work. I also participated in outdoor interactive theatre activities performed by the troupe Outta Hamra ('Red Tomato').[10] My engagement with these organisations and communities cultivated in me an appreciation of the necessity of establishing long-term alliances and partnerships with communities at a granular and grassroots level if change is to be impactful, and an appreciation of the investment of time and resources needed to build these relationships.

In terms of barriers to access to mental health services, I identified a number of issues: absence of clear referral protocols, dearth of human resources, lack of political will, inadequate supervision of existing practitioners, absence of centralized action from policymakers, an absence of mental health services in primary care in rural areas, stigma, and a system focused on treatment rather than health promotion and illness prevention. I fed back these findings, and proposed solutions drawing on my WHO work, to policymakers in the Ministry of Health, universities, and civil society partners. Armed with my newfound knowledge on local barriers to access to mental health services, I resolved to gain first-hand experience of delivering a community mental health intervention.

The community mental health experience

I volunteered for a trauma-focused community mental health intervention targeted at a community of Sudanese refuges in the Nasr City district of Cairo. Under the leadership of Kate Ellis, professor of psychology at the American University in Cairo, Sudanese refugees were recruited via community leaders with the express purpose of training them in Narrative Exposure Therapy (NET), a trauma-focused psychological intervention designed for implementation and replication in low resource settings and with minimal specialist input.[11]

---

[9] Dreams of a Safe Home: How Banati Foundation Fights Against Child Abuse in Egypt | Egyptian Streets; Facilitating access to education for disabled children in Egypt – Fondation Air Liquide

[10] Outa Hamra stirs up change with street clowning, social theatre: VIDEO - Stage & Street - Arts & Culture - Ahram Online

[11] An initial evaluation of narrative exposure therapy as a treatment of posttraumatic stress disorder among Sudanese refugees in Cairo, delivered by lay counselors | Middle East Current Psychiatry | Full Text (springeropen.com)

NET was developed by Frank Neuner in refugee camp settings in Uganda.[12] The use of narrative methods in trauma therapy with refugees is well established.[13]

After receiving training in NET, Sudanese lay counsellors, themselves refugees, were assigned clients with symptoms of PTSD from among their peers in the community. They provided structured therapy sessions with regular supervisory input from Dr Ellis. I volunteered to conduct an early process evaluation, whereby I interviewed the trained lay counsellors and explored their experiences of receiving training and providing therapy to their traumatized compatriots. This project had all the hallmarks of a scalable global mental health intervention. It was designed to be rapidly replicable via a 'training the trainers' model, requiring minimal investment and specialist input, and was delivered by community members to their own peers.

In working with the trained front-line refugee providers, it was refreshing and invigorating to understand how they felt empowered and resilient as newly minted NET therapists. Many found individual psychological benefit in it. One man told me 'the training I received treated me before I could treat someone else'. Another man told me 'the course gave me the positive motivation necessary to help people in need'. Another man also described his newfound motivation to me: 'I definitely believe that I will continue to help people with trauma issues'; and the implausibility of *not* using his newfound skills to benefit others: 'We have started to help the whole community now – after the training, I cannot, after I have gained this information, keep it to myself. It is very important to try to deliver what you know to help others.' One of the counsellors was even more ambitious: 'It starts with me, then the family, then the community.' One 22 year old woman from South Sudan, working as a schoolteacher in Egypt, managed to maintain a cheery disposition despite all her adversities: 'Tomorrow is definitely sunny and tomorrow is definitely good. There are good things in the world and the future, no matter how many bad things we've been through. Tomorrow can be better'.[14]

Conclusion: reflecting on the ethics of volunteering

What, exactly, constitutes volunteering? It is generally accepted that to volunteer for something is to do it without expectation of payment. The *Oxford English Dictionary* offers the definitions 'to offer of one's own accord to do something' and 'to offer one's services for some special purpose or enterprise.'[15] It does not stipulate that altruism be part of the motivation, yet this is commonly expected. The experiences detailed in this essay were undertaken as part of my MA in Community Psychology degree at the American University in Cairo. They took the form of internships chosen by myself in consultation with graduate advisors. Does this make them qualitatively less of a volunteer experience? Not necessarily, I

---

[12] Treatment of posttraumatic stress disorder by trained lay counselors in an African refugee settlement: a randomized controlled trial - PubMed (nih.gov)

[13] The testimony of political repression as a therapeutic instrument - PubMed (nih.gov); The Trauma Story: A Phenomenological Approach to the Traumatic Life Experiences of Refugee Survivors | Psychiatry: Interpersonal and Biological Processes (guilfordjournals.com)

[14] Lay counselors experiences with counseling their peers; the impact of being a lay counselor and providing therapy to traumatized Sudanese refugees in Cairo (aucegypt.edu)

[15] volunteer, v. : Oxford English Dictionary (oed.com)

would argue. However, in order to be responsible and reflective volunteers, we must constantly reflect on our motives. This necessitates an awareness of how the current model of volunteering is an extractive one; and recognizing our complicity in perpetuating (often racialized) hierarchies and inequalities by virtue of our participation in them. The time required to build sustainable alliances and partnerships with communities is often directly at odds with the short-term nature of research funding cycles and grants. Accordingly we must be aware of the dangers of diverting local talents to internationally funded projects and undermining local resources only to leave them in a worse position in five years' time. There is also a bias in favour of certain topics that funders are likely to support: a major example here is trauma and victimhood, a favourite among Western funders.[16]

Ultimately, my volunteering experiences increased my appreciation for the humanity of the people I work with in a way textbooks and exams could not. With this came an increasing awareness and tolerance of uncertainty and comfort with the ambiguity of the 'real world'. After a stint in the medical humanities during which I qualified as a historian of medicine and migration, I returned to clinical practice. I continue to pursue my interests in refugee mental health as a clinician and researcher. In clinical practice, I constantly remind myself of the inherent power imbalance in doctor-patient relationships. In research, I do my best to avoid being a parasite who extracts value from communities without remuneration. In short, my early volunteering experiences taught me two lifelong lessons which I will take forward as a volunteer psychiatrist with refugees and asylum seekers: humility and humanity.

Dr Baher Ibrahim, CT1 Psychiatry, West of Scotland
Email: baher.ibrahim@gmail.com
I declare no competing interests.

[16] The 'Trauma' of War and Violence | SpringerLink