Training For Teaching Medical Anthropology in Egypt/The Arab Region

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Abstract:
Medical anthropology is a growing subfield of anthropology, especially as a subject within health education. Medical anthropology knowledge and skills can improve the satisfaction of patients and health professionals, result in better health outcomes for patients, improve communication, and help avoid conflicts. The Arab region is trailing when it comes to offering medical anthropology in health education. We carried out the first project that trained teachers for medical anthropology in health education in Egypt/the Arab region in 2020/2021. Training with a regional focus is crucial to create a competent local workforce.

Keywords:
medical anthropology, health education, train-the-trainer, Arab region

Introduction: Medical Anthropology and Health Education

In this article, we would like to shed light on the first initiative of a train-the-trainer (ToT) for teaching medical anthropology for health education in Egypt and the Arab region in 2020/2021. We will show how innovative initiatives can enhance empowerment and contribute to health professionals' ability to offer good care to all. In this regard, the authors of this article were able to offer training in medical anthropology for future teachers in the region due to Mustafa Abdalla's (author 2) embeddedness in the culture and his engagement with the field of medicine in Egypt for many years. Margret Jaeger's (author 1) expertise in training health professionals worldwide in the last 15 years as a medical anthropologist added fundamental competencies to the team. Lamia Mognhieh participated in the development of the curriculum and some online classes during the first months.

Medical anthropology is a growing subfield of anthropology. It investigates the human experience of health and disease as well as local medical knowledge and healing practices. It further scrutinizes biomedical interventions on local, regional, and global level (McMahan and Nichter 2011). Over the past decades, medical anthropology was gradually introduced to become part of the education of nurses, medical doctors, and occupational therapists in undergraduate and post-graduate programs (see Leininger 1991; Martinez and Wiedman 2021; Mattingly 1998). The World Federation of Medical Education (WFME, 2020) recommends medical anthropology and other social sciences like psychology, sociology, and communication science to be included in the medical curriculum. Based on this recommendation, medical schools outside of North America and United Kingdom have started to pay attention to the importance of medical anthropology in the training of their students and have been attempting to integrate it in their curricula. Nursing schools in the U.S., later in other countries of the Global North, have included anthropological knowledge since Madeleine Leininger's work that started in the 1970´s. Studies show the positive impact training health professionals in medical anthropology can have on doctor-patient communication (and other professions), therapy management, cost effectiveness of interpretation services, and epidemic emergencies (Good and Good 2000; Hudelson 2005; Kutalek et. al. 2015)

Despite of its long-standing contributions in the Arab region (for example, in Sudan and Egypt), medical anthropology has not received enough attention in health education, and its presence is educational health programs is still limited. Few anthropologists can be found working across the 22 Arab countries, in medical/health faculties. Small research strains of medical anthropology can also be found in some anthropology departments, for example at Ain Shams University in Cairo, Egypt. Paradoxically, there is a growing demand for

medical anthropology content in undergraduate and post-graduate education in the region, especially among health professionals.

Yet, and very generally spoken, departments of anthropology often do not prepare their graduates to become medical anthropology educators in health education. Therefore, teaching medical anthropology successfully in health education in the Arab region, like elsewhere, still needs extensive efforts and preparations. This has been a hotly debated issue among members of the special interest group of "teaching medical anthropology to (future) health professionals" (MAE-Medical Anthropology Europe – an EASA network) since 2015 (closed in January 2023). The debate continues in the newly founded (2022) international group "Health Professions Education Special Interest Group of the Society for Medical Anthropology" (HPE-SMA) that has the mission to *"support anthropologists in making a positive and lasting impact on medical and health professions education by creating an organizational space that nurture's healthy professional identity, promoting lifelong career advancement, and serve as a representative voice for anthropology among the health professions and the public."* (see homepage). The new group aims to bring together trainers from all over the world and is divided into different working fields that foster development.

Martinez and Wiedman (2021) formulated 15 recommendations at the end of their book about teaching medical anthropology in medicine that brings perspective from different countries together. They highlight the importance of the significance of exposing medical people [sic] to concepts and theories of medical anthropology. While we agree with Martinez and Wiedman, our approach to teaching medical anthropology has a broader perspective by including all health professions in our planning and thinking about teaching medical anthropology to them. This view stems from our concern of having an encompassing approach to health challenges facing humanity, which must be tackled from different angles. Yet, to employ this approach, there is a crucial need for anthropology graduates who are trained to teach their subject in health science settings. However, graduates in medical anthropology are well trained in theories/and concepts and qualitative research methodology but they lack holistic knowledge and sometimes hands-on experience with local health systems (public health, finances, economics, professional duties, boundaries, inter-professional collaboration etc.). Furthermore, they need to learn to choose between the various existing theories and concepts to make professionals capable of offering high quality healthcare that addresses the needs of the local population, including minorities and special needs of groups like migrants or people with a disability.

Internships in health care institutions may help to understand the professional roles, daily practice, and challenges as well as the system itself and its company cultures. During fieldwork in a healthcare institution, anthropologists may certainly make important observations but often their focus is limited to their research questions. In contrast, internships in healthcare institutions offer an opportunity to focus on different aspects of day-to-day practice. This may better reveal the discrepancies between public health planning (and financing) and "the reality out there".

In countries in which the training language of health professionals differs from the spoken local language(s) (many countries in the Global South have a big language diversity itself, without considering international migration), health professionals face the challenge that they learn medicine/nursing/therapy professions in technical terms and sometimes in another language other than there first one (such as the ones of colonial heritage: English, French, Spanish and Portuguese). When it comes to practice, they must address daily problems and tackle issues of health and illnesses in another language or a different dialect and need to learn to "translate" these back into local languages such as in Arabic-speaking countries where, for example, in Egypt, they must translate from English, and in Morocco from French.

We have learnt during our lobby work since 2015 and workshops in Cairo and Mansoura (2018 and 2019, see link from DAAD-German Academic Exchange Service, Egypt) how important it is to use both languages (English and Arabic) in training. Besides this, training materials such as texts, films, videos, medical comics etc. are also fundamental to be used within the local language diversity. This focus on local realities is important because many institutions use textbooks/teaching materials either translated from Arabic into English/French or use the British or American originals. These resources include examples originating from the global north with very different realities to local societies and thee healthcare systems across the Arab region. During the workshops we held in Egypt in 228 and 2019, participants (both professors of Public Health and students of different disciplines) complained about this discrepancy in realities, and we wanted to include this critique into our training for teaching.

Training Trainers for the Arab Region

Putting Things into Practice:
While the trainers were developing the curriculum and the training syllabus, we opened a call for applications in December 2019 and selected 15 trainees to train until March 2020. While our original goal was to train anthropologists/social scientists to teach, the best fitting applications came from health professionals with extra education or informal training in anthropology/social sciences. Flexibility was crucial to designing training that addressed the trainees' needs and wishes. We changed our course content to add more basics of medical anthropology and excluded content about the health system. For this reason, our curriculum is not easy to copy for universal training applications, but this decision turned out to be fruitful.

Our six content modules involved the following chapters:
- setting the ground: introduction, organisational aspects, group building activities, introduction to medical anthropology (discussion about useful theories and concepts for teaching)
- how to become a health professional (medicine has the "white coat ritual", Salhi 20216): professional cultures, company cultures, biased knowledge, colonial versus decolonialised curriculum content
- ethics in medicine (healthcare): from the Helsinki declaration to medical practice, 'culturalized' practices such as female genital cutting, end of life care etc.
- managing diversity in healthcare: diversity aspects of patients and staff, and their influence on health services management (interpretation services, cultural consultation)
- health literacy and social determinants of health
- mobility and its impact on individual health and health services: voluntary and forced migration, labour migration, health tourism/travel, tourism
- global health: lessons from the Covid-19 pandemic, access to treatment/medication etc.

The seventh module was about didactics and included the creation of a case database for teaching, which collected local cases based on Cohen-Emerique's (2015) form of a case report in her "critical incident method". This case database is important because in Egypt many textbooks in medicine are from abroad and include cases from these realities, such as the UK and the U.S. Population, life realities and medical systems are different, and these cases are not adequate for teaching in the Arab region.

Assessment of Trainees:
Active participation was required during the whole training and *Moodle* offers useful functions to evaluate participant's access and activities within the system. Throughout the training, the trainees worked on their learning process portfolios. This assessment method was chosen to accompany the process of learning and train them in writing in general, but especially in a reflexive manner about their knowledge and experience. This type of portfolio is "flexible and supports an evidence-based process that combines reflection and documentation. It engages students in ongoing, reflective, and collaborative analysis of learning. It focuses on purposeful, selective outcomes for both improving and assessing learning" (Zubizaretta, 2004:2).

Partly, the content was produced first for forum entries, on which they received comments from the other trainees. They were able to read the other's experiences and reflect and discuss them on *Moodle* and issues were later addressed during the teaching sessions. After the teaching session of the module, these entries were copied into the portfolio document and an overall reflection had to be added at the end.

Although the training was only meant to take place over six months (five months online and two weeks teaching in Egypt), the training was affected by the coronavirus pandemic and lasted from August 2020 until November 2021. The training took place online from August 2020 until September 2021. The teaching concept was modified and was as participative as possible, which included guest speakers, group discussions, group work, forum interactions, etc. The online learning platform *Moodle was used* to organize content and as a training resource itself.

Our onsite training took place in Cairo in November 2021, finishing the training programme with practical teaching training with extensive feedback and discussion of teaching materials, and a field visit (which, unfortunately, had to be cancelled at the very last moment). The field visit had the goal of letting trainees experience a health institution from another perspective than being a patient/relative themselves or a health

professional in action. Changing perspective is a fundamental learning experience and would have added great value.

We would have liked to let this run for two weeks, but our trainees were not (under-) graduate students who could do this during their studies, but rather had taken a week of holiday from their jobs or doubled their workload before and after in their regular jobs to be able to participate. Commuting and childcare duties also affected their availability during the onsite training. If such training is done during graduate school, it is possible to develop a much more flexible curriculum than it is possible when training professionals who are already out in practice.

Conclusion:

This training was unique to the region and local context and cannot easily be applied in a different region without further context analysis and funding for it. It was a pilot project that aimed to train teachers which was achieved. Participants were empowered and had access to resources that would have been difficulty to organise oneself without further support.

By December 2021, we certified seven of our trainees with 10 ECTS[1] by *Sigmund Freud University* (Jaeger´s employer at that time). A further two participants received 5 ECTS for their participation as they were not able to complete the whole training. We had also created a case database drawing on local case examples that could be used in teaching. The team developed a syllabus for an elective course in medical anthropology for 2nd to 3rd-year students in medicine and included all teaching materials. Due to the funding and a donation from Jaeger, it was possible to buy a collection of books on medical anthropology and qualitative research methods which is now located at the *French Institute* in Cairo.

We collected written feedback after each module through a form on Moodle. At the end of the training in Cairo, we collected oral feedback from the participants that turned into very emotional statements. These showed the personal and professional value of the training as a group of voluntary learners who did not know each other before. A joint article was already published about this experience (see Jaeger et.al 2024).

For the future, we suggest that training medical anthropologists for health education duties, should be included in graduate training. A structural integration of "teaching as a career" that illustrates different streams of how and where a (medical) anthropologist can work outside academia, would make it easier to finance further training, give more students the chance to participate, have more time and resources available for field visits, internships, and guest speakers. We continue to lobby for this within the HPE-SMA group and outside with health professionals who are responsible for education.

We conclude that any training needs a sound base of a mix of awareness creation, including unconsciousness bias, knowledge, and skills, as Dogra, Reitmanova, and Carter-Pokras (2009) recommend. Furthermore, it is crucial to establish any training to respond to local and regional health systems and beliefs, language and cultural diversity, and different determinants of health. We are looking forward to seeing our trainees teaching in the region.

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[1] ECTS = European Credit Transfer and Accumulation System, explanation to be found here: https://education.ec.europa.eu/education-levels/higher-education/inclusive-and-connected-higher-education/european-credit-transfer-and-accumulation-system [21.06.2024]

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