Health education for urban refugees in Cairo

A pilot project with young men from Sierra Leone and Liberia

Reproductive Health for Urban Refugees Initiative
Forced Migration and Refugees Study (FMRS) Program
The American University in Cairo

Authors: Elizabeth Coker, Alison Bichard, Andrea Nannipieri and James Wani

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And from one of the participants:

> *'I want to thanks you all the organizers and the people who have offered their time and knowledge to us, I called it a golden chance for us. I would like to appeal to you the organizers and FMRS to work hard to provide another course like this …I am proud I have learned useful things that would help my community and me. And lastly since you the organizers do have the chance of meeting important personalities who are concern with refugees…please tell them all our problems that we face in this land so that they will know and come to our aid.'*

Summary

This pilot project, conducted under the auspices of the Forced Migration and Refugees Studies Program (FMRS) at the American University in Cairo, arose as part of a continued commitment to outreach projects of direct benefit to the refugee community. Maintaining healthy behaviors and accessing adequate health care are particular challenges for refugees living in large urban areas such as Cairo. Young refugees are at risk for unplanned pregnancy, sexually transmitted diseases, and other health-related problems such as nutritional deficits and stress-related disorders. Education in their country of origin may have been disrupted, and in Cairo they may be separated from their families and have little or no access to formal schooling. At the same time, we know little about the health behaviors of refugees living in Cairo and there is limited research and documentation of their particular health needs.

The participants in this pilot project were refugees from Sierra Leone and Liberia, who were young healthy men who had not experienced serious health problems in the past. A needs assessment at the outset showed that their health concerns included: an increased incidence of colds and flu (often attributed to the weather), general physical 'weakness', lack of exercise, sleep problems, frustrated sexual desire, general body aches and pains (headaches, stomachaches, etc.), poor nutrition and eating habits, and feelings of frustration, hopelessness and general stress.

The program was in the form of an action research project designed to provide participants with information relevant to the specific health issues they may face as urban refugees, and to facilitate health problem-solving strategies through the use of focused discussion groups. The health education program consisted of a 10-week lecture series to address the concerns voiced by the refugees during the first session. The first half of the program focused on issues of reproductive health, including relationships, sexual practices, reproductive anatomy and physiology, fertility and family planning, female genital mutilation, and sexually transmitted diseases, especially HIV/AIDs. The second half of the program widened the health topics to cover nutrition, stress and coping mechanisms, and access to health services in Cairo.

Interviews with participants after the program showed that some of the most important benefits of the program as a whole were that it gave them a place to gather, a forum for discussion, and intellectual stimulation. These particular refugees do not work or go to college nor do they have any real social support. They are inhibited from gathering in large numbers and therefore spend their days bored, frustrated and lonely. For this reason, programs such as this are highly valued in the community.

Based upon the outcome of this pilot project, we recommend that the following steps be taken to continue the health education project for refugees in Cairo:

1. Develop flexible 'content modules' for different health education topics that can be easily accessed as needed.
2. Train refugees from each community to administer the health education programs.
3. Maintain ties with the health care community in Egypt.
4. Create ongoing programs for groups who demonstrate a need.
5. Find ongoing funding for the above-mentioned projects.

Introduction and Objectives

Urban refugees in Cairo

Recent figures indicate that the number of refugees moving to urban areas is on the increase. While the reasons for such movement vary, protection standards in urban areas are not necessarily better than those in camps, rural areas or other urban centers (Obi and Crisp, 2002).

For most asylum seekers in Cairo their stay is marred by a series of obstacles. The Cairo office of the United Nations High Commissioner for Refugees (UNHCR) has taken over the responsibility for refugee status determination in Egypt and, owing to a large backlog of asylum seekers, the process can take up to 14 months. Recognized refugees and asylum seekers (those refugees not officially approved by the UNHCR) get little support from Egyptian authorities that are hard pressed by an ailing economy and complicated demographic situation (Sperl, 2000).

Most refugees in Cairo hope to be resettled in the West, but only a minority of them achieve this. Roughly a third are resettled. Local integration is the other option for those who cannot return home. Refugees locally integrated are not illegal (they are given residence permits) however they do not have the right to work.

Refugees from Sierra Leone and Liberia

Cairo accommodates one of the five biggest refugee populations residing in urban areas in the developing world. Refugees from more than 25 countries are known to currently reside in the city and its environs. While no one knows how many asylum seekers there are in Cairo, estimates range from tens of thousands to over one million. Records show that the majority are Sudanese and Somali (Sperl, 2000). As of October 31, 2002 the small number of recognized refugees from Sierra Leone and Liberia in Cairo stood at around 50 and 90 respectively:

Both Sierra Leone and Liberia have experienced prolonged periods of civil war. Fighting has lead to widespread human rights violations including the massacre, mutilation, torture and rape of civilians. Children in particular have been targets of the armed conflict as security forces and various factions recruited boys as young as eight or nine years to fight as child soldiers. This extreme violence and brutality has caused the displacement of millions of people. Most have become internally displaced while hundreds of thousands have fled as refugees, predominantly to neighboring countries such as Guinea, Ghana, Nigeria and Cote d'Ivoire. Remarkably, some of the displaced people found their way to Egypt via other countries and many were able to escape on student visas to study Arabic and Islamic studies (Human Rights Watch, 1998, 2002).

While political developments have made the West African region more secure, the situation remains highly volatile. Periodic eruptions of violence continue to threaten security and consequently many refugees are reluctant to return home. Some have no idea how many family members survive and have little or no knowledge of their whereabouts. A significant proportion of Sierra Leoneans and Liberians are former combatants (often as children) or, as young men returning from abroad after a long period, would be suspected of being combatants. Many of the Liberian refugees did not flee war/general violence but fled government persecution because of their race or imputed/actual political opinion.

The situation of Liberians and Sierra Leoneans in Cairo is markedly different from other asylum seekers. They do not have the back-up that comes from a long-standing large community of refugees (as do the Sudanese, for example) and they have limited access to family and other social support networks. They have an entirely different ethnic, linguistic and cultural background from the Arab world and generally feel alienated in Egypt. Since they are mainly young men (adolescents and young adults) they may have no parental or role models, and have missed vital years of education during the war and their current time as refugees. Moreover, they are easily identified and there have been allegations of harassment and discriminatory treatment while in Egypt (Sperl, 2000). This means that the long-term prospects of Liberians and Sierra Leoneans, their motivation to integrate and chances of securing an acceptable level of independence are considerably lower than those of other refugees.

Health education for urban refugees

Self-settled urban refugees in developing countries face challenges both in maintaining their traditional health practices and in accessing available health care. Studies have shown that refugees are particularly vulnerable to diverse health problems because of poor living conditions, lack of money for food and medicine, and lack of access to proper health care (Zotti, 1997). While UNHCR-recognized refugees have access to certain funds and clinics, refugees still 'in process' must rely on their own funds or on charity clinics, often run by religious organizations. Most health care for non-recognized refugees in Cairo is provided by several church/community-run health clinics that have referral agreements with area hospitals and clinics. These clinics are very overcrowded, and because of severe budget constraints, refugees are required to pay for some of their care or medications themselves. In addition, this treatment is only available as long as the individual is still "in process"; if he/she is denied refugee status, then this health care option will no longer be available. In sum, barriers to health maintenance for refugees in Cairo include:

- difficulties in maintaining a healthy diet,
- extreme stressors relating to the refugee situation for which coping mechanisms have not yet been developed,
- financial barriers,
- suspicion of host-country physicians,
- conflicts in health beliefs and practices between the host country physicians and the culture of origin, and
- lack of knowledge of refugee populations among health care workers (Frye, 1995).

These barriers are mediated by factors relating to the specific situation of the refugee population in question, including gender, age, religion, educational level, knowledge of the host-country language, the loss of important social supports and many more.

Refugee health education programs have been designed and implemented in different settings to address some of the unique health issues facing these populations, with varying degrees of success (Kamel, 1997; Morgan, 1994; Omidian and Lipson,

1996). For example, sexual and reproductive health is particularly important for young refugees such as those who participated in the present group. Many refugees have been forced into prostitution, and others find themselves unable to regulate their pregnancies due to the unfamiliarity or unavailability of effective birth control methods. Unplanned pregnancies, sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) and other reproductive health issues are increasingly important targets for refugee health education (Crane & Carswell, 1992; Nakyoni, 1993). In keeping with recent efforts to target reproductive health education efforts at males as well as females, the present program emphasized contraceptive use and family planning issues (Green, et. al., 1995; Helzner, 1996; PATH, 1997). In addition, it included a heavy emphasis on other health topics identified by the participants, including nutrition, stress and coping, and how to access health services.

The need for education for refugees is particularly salient in developing countries such as Egypt, where 'temporary' asylum can sometimes lapse into years, and educational opportunities in the host country may not be available due to lack of funds or limitations placed on the rights of refugees (Preston, 1991). However, as Preston points out, research on the provision of education (both conventional and non-conventional) in places of first asylum is not well-integrated, and consists mainly of a reiteration of the need and the various barriers (language and otherwise) to providing it. In addition, donor agencies may be oriented more towards providing emergency relief than sustainable programs, and refugees themselves may not be well-equipped to take on the challenge of developing educational programs. She argues that the study of education for refugees in settings such as Cairo should take careful consideration of the characteristics of the refugee populations, as well as the availability of current educational programs that could be utilized (Preston, 1991).

The present program was developed after taking all of these factors into consideration. This is the first project of its kind to be implemented for refugees in Cairo, and as such it served as a pilot project and as a source of information for any possible future health education projects. The Liberian and Sierra Leonean group was chosen because of their small numbers, their obviously-demonstrated need for educational stimulation, and their noted lack of social and family support compared to other, better established refugee groups such as the southern Sudanese. Little was known about the health needs of this particular group prior to the start of the study, and so the curriculum was developed based upon information gathered during the first session.

The literature has suggested that health care education programs for refugees must take into consideration the unique cognitive styles shaped by factors in the country of origin, such as literacy levels and social organization (Shadick, 1993). In a pluralistic model of health care education, the cultural and historical realities of the learners become a part of the learning process, as opposed to a model in which information is imparted purely on the basis of the instructor's understanding of the material. Using this style 'learners are thus able to locate themselves concretely in the world and see the connections between the educational setting and the lived day-to-day experience' (Shadick, 1993: 51). In the present project, the topics and the seminar contents were developed to reflect and address the lived needs of the refugees in this particular context. Organizers and presenters took care to contextualize health information so that it could more readily be translated to actual practice.

It must be noted that our Liberian and Sierra Leonean participants were all literate and highly motivated to gain education that would help them advance in the future. Like many, if not most refugees, they are deprived of educational experiences and eager for these in order to improve their social and economic status (Preston, 1991). They also were eager to improve their English, and so looked at this seminar as a way to do this as well as to learn about health and health care. Therefore, no attempt was made to 'simplify' learning materials, nor was oral presentation relied on exclusively as might be necessarily with other refugee populations with different backgrounds (Shadick, 1993). Printed materials were handed out at every session, and these were highly prized by the participants, who studied them carefully afterwards.

It has been effectively argued that quality health care education with refugee populations must incorporate health beliefs and practices from the culture of origin (Frye, 1995). Aspects of the culture of origin and the current refugee experience relevant to the topics discussed were integrated into the curriculum largely through the active learning style that was promoted throughout the sessions. Conflicts between the information presented and cultural/religious beliefs were actively discussed when they arose, and are presented in the discussion to follow. Participants played an active role in shaping the sessions as they brought up experiences, current and past, that related to the material provided. The dynamic nature of the interactions and the active way in which the participants engaged the subject matter provided as much of a learning experience for the organizers and the presenters as for the refugees themselves. The outcome of these discussions provides the basis for an analysis of the implications of providing health education for refugees in urban contexts, and highlights the importance of making participant characteristics and input a key factor in program development.

The health education program

Overview

This pilot project, conducted under the auspices of the Forced Migration and Refugees Studies (FMRS) Program at the American University in Cairo (AUC), arose as a continuation of the FMRS Program's commitment to outreach projects of direct benefit to the refugee community. Maintaining healthy behaviors and accessing adequate health care are particular challenges for refugees living in large urban areas such as Cairo. Young refugees are at risk for unplanned pregnancy, sexually transmitted diseases, and other health-related problems such as nutritional deficiencies and stress-related disorders. Education in their country of origin may have been disrupted, and in Cairo they may be separated from their families and have little or no access to formal schooling. At the same time, we know little about the health behaviors of refugees living in Cairo and there is limited research and documentation of their particular health needs.

Thus the overall goals of the program were:

- To provide information about reproductive and other health issues relevant to young male refugees.
- To provide a forum for refugees to discuss and share ideas and concerns about health topics.
- To initiate research into the knowledge, attitudes and practices towards reproductive and other health issues of young male refugees living in urban Cairo.

The program was in the form of an action research project designed to provide participants with information relevant to the specific health issues they may face as urban refugees, as well as facilitate health problem-solving strategies through the use of focused discussion groups. The discussions were carefully recorded with the permission of the participants for the purpose of obtaining information about existing health knowledge, attitudes and practices. In addition, exit interviews were conducted in order to obtain a measure of outcome and satisfaction with the program. One of the main goals of this pilot project was to remain responsive to the expressed needs of the participants, allowing the project enough flexibility to address important issues as they arose. Participants were strongly encouraged to advise on curriculum design and development and were active decision-makers throughout the program.

Participants

The participants in this pilot project were 41 refugees from Liberia and Sierra Leone. The majority of them were young men living alone (without their families), some of whom had been child soldiers who came to Cairo as unaccompanied minors. In addition to the young men, there were four young women who attended the sessions on an occasional basis. With no access to work or schooling, young urban refugees may feel bored and eager for educational opportunities, and therefore, initially interest in the program was very enthusiastic. Participants were provided with refreshments during each session and travel costs were reimbursed.

Attendance at the sessions averaged around 35 participants, as not everybody was able to come every week. Therefore, the following participant information is based

upon a sociodemographic questionnaire distributed at one of the earlier sessions. As Table 1 shows, the vast majority of the participants were young (under 25 years), male, single and unemployed. Sixty-eight percent were from Sierra Leone, while the rest were from Liberia. Most were Muslim (88%), and 46% had achieved some sort of formal refugee status through the UNHCR.

Table 1: Demographic distribution of participants (n=41; some non-responses)

	No.	*(%)*
Age (years)		
15-19	13	32
20-24	21	51
25-29	5	12
30+	2	5
Sex		
Male	37	90
Female	4	10
Country of origin		
Sierra Leone	28	68
Liberia	13	32
Religion		
Muslim	36	88
Christian	2	5
None	3	7
Marital status in Cairo		
Married	0	0
Living with partner	2	6
Single	32	91
Divorced	1	3
Refugee status		
Registered	2	5
Accepted	15	41
Pending result	13	35
Temporary protection	1	3
Rejected/File closed	6	16
Level of education		
Primary	16	39
Secondary	21	51
University/college	4	10
Employment in Cairo		
Yes	4	10
No	37	90

Seminar structure and time commitment

The participants attended a two-hour session once a week at a seminar room on the University campus. Volunteer guest speakers who had expertise in the subject area

(some with experience of working with refugees) were invited from various universities and non-governmental organizations (NGOs). Typically, the first half of the sessions was an introduction by the program coordinator followed by the guest speaker's presentation. The second half of the sessions consisted of questions and answers and small group discussions. Subsequent focus group discussions were usually held at the seminar sessions following the guest speaker's presentation. The size of the groups depended on attendance (no more than 8-10 people per group) and lasted for approximately one hour. Note-taking rather than tape-recording was used to record the sessions so that participants would feel less inhibited discussing sensitive issues. It was felt this would also minimize participants' worries about security and enhance their feelings of privacy and confidentiality.

Ethical issues and informed consent

Refugees in Cairo, particularly those who are as yet unrecognized by UNHCR, are an especially vulnerable group politically, socially and psychologically. For this reason, special care was taken to protect the privacy of the participants, especially given the very sensitive nature of some of the topics discussed. A verbal consent procedure was used before the needs assessment began. The purpose of the project was clearly stated along with the right to withdraw at any time. Participants were informed that they may be discussing subjects of a sensitive nature and were assured that the information they provided would be kept confidential. A list of guidelines was also given out which highlighted the need for respect and cooperation amongst all facilitators and participants.

At the beginning of the project and at intervals thereafter, consent was obtained from participants to use their (anonymous) statements for research purposes. Participants were frequently reminded that anything said in the context of a large or small group discussion was not to be discussed outside of the group (or at least not attributed to any particular individual), and they were assured that their participation was entirely voluntary and that they were under no obligation to provide information if they did not feel entirely comfortable doing so. They were, in addition, assured that their participation in this group would not affect their refugee status in any way, nor their access to health care or other programs at AUC or elsewhere.

Development of the health education curriculum

Small-group discussions were held during the first session to assess participants' views of their own health needs and their expectations for the seminar series. These discussions covered topics related to access to health services, types of health problems encountered in Cairo and health risks people take. The respondents reported multiple health concerns specific to living in Cairo (that is, health changes that they viewed as being related to the refugee situation). Common concerns included an increased incidence of colds and flu (often attributed to the weather), general physical 'weakness', lack of exercise, sleep problems, frustrated sexual desire, general body aches and pains (headaches, stomachaches, etc.), poor nutrition and eating habits, and feelings of frustration, hopelessness and general stress. The respondents often saw these issues as interconnected. For example, excessive worry can affect the health by making one lose weight, leading to an excess of colds and flu, etc.

The health education program consisted of an 11-week lecture series targeted to address the concerns voiced by the refugees during the first session (see Annex 1).

The first half of the program focused on issues of reproductive health, including relationships, sexual practices, reproductive anatomy and physiology, fertility and family planning, female genital mutilation, and sexually transmitted diseases, especially HIV/AIDs. The second half of the program widened the health topics to cover nutrition, stress and coping mechanisms, and access to health services in Cairo.

Individual exit interviews

Individual interviews using a semi-structured questionnaire were conducted after the program of lectures had finished. These were a means of analyzing participants' views of the program and to provide a rough indication of behavior and attitude changes. Twenty-seven participants completed exit interviews and were awarded informal 'Certificates of Participation' from AUC if they had attended three or more sessions. These were highly valued by the participants.

Themes and outcomes

With a couple of exceptions, each segment of the seminar series operated as a self-contained 'workshop' on the topic of interest. However, there were certain themes that cropped up again and again in the small and large group discussions that reflected major areas of concern for this particular group of individuals. The following sections will review some of the major themes covered by the guest lecturers, as well the main related discussion points and areas of concern that arose for the participants in the context of the subsequent small-group discussions and exit interviews. The participants were encouraged not only to comment on the issues raised in the lectures but to add additional points that they felt were relevant to their own situations as urban refugees. The juxtaposition of these viewpoints is crucial to understanding the ways in which similar health education programs could be better adapted to address the needs and concerns of particular groups of refugees, taking into consideration factors such as age, gender, religion, educational level and culture of origin.

Reproduction, sexual anatomy, fertility and contraception

Reproductive health issues

Small group discussions with the group focused on the sexual frustration experienced by the young male refugees and the different sexual mores in the refugees' home countries compared to Egypt. These were very important issues for this group, all of whom were single, unaccompanied by family members, and at the age at which marriage and family become important social priorities. The discussions revealed very clearly that the lack of appropriate potential marriage/sexual partners is a key psychosocial issue for refugees of this age group, and a major focus for their sense of loss. Comments centered on the dangers of prostitution and STDs stemming from maladaptive coping strategies, but also on the psychological effects of becoming essentially 'invisible' to the opposite sex in a society in which they, because of their marginal status, are not considered as appropriate marriage partners. The following are the main issues that stemmed from the discussion groups:

Relationships, love and sexual identity

Although the need to satisfy sexual frustration in any way was clearly an issue for these refugees, many of them said they were lonely and simply missed the 'companionship' aspect of a relationship. In the restrictions on contact between the sexes in Egypt, even friendships with girls are difficult and this was a source of sadness to the men. They spoke about how sexual relations and even just friendships between boys and girls were much freer in Sierra Leone/Liberia than in Egypt, even though almost 90% of the group are Muslims. There, a person can have more than one partner and fall in and out of love with many people. For many refugees, this added to their problems with adjusting to life in Cairo. In interviews, many of them spoke disparagingly about the 'Egyptian mentality' or the 'Arabic mentality' towards any contact between the sexes.

Most participants agreed that the following things were needed in order to get married: money (enough to support yourself and your family and to prepare for children); a house, job and stable income; and a sense of self-responsibility; and, for some, love (although the importance of love was a matter of some dispute). Acquiring the means by which to marry was viewed as an impossible task for refugees, and therefore most people did not have any hope of getting married in Cairo. Furthermore, marriage was out of the question for many of the respondents because they viewed their future as very uncertain, and did not want to commit themselves to a course of action such as marriage that might require them to stay in Cairo and lose the possibility of returning to their home country.

Because of the impossibility of establishing legitimate relationships, sexual frustration is a major problem in this group and there are few acceptable avenues of recourse to deal with this. The young men complained bitterly about lacking the 'control' (in the form of money, property, etc.) that would allow them to establish secure relationships. Relationships with local women were considered to be potentially very dangerous and difficult to negotiate, and rumors abounded about violent attacks on males who were seen in public with Egyptian women (or even with foreign women). For example, several of the refugees commented about an incident in

1996 when a refugee from West Africa was reputedly killed for having an Egyptian girlfriend.

As this suggests, the sexual frustration that these young men complain of is part of the social, economic, and psychological marginalization that goes with being a refugee in a specific context, and cannot be understood apart from the larger whole. In the discussions, their status as asylum seekers was an all-consuming worry to the group, and was seen as related to all types of health problems. This point was brought up even in connection with sexual matters, and some of the men thought that their problems were compounded by the UNHCR and the uncertainties that they faced in relation to determining their refugee status and whether they would be resettled.

Sexual frustration and coping strategies

In the focus group discussions to assess needs at the start, sexual frustration was clearly identified as a core issue for this group of mostly single young men. In response to a direct question about what proportion of the Liberian/Sierra Leone community are sexually active, the guesses ranged from 0 to 25%. Sexual frustration was described as a form of 'madness' that could really drive a man 'crazy' and lead to other health problems as well. Without regular sex one gets sick quickly and become tired and lethargic, loses one's appetite, eats all the time and sits at home 'like a woman'. These comments suggest that sexual activity and identity are crucial to the sense of one's self as a complete, functional man, and that without this outlet one becomes compromized on many levels. Men who had been married in their home country and had fled to Cairo without their wives were thought to suffer especially badly.

The men rarely discussed their personal experiences with regard to sexual activities but tended to speak about Sierra Leonean/Liberian refugees in general. The lack of available sexual partners means that many have simply given up on sexual activity whereas some of them resort to prostitution. Almost all of the men agreed that sex for refugee men in Cairo (when it exists at all) is a commercial activity. According to some, the financial barriers to accessing prostitutes are not too great, as sexual intercourse with a prostitute can cost as little as 10-12 Egyptian pounds (around 2-3 US dollars).

In sum, many men felt that they had celibacy forced upon them by the environment, and that this was affecting their health. Masturbation was not considered an acceptable solution for sexual frustration. They did not approve of masturbation because it was indulgent and against the Koran, lessened feeling in the penis so that sex would not be pleasurable, or was simply not something one should think about given the greater problems one faces [as a refugee]. However, the lecturer and facilitators received a barrage of questions about the medical status of masturbation; whether it was harmful or not.

Family planning

Only two or three of the men were in regular relationships that involved some kind of family planning decisions. In general, however, they knew that contraception was widely available from pharmacies and they had no qualms about obtaining it. In the interviews after the program, many respondents said they already knew about the condom as a method of contraception but often this was the only method they knew. Some had heard about the condom but did not know how to use it. Several also knew

about the Pill and one or two of the interviewees had learnt about other methods such as injectables and sterilization. Information on contraception had come mainly from school.

The main benefit of this part of the program seemed to have been to educate participants about the alternative methods available — one interviewee remarked on how he did not know how varied different types of contraception could be. Another person mentioned that before the program he did no know there was any family planning available in Cairo. A few men had never heard about condoms. Several of them said that information about the Pill was new to them and a number also mentioned Depo-Provera injections and the intrauterine device (IUD) were new to them. A few were surprised to hear about female condoms and spermicides. Withdrawal as a method of contraception was new to several. Said one man:

> *'I also learned how to used contraceptives to prevent pregnancy. Some of these I learned include; injectables and IUDs. I did not know them before that session. I only knew the condoms.'*

Sexually transmitted diseases, including HIV/AIDS

Changes in knowledge and attitudes about HIV/AIDS

The needs assessment conducted at the outset of the project revealed that many participants' knowledge of STDs including HIV/AIDS was inaccurate and incomplete. A whole range of misconceptions concerning the origin of HIV surfaced during preliminary discussions. Some participants thought HIV was the product of humans cross breeding with monkeys while others believed in conspiracy theories relating to chemical warfare and 'America's Intention to Destroy Sex'. Many participants believed that transmission was also possible through kissing, mosquito bites, toilet seats and sharing drinking cups with someone who is infected.

> *'I heard about HIV/AIDS before – in Sierra Leone, in Liberia, in Egypt – but I didn't believe. But through the classes, talking together, I realized it was true. (why?) Because the doctor explained it better. I was convinced totally.'*

Some participants were unaware that condoms could be used as a form of protection. It was also thought that condoms were a hindrance and interfered with sexual pleasure. In one discussion there were hints that one or more of the male refugees might be earning money through prostitution and feel they have no control over whether the 'customer' wishes to wear a condom or not. In other instances it was reported that refugees who engage the services of prostitutes are strongly discouraged from using condoms because it implies the prostitutes are dirty. This 'lack of control over sexual practices' was a recurring theme among group discussions.

Post-seminar exit interviews indicated that all participants became aware of HIV and recognized the potentially lethal consequences of sexual activity. An understanding of protective measures seems widespread, with many advocating the use of condoms and monogamous relationships. The risks associated with infected blood also seemed to be well understood at the conclusion of the seminar. In relation to HIV transmission there were a few who still subscribed to the old myths of cup sharing and toilet seats. In general, however, participants seemed better equipped to assess the risks of their behavior and claimed that they would approach future sexual encounters with care. The enthusiasm for peer education activities is encouraging and worthy of continued support. It is worth noting that hardly any mention was made of mother-to-infant transmission during the seminar series. Given that this is a significant cause of infection it may warrant further exploration in the future.

> *'..I previously didn't believe in the existence of HIV/AIDS, I got convinced somehow. It had been stressed again and again that the disease has no cure and now I have to avoid sexual intercourse without wearing a condom..'*

HIV prevention strategies

In the individual exit interviews, almost all the participants were able to identify the condom as the best form of protection from HIV. Monogamous relationships and being with someone you 'trust' were also considered effective preventative measures by a majority of the group. Only a very small proportion of the group considered abstinence an option.

'I learnt about protecting yourself from AIDS with condom and sticking to one partner. Even sex just one time can give you AIDS'

'Be honest with your friends. Don't go from woman to woman. Be straight with your partner…Use a condom for protection – a strong one with no holes'

For many participants the transmission of HIV through contact with infected blood (shared or reused syringes, shared razors) was new information. Several participants however, were acutely aware of the dangers of shared razor blades and syringes and offered ideas on how to reduce this risk.

'..when you go to barber take your own razor. Bring your own syringe when going to the Doctor'

Having a partner's blood tested before engaging in sexual relations was generally thought to be a reliable means of protection. Participants learned about other points of contact or situations that can lead to infection including female genital mutilation, direct contact with exposed wounds and blood transfusions. Participants also learned that the risk of catching HIV through oral sex was low compared to other forms of sexual contact.

Negotiation and communication skills

Participants were asked how they would react to a partner who wanted to have sexual intercourse without the use of a condom. Most agreed that they would try to educate their partner and inform him or her of the risks involved. Some were concerned about becoming infected; others were worried about passing on the infection. Almost all participants were unanimous in their decision to not have sexual intercourse with anyone who refused to practice safe sex.

'I would try to convince her. If unsuccessful I wouldn't have sex. Why should 20 –30 minutes affect the rest of your life?'

'I would tell her you don't know if I have it. And if not, I find another woman'

'I would explain the importance of family planning – how we don't need another child. Being rich [being healthy] is good compared to someone who is sick'

As a further measure of ensuring that participants had processed seminar material, they were asked if they had a message about STD's and HIV/AIDS for their community and if so to tell us their message. Most messages centered on what one could do to reduce the risk of contracting the HIV virus, such as wearing a condom and being faithful to one partner:

'Be very careful with sex. Put it more in the open – the risks and consequences of having sex with someone who has AIDS..'

'Keep to one partner whether married or not. Be fair with each other. Protect yourself from HIV/AIDS – use a condom.'

As with the protective measures mentioned earlier, the need for physicians and barbers to use sterilized equipment was also emphasized by the respondents. Messages frequently included some kind of general warning or caution to 'be careful' and to 'take care' when engaging in any kind of sexual activity. Several references were also made to the 'consequences' of risk taking, and the fact that there is no cure for the virus.

> *'AIDS is a sickness that has no cure – you can only treat it not cure it. The only way to prevent it is to keep from having sex with someone you don't know. If not, use a condom.'*

Interestingly, some participants commented on the need to educate others about HIV and expressed their desire to take part in awareness raising programs. There were several requests for educational materials including manuals and audio/visual resources to assist them with this knowledge sharing exercise.

Female genital mutilation

Religious and cultural perspectives

FGM did not surface as an issue during the needs assessment session at the start of the project. However it came out as an issue during the lecturer's presentation about HIV/AIDS when it was mentioned as a possible mode of transmission of the virus. The lecturer's condemnation of the way it was performed and his declaring it an un-Islamic practice spurred a heated argument among participants, some of whom supported the practice and some of whom did not. As a result, considerable time was devoted to this issue to address the uncertainty and controversy over FGM among the participants.

Most Muslim participants believed that FGM is an Islamic practice that should be upheld if the practice can be carried out under medical supervision. Although the lecturer directly contradicted this, some continued in the exit interviews to argue for the religious importance of FGM. Other participants remained unsure about FGM and its religious significance. Thus the religion and Islamic/sexual health nexus may warrant further investigation.

Others (notably Christians) in the group believed that FGM is a cultural practice in their society and they were not comfortable with the religious focus of the discussions. For example, one participant stated that in some tribal societies a woman who is not circumcized is seen as 'incomplete' and would face harassment. In such a society it could be likely that an attempt to impose abolition of FGM or its condemnation would have little effect. However, educating the communities by showing videos or slides and films was viewed by most as the best method to change people's attitudes towards FGM.

Changes in attitudes towards FGM

All the participants claimed to have gained some knowledge about FGM. In the exit interviews, they appeared to understand how harmful it is to women, especially during childbirth, that it could increase HIV/AIDS transmission among females and that it is not a means of controlling female sexual desire. Many participants wished to deliver a message to their communities about FGM: that it is in fact un-Islamic and carries considerable risks to women. However, it is worth noting that FGM still remained a controversial issue among the participants even after the seminars and the group discussion. Some participants were convinced that FGM is not a religiously (Islamic) sanctioned practice as they had thought it to be because they heard an Islamic scholar speaking against it. Most indicated their unwillingness to circumcize their daughters; however a few would still consider circumcizing their daughters because of the cultural and religious values attached to it, but only in proper medical facilities.

> *'FGM is a respected practice back home. If women in a certain ethnic group aren't circumcized then they are not considered a complete woman. A vast majority are circumcized. Those who choose not to are isolated and not considered full women. It is believe that women who are not circumcized are anxious for sex. Men are afraid of these women. FGM is thought to be a way of preventing adultery or controlling women. In Liberia no one publicly condemns FGM. I had heard something about it on the BBC, but this was*

about people in Ghana. The lecture was the first time someone really condemned FGM. The film was touching. I wouldn't allow it to happen to my daughter. I'm totally against it. '

'We thought it was part of religion. Now we know it is not.'

'I would never consider circumcizing my daughter now. I can be a preacher against it now. I don't like it. It is too dangerous.'

'I already knew about it – it's our tradition. But I saw the film and was very shocked about how dangerous it was.'

'I'm against abolishing it by force – when I was at home the government tried to say no to FGM. If she wants, I can now look at the safest way of doing it. If she doesn't want–I'm obliged to stop it.'

In sum, before hearing the lecture and viewing the films and slides about FGM, almost all the participants had positive attitudes towards FGM because it was thought to control women's sexual desire, and because of the religious beliefs and the cultural values attached to it. However, the films and slides about FGM had a great impact on the attitude of the participants towards it. The majority now have a negative attitude towards FGM and have stated their willingness not to circumcize their daughters. Most of them had no idea exactly how FGM is performed as it is generally done in the company of women alone. They had never seen how girls grappled with severe pain and bleeding during and after circumcision, and now almost all the participants had changed their views of FGM, at least as it is traditionally performed:

' I learnt about many things that I never knew before. For example in the FGM video, I saw things that are usually hidden. Its side effects can be very bad – it reduces sexual pleasure.'

'I know now about the risks. Now I know how to make it safer, more medical, so it is done in a more healthy way.'

'I can't force her to do it or not do it. It's a cultural thing. It's up to her. I would discuss it with my wife'.

Nutrition

Food security

Consumption patterns and food procurement have significantly changed with relocation to Cairo and are difficult problems to deal with. The needs assessment revealed that a lack of 'food security' or not having adequate access to quality foods to satisfy dietary needs was a health problem for the refugees. The principle causal factor is financial, having little or no income to purchase basic ingredients. Financial barriers were seen as the major obstacle to accessing quality products and meeting dietary needs, while limited knowledge of local ingredients, cooking methods and markets (including location, bargaining practices etc) were other factors inhibiting a balanced diet.

> *'..for me not all Egyptian foods are bad. Our problem here is money if one has the money, he can eat the best food. Because we have no money we are forced sometimes to eat tamaya and fuul every day.'*

> *'I find it difficult to eat what I need. Chicken eggs, potatoes, peppers are cheap, but fish, liver, oranges are very expensive'*

Individual interviews after the program indicated that most participants now have a greater awareness of basic food preparation and nutritional value. Many now realize for instance that meals that are overcooked and continuously reheated will result in nutrient wastage. Similarly, many participants learned about the importance of food storage and hygiene. The need to wash their hands and take extra care with meat and other perishable foods was frequently mentioned as 'new' and 'useful' information.

Attitudes towards Egyptian food

It was discovered during the needs assessment that there is a general fear and mistrust of foods here in Cairo. Many believe they are compromising their health by eating unfamiliar and 'spoiled' foods. A common complaint was the lack of cleanliness observed among vendors who prepare and sell food on the street. The use of pesticides and herbicides is also a major concern and are blamed for the 'strange' taste of foods in Cairo.

Participants seemed surprised at the taste and quality of the food prepared during the first seminar session. There was some debate over whether the food was in fact Egyptian with one participant commenting: 'It is Egyptian food, but not Egyptian food'. This kind of response highlights the prejudice that many hold towards Egyptian food and is further demonstrated by the perception that local foods such as *fuul* and *tamaya* are thought to induce laziness and be unhealthy. The refusal to believe that local food can be good also suggests that the refugees are unwilling to find replacement foods and adapt to a new food culture. However, there were some participants who admitted that adapting to change takes time:

> *'The longer one stays in a particular place the sweeter the fruit becomes.'*

Interviews after the program revealed that attitudes towards Egyptian food had not really changed. While some participants acknowledged that it is possible to eat well in Egypt, the general consensus was that the food in Cairo is inferior in taste and

quality. The unavailability of West African staples such as 'red palm oil' and 'cassava' have left gaps in individual diets that have not been filled.

To make their diets more healthy, many participants commented on the need for a varied diet including more meat, dairy, fruit and vegetable products. Cutting down on foods that are heavy in fats and oils was also deemed necessary and for some this was only thought possible by avoiding locally prepared food. For a few participants, only food that was bought, prepared and cooked by the individual was considered healthy. Participants still retain some skepticism towards Egyptian food, which is thought to be 'unnatural' and polluted with chemicals:

> *'.. I don't buy readily cooked food by the Egyptian, however I do buy fuul beans, but I have to fry them again and add eggs and Maggi into it before I eat them.'*

> *'I go to the food market and buy food items and I will prepare for myself to make it more appealing to my taste.'*

> *'I always think that food cooked by Egyptians do not make a good diet and so I prepare my own food..'*

On the other hand, for some participants the seminar sessions did bring about minor revelations concerning the quality and appeal of Egyptian food. One participant commented:

> *' I didn't buy even eggs before because I thought they were not natural – they force the fowl to produce them – now I know they are natural from chickens. Now I don't fear that. I can buy eggs and fry them. I didn't drink milk since I came to Egypt – I can drink milk now'*

Overall it seems that participants' knowledge of food and nutrition did improve as a result of the seminar. The seminar sessions helped to clear up some of the myths and stories that surround local foods. However, there are many who still remain skeptical and continue to resist the local food culture. Financial barriers are still perceived by many to be a major obstacle to eating well. In relation to food management, participants seem better equipped to maximize their nutrient intake and maintain hygienic and sanitary food preparation practices.

Primary changes to refugee diets in Cairo

The needs assessment revealed that most participants come from families where the responsibility of food preparation lies with the mother. Here in Cairo, the absence of family support networks has meant that participants have had to learn how to cook for themselves and for each other. Group discussions revealed that meat, fish, fruit and dairy products are thought to be far too expensive to consume regularly or as often as one would like. The reduced consumption of meat in particular is a major change in dietary intake.

Another important change relates to the availability of food. Foods that were readily available and eaten freely back home are not only expensive, but also difficult to find in Cairo. Popular West African cooking ingredients such as red palm oil, cassava, plantains and kola nuts are greatly missed.

For participants who came from rural areas, there are significant changes relating to the procurement of food. Food producers are now mostly consumers. Fruits such as mangoes, papaw, guava, bananas and cucumber, which were grown in many backyards, are now only available in grocery stores and markets and are simply unaffordable.

Dietary-related illness in Cairo

One participant stated that he vomits when he eats Egyptian food and he attributes this to the food's high fat content. Some mentioned stories of weight loss, uncontrollable appetites and meals being substituted by water. Diets in Cairo may be rich enough in calories, but there is a real possibility that they do not contain adequate quantities of other essential nutrients such as proteins, essential fatty acids and vitamins (Pinot, 2000). There is evidence to suggest that some individuals have nutrient-deficient diets and may need medical attention. For example, it is likely that deficiencies in vitamin A, iron and iodine are prevalent throughout the group and that some suffer from anemia.

The psychosocial significance of food

For most participants, the psychological satisfaction or feeling of security and well being that is usually experienced when eating traditional or familiar food is lacking in their new environment. This illustrates the fact that food often carries cultural and symbolic weight that goes beyond any biological value corresponding to physiological needs (Pinot, 2002). For example, discussions revealed the belief that food has the power to influence the body and act as an aphrodisiac. Some foods were purported to make men sexually active and strong. Examples frequently mentioned were *cassava, shabani* (a kind of leaf) and *gargir* mixed with salad. For some discussion group members a lack of sexual activity was also thought reduce appetite while for others it makes one want to eat all the time.

Stress and coping

Experiences of and attitudes to stress

In the focus groups to assess needs at the start of the project many of the participants were concerned with problems such as 'weakness', not sleeping or sleeping too much, 'thinking too much' and feelings of hopelessness [about their situation]. This was interpreted as a need for help to deal with psychological problems such as depression and stress.

During the small group discussions in the program, the way participants explained stress and the meanings they assigned to stressful events seemed to have great influence on their processes of coping and responses. They often tried to give interpretations to the events that help them organize their experiences and apply them appropriately when needed. This is necessary as an important self-protective act at a given time of the stress.

The physical aspects of stress were highlighted by sleep problems, the possibility of confrontation with Egyptians and 'thinking too much' about deprivation from those things that they need for better living. The combination of these often results in sleep problems and bodily exhaustion.

The emotional aspects of stress seemed to be the most common among the participants. They seemed to be overwhelmed by feelings of loneliness, hopelessness, and the perceived threat of discriminatory treatment from the host community. Other common stressors included: religious discrimination by some Egyptian employers who reportedly prefer to employ Christians only, being sent away from a mosque for being a 'black man', and lack of appropriate sexual outlets.

It is interesting to note that most participants directly or indirectly linked some of the stresses, such as sleep problems, 'thinking to much' or worry, and confrontations with Egyptians (resulting in injuries), to physical and psychological health risks. Many argued that 'thinking too much' affects their health directly by causing them to lose appetite for food, which in turn lead weight loss and illness. 'Thinking too much' is also blamed for loss of self-control, loss of energy, and headache.

Lack of available sexual partners and /or changes in sexual practices due to different mores in Egypt compared with Liberia and Sierra Leone was said to be a source of stress that could lead to negative health effects. This brought up many related issues, some of which have been discussed in earlier sections. For example, the lack of available sexual partners may lead one to seek and or resort to prostitutes, which incurs risk of STDs including HIV/AIDS.

In sum, it was clear that participants vary greatly in their overall vulnerability to stresses and ways they deal and cope with stresses. It was obvious that failure to meet the requirements of the day and of future life is stressful. Some of the physical, emotional and social conditions that directly or indirectly promote stressful situations daily include: chronic lack of money; unemployment; disconnection from family and other kin; the perceived hopelessness; sleep problem and 'thinking too much'; the desire to be resettled to the West; attached self-worth seen as no longer attainable; problems of uncertainties surrounding them; confrontation with the locals; and annoying events in their everyday life

Coping strategies

The exit interviews with individual participants revealed that the refugees were employing the knowledge they had gained about stress. Ignoring or avoiding stressors, laughing at those who ask them odd questions, doing things to make others look stupid, pretending not to know the Arabic language, or keeping silent were some of the strategies participants have used with positive results.

Responses indicated that participants have improved their ability to cope with stress when overwhelmed with problems. Each would try to solve the stress in a positive way. One participant illustrated this vividly:

> *'This morning when I was in a bus on my way here, five Egyptian boys came to me shouting, clapping their hands and calling me 'ya samara, ya bungga-bungga' and others started pushing me. I became furious and I could feel the anger within me and the tendency to respond violently. The Egyptians in the bus just sat watching as if it was a drama. I wanted to fight but I recalled what I learned from the class about stress that one of the coping strategies was to keep cool and be able to predict the consequence of the response. So I just sat there without responding. After sometime, they kept silent. I was able to predict that in a bus moving on, if I reacted violently the Egyptians may beat and throw me out of the bus and that saved me from many unforeseen things.'*

Participants used different coping strategies to overcome stress resulting from thinking about family members. These include: mimicking the voices and the particular words used by mothers and other kin when they were at home; listening to the voices of my family members recorded in tapes; and looking at photographs (albums) of family members sent from home.

Generally, almost all the participants agreed that talking to close friends about ones problems and engaging in sport such as football could relieve them from stresses. Seeking spiritual counseling and reading the Bible or the Koran were said to relieve stress too. Other strategies were reading pamphlets, magazines, listening to or playing music and watching TV programs and movies. Some mentioned that the health education seminars helped them reduce or eliminate some of their stress:

> *'I don't know what we can do when this seminar ends, surely our stress would increase. When we come here, we express the problems we face here in Cairo and we feel that we have people who are ready to listen and who do mind about our problems. We are better here because we have come together as one people from the West African region, we meet those brothers whom otherwise we couldn't meet them regularly as we do now.'*

All the participants stated that the class about stress helped them to recognize stressful situations, which in turn enabled them to cope with stress better than before the class. They had gained some knowledge from the presentation and from their own colleagues when they heard them speak out about their problems and the things they do to overcome them.

Desire for more information

All the participants stated that they found the class about stress easy to understand, interesting, useful and had gained better knowledge of how to manage stress.

However they expressed an interest in learning more about stress and depression and better coping strategies. Participants said that they lack knowledge about sporting activities (like football) and body fitness. They wanted to learn more about them because they believe that these are resources to use when overwhelmed with problems or stresses. Some of the participants wanted to learn about 'First Aid', which they need for emergency situations in their life as refugees in Cairo.

Access to health services

Mistrust of doctors

In the needs assessment at the start of the program, discussions about use of health services showed that most of the refugees were very reluctant to use Egyptian health care facilities. This stemmed from their experiences of Egyptian doctors and pharmacists as uncaring and unsympathetic. They also perceived them as 'money hungry' and 'incompetent'. Accounts of maltreatment and misdiagnosis are common among refugees and many believed that the medical establishment in Egypt is involved in 'organ stealing'. Overall, their discussions conveyed a deep-seated fear and cynicism of the current health system.

An objective of this program was to allow the refugees to feel more comfortable about seeking health care when it was needed. The group was informed about the positive links that had been built between refugee clinics and number of Cairo hospitals who welcomed refugees and were gaining more experience of their problems. The group discussed the possibility of creating a special relationship with a clinic for the Sierra Leone/Liberian community. The lecturer talked about how some members of the medical establishment are nervous about treating refugees and are unfamiliar with their special problems. The lecturer also mentioned that medical corruption and incompetence can happen anywhere in the world. However, the case studies that the group discussed in the program may in fact have reinforced refugees' negative views. One of these, based on a real case, focused on an Egyptian doctor accepting a bribe to record a false-negative HIV result for a refugee.

In interviews after the end of the program participants were asked whether they had changed their attitudes towards the health care system in Egypt. Disappointingly, few of interviewees said they had gained more confidence in doctors after the program:

> *'Before I didn't believe and didn't trust them. Now I know you must trust [doctors] otherwise the problem comes again.'*

At the completion of the program many participants had a less favorable view of the system, specifically mentioning that they had lost trust or confidence in doctors or hospital care in Egypt or had begun to realize how incompetent doctors could be. Half of the group said they had not changed their views of the system, mostly because they already had no confidence in the Egyptian doctors and thought they were dishonest:

> *'I hardly go to Egyptian hospitals and what the doctor said did not change my attitude that Egyptian doctors are very malicious and very dishonest towards black Africans in this country.'*

> *'My attitude towards the Egyptian health system have not changed after the presentation, instead it did reinforce my attitude towards the Egyptian doctors. But now I understand why they are like that.'*

Financial barriers

The other key barrier to using health services is financial. In the needs assessment, refugees talked about how they knew of medical practitioners who they can trust but

who they cannot afford in the Egyptian private care system. Thus minor ailments such as influenza and toothache are left untreated. Participants mentioned that they sometimes get advice about medical problems from their friends. Participants sought financial support from family, friends or the community for the treatment of major illnesses.

Unique problems of refugees

While many of the group agreed in interviews after the program that poor Egyptians were also disadvantaged, they felt that they, as refugees, faced unique problems:

> '*Our health problems as refugees include lack of money to pay for the medication, discrimination, language and information about who are the best doctors and the best hospitals and how to access them is lacking to many refugees.*'

Refugees felt that racial discrimination against them in hospitals and clinics was one of the biggest problems they faced. Almost all of the participants talked about how refugees suffer racism and discrimination and that Egyptians get preferential treatment. While the participants did not necessarily feel more positive about the Egyptian health care system at the completion of the program, the lecture encouraged refugees to empower themselves by finding a trusted advocate who can fight for them.

Many refugees talked about language and communication problems associated with accessing health care and getting appropriate treatment. Few of the group speak Arabic well, except for those who have been in Egypt a long time. Again, the lecture encouraged them to feel more positive; all refugees from Sierra Leone and Liberia speak English, albeit with a strong dialect, and all doctors in Egypt speak good English because this is the language of medical training. It was also suggested that refugees could do more to help themselves by taking someone to translate for them.

In the lecture, the 'locked gate' syndrome was discussed, with the difficulty that refugees can have even getting past doormen in hospitals without ID papers or passports. The lecturer reported that the UNHCR in Cairo was planning to give ID papers to all refugees applying for recognition and that this would help access problems to health care. Certainly in the needs assessment and in informal discussions with refugees, the biggest concern for all participants is the need to be recognized as refugees by the UNHCR and resettled.

This small group of Sierra Leonean and Liberian refugee groups in Cairo felt they suffered from a lack of social support networks and were disadvantaged compared with other refugee groups. For example, refugees from Sudan and Somalia were thought to be treated more favorably by the authorities and many participants feel resentful and jealous of their counterparts. In the interviews after the program, some refugees talked about the need for good 'local' information about the good doctors and clinics to visit and the lack of this was a particular problem for refugees.

Empathy with the local population

As a corollary to their experiences of racial discrimination, the initial focus group discussions and many informal discussions showed a strong lack of trust and poor relations between the refugees and local people and a belief that Egyptians receive better treatment. Thus, another aim of the program was to reduce the suspicion and

mistrust that exists between refugees in Cairo and local residents. The lecture had emphasized that many Egyptians were also poor and had problems finding affordable health care. The refugees were certainly sympathetic to this view. In interviews, more than two-thirds of them agreed that the local population were also disadvantaged, because they were poor and had access problems, and also suffered at the hands of incompetent doctors:

> *'They treat their own people badly as well as us.'*

> *'Poor people have problems accessing health. I know some Egyptians are very poor, struggling, some refugees are better off.'*

The session looked at solutions to providing health care for refugees: ideally there should be more health professionals working in clinics geared solely towards refugee's medical needs and problems, including the training of hospital staff in refugee situations. Yet the lecture also highlighted the difficulties of providing dedicated services in an underdeveloped country such as Egypt. This message clearly made sense to the refugees as a number of them spoke about how they would like to see special clinics set up for refugees in Cairo but recognized that this would create resentment from the local communities who would feel that refugees were receiving special treatment.

Unfortunately, about a third of refugees were still unconvinced that Egyptians ever had problems with health care. They believe that local people are always treated better than refugees and never suffer discrimination.

Anecdotes about access

One of the facilitators wrote about discussions he had had on access and attitudes to doctors in Cairo:

> *'A conversation about illness and medicine was preceded by the story of Aschule, a Sierra Leonean goalkeeper who played for a Cairo football team. He was a very good goalie. Voted the best goalie in West Africa twice. The goalie that was there before him saw Aschule was a good goalie and was worried, and put something in his food to make him sick. He went to the doctor, who gave me an injection, and two days later, he died. Then the Egyptian doctors remove his heart and his lungs and all his organs. The Egyptian government did not want to send the body back to Sierra Leone, but they had to in the end. First, they spread rumours that he had died from taking drugs and that he was a drug dealer. That was what we heard on the camp in Guinea. When they sent the body back, the Sierra Leonean doctors found there were no organs, and the Egyptians said it was from drugs[1]. He was a good goalie, he did not take drugs. When I asked what they did with the organs – they said the had been taken so no one would know he had been poisoned – Issa said he had heard that in a hospital somewhere in Cairo they kept huge high bottles full of taken organs.'*

> *'This was followed by a conversation about health problems and doctors. Issa suffered from non-specific pain all over his body, he said he has*

[1] See Barbara Harrell-Bonds article on poisoning as boundary marking in SL, and Ferme's book on Mende culture in SL for some enlightenment on the political economy of who eats with whom.

no idea where it comes from. He also sometimes suffers from a thick yellow discharge when he pisses; but he has no money to see a doctor, UNHCR[2] said he must pay 70% of all medical costs, and he does not trust Egyptian doctors anyway. He was forced to pay everything for his dental problems. He sleeps only 1-2 hours a night because he spends all the rest of the time thinking about his future.'

'Saeed suffers from intense pain in his elbow and stomach, he said he suffered from it in the bush[3], that it had gone away in Guinea, where he had been on a camp, and had re-occurred when he came to Cairo. Once he spent all night coughing violently, and had to go the hospital, where they only gave him ibuprofen for the pain. He complained and said this will not solve the problem, but the doctor insisted that is what he took, and he had to pay 3EP for it. It had no effect, and the coughing remerges sometimes.'

'Saeed also told me a story of a man with diabetes that they removed a pint of blood from at an Egyptian hospital who died the next day; 'The doctors, they just want to do harm to us.' Saeed equally never slept, his nickname is 'thinkin' for all he ever does is think; about his future, about the fact Cairo slowly destroys your life, that you have no future here, that he must start a new life, and plan how to do it. They each take it in turns to cook, but 'thinkin' will put on some stew or some soup, and be thinkin, the soup will boil over the top of the pan.'

'Abudu slept all day, he said; for sleep is easy and makes you forget. He suffered from crying from the dust and pollution in Cairo, the water equally upset his stomach and he still has problems drinking it a year into living in Cairo.'

(End of Excerpt)

I heard hundreds of variety of this story, and stories like it. Last night in the group, I heard Aschule had died from the food not an injection, but the rest of the story was the same. The main problem with hospital access was money, and people did not know of any of the free clinics around Cairo. They claimed CARITAS used to provide some of the money for them and now it provides nothing at all. There are some Egyptian doctors who are good, but most lie to you and want to do you harm because they are no good; some practice without licenses, a man told me. In '96, they did not give the man who was dying medicine, and pretended everything was ok when it was not. They leave things in people's stomachs and make them have expensive X rays and blood tests for no reason. The one good Doctor mentioned was the only one who spoke English, the rest never tell you anything. So even with money, people are reluctant to go to Egyptian Doctors because of trust issues.'

[2] When Issa phones the UNHCR, they immediately put the phone down if he is not a recognized refugee. They know nothing there about refugees of Africa, they are bored, all Issa can think is that they intentionally want to damage us, the criminals of the world. All the world's greatest terrorists and criminals are Arab he said, in a strange twist on Bush's pronouncements.

[3] Where he lived for three months after his parents were killed in front of him.

Participants' views about the program

One of the goals of the present pilot project was to obtain an accurate assessment of the overall success of the health education project in terms of changed knowledge, attitudes, and practices regarding health issues. While it is acknowledged that verbal accounts are not always adequate indices of actual practice, exit interviews were able to provide a rough assessment of the overall impact of the program (both anticipated and unanticipated), as well as identify areas in which such a program might be improved. In general, the exit interviews, which were semi-structured and open-ended, had the following aims:

- To assess the success of the program in terms of participants' views of the benefits;
- To assess the success of the program in terms of participants' knowledge of the issues that had been covered.
- To give them an opportunity to ask questions and suggest improvements to this and future programs.

Educational and psychosocial benefits of the program

The refugees interviewed were asked whether they thought that the presentations and discussions about health had been of benefit to them and also in what way. All of them said that the program had been beneficial and some expressed this quite strongly, saying how disappointed they were that the program was finishing and hoping that we could continue with it:

> *'It benefited me a lot. I liked it too much. It would be very important if it could be continued. It was very interesting ... I'm very sorry it is finishing.'*
>
> *'The program was very nice. I appreciate it very much. It really benefits us.'*
>
> *'The small time you spend with us we learnt a lot. It was very important.'*
>
> *'I would like to appreciate your collective efforts to bring us together to learn things that are very useful for us as refugees. I wish this would be a continuous program for us.'*
>
> *'I am thankful to all those who initiated this program. I have learned useful things during the presentations and discussion. I hope FMRS would organize another one.'*

The participants reported learning 'many new things', not just from the lecturers and pamphlets but also from each other (for more about this, see the discussion about benefits of the group discussions later):

> *'I learned through interacting with my follow refugees.'*
>
> *'I learned a lot both from the group and from the professors who led the presentation and I also learned how to talk to people in a group as we exchanged views.'*

'This is the most important class we have had.'

'The health class gives us more ideas, more experiences than the English class. We talk about it among afterwards among ourselves.'

Educational benefits

The aim of the project had been to educate refugees about reproductive and other health issues. So, not surprisingly, the most common benefits of the program mentioned by the respondents were educational, in particular improved knowledge about health issues. Some respondents expressed this in terms of their desire for education:

'You see I left my country to seek education but I was unable to continue and when I was informed about this program, I though it would be an alternative for learning and I though my dreams for education are becoming a reality. The certificate you give me will push me up a little a bit.'

Many respondents (7) felt that the key benefit was learning how to protect themselves from illness and disease in general:

'I learned about how to take care of myself in order to maintain good health.'

'We learnt how to live with others and protect ourselves.'

'It has been enriching and I have gained some medical vocabularies.'

The specific issue that the largest number of interviewees mentioned spontaneously was improved knowledge about HIV/AIDs and STDs (10 respondents).

'It was the first time I heard about the AIDS program and how many people in Africa are suffering from AIDS.'

'I learnt how I should protect myself from HIV/AIDs by wearing condoms during sexual intercourse.'

Similarly, the sessions on FGM had a big impact on the refugees: a number of them (9 respondents) spontaneously mentioned this:

'Yes, before those classes I didn't see how FGM was done traditionally. It was my first time to see how it is done.'

'FGM: I just heard about it and I had the wrong idea.'

The topics on STDs and FGM were covered in more than one session and included a certain amount of 'shock tactics'. In the case of FGM this was a graphic video, and for HIV/AIDS participants were provided with some dramatic statistics by a particularly charismatic presenter. These topics were not followed during the program as detailed questions followed later in the interview.

Although there had been only one session on coping with stress, it had also had an impact on the refugees, with a number of them (5) mentioning that learning about stress had been beneficial.

> *'Especially the presentation about stress was both very interesting and enjoyable to me because I could now at least try suppress my stress and frustrations through what the doctor illustrated to us. I can now identify and predict situations that would result in stress and am therefore able to avoid them.'*

Only one respondent mentioned the benefits of the two classes on nutrition and cooking even though the needs assessment at the start of the program had identified healthy eating as a particular problems for refugees in Cairo: the difficulties of finding familiar foods and cooking the types of food that they wanted to eat and believed were healthy for them.

Similarly, the class on contraception and family planning did not have a big impact on the respondents: only one person spontaneously mentioned that he had gained new knowledge about this topic.

Health issues were not the only educational benefit. Although this had not been one of the explicit aims of the project, a few of the refugees spoke about how the program had helped their English language skills. The benefits came from the focus groups discussions with each other and with native English speakers and the handouts that many respondents had taken the time to read after the classes:

> *'It's not easy to communicate in English with other people in this country [Egypt]. It made us communicate in English.'*

> *'It improves our English language. You gave us papers to read.'*

Another benefit, which could be said to be the aim of any educational program, was in terms of intellectual activity. A few of the refugees (3) talked about how the program had developed their thinking skills, activated their minds and given them something to think about:

> *'We remember the lessons. They give us something to think about.'*

> *'It developed thinking.'*

> *'I was doing Biology GCE A level in Sierra Leone. Now I have no books in Egypt. So the program reminds me of health education at school because I have forgotten a lot of things. It reactivates my mind.'*

Psychosocial benefits

The interviews and informal discussions with the refugees showed that the health education program had had benefits for them that went far beyond the practical information-giving that was the original intention of the organizers. Many respondents were uninhibited about mentioning the social side of the program: how they enjoyed the chance to get together every week with their peers; the party atmosphere; and having something to look forward to. These were seen a real tangible benefits to them with at least as much value as the educational component.

'I was very happy to meet different people every week and meet my brothers. We joke together and laugh together.'

These group benefits of the program were discussed in more detail later in the interview (see later). One respondent was frank about the benefits of the free drinks and sandwiches that were available at the classes: 'It was nice to have some food.'

Some of the refugees spoke movingly about the program as having deeper benefits in terms of helping them to cope better with their life in Cairo, giving them something to do, stopping them 'thinking too much' [about their situation]:

'It gives us somewhere to go. I feel upset because the program is closed now. Right now I have nowhere to go every week. I will sit down and think where can I go, how can I get out of the house?'

'People have nothing to do and this program gave them some purpose.'

Benefits of getting together as a group

The respondents were asked whether they thought that getting together as group to discuss these topics had been a good idea and how. A large number of the respondents (15) thought that the most important benefit of the groups was educational: the opportunity to discuss the issues and to learn from each other:

'Getting together has been a good thing for me because apart from learning from the lecturers we learned from each other. Nobody knows everything and by coming together one shares his ideas with others and learned from one another.'

'It is a vital thing to discuss problems together because you get varieties of ideas whether against or supporting the issues discussed and learning is like that.'

This was also seen by some as a psychological benefit because the group discussions gave them the chance to discuss problems with each other that had therapeutic benefits:

'It is very good to have someone to talk to about problems. For sharing and discussing certain issues. It helps us.'

Similar themes were sharing ideas and information to understand each other better (6) and understanding more about people from other countries (2):

'We can understand and able to know people from another country. I don't know people from Liberia – how they live.'

However, social reasons were equally important to the refugees such as getting all the Sierra Leonean/Liberian refugees together at the same time, having someone to talk to, to meet up with their friends and meet new people (other refugees, the group facilitators and the lecturers). Some ven said that it was a 'nice social event' and that it 'made people happy'.

'It has brought together people from Liberia and Sierra Leone.'

Some mentioned that the chance to meet people from their own country and the story-telling that went on in the group discussions reminded them of life back home:

'Some of us used to live in the same area at home. It's like story telling.'

'It brings people together. It feels like home – sharing problems, socializing.'

Barriers to expressing views

Interviewees were asked whether they felt able to freely and fully express their personal views in the group discussions. All the respondents were uncomfortable discussing their views and some mentioned that being among friends was helpful. As many of the group are Muslim they were asked about the presence of female facilitators and the women refugees who attended some sessions. All of them said they were happy with mixed sex discussions groups, even for sensitive topics such as HIV and FGM. Many respondents made the point that it was an education class and were critical of the 'Arab mentality' that segregates the sexes and compared it unfavorably with attitudes in West Africa:

'We have no problems with women in the group. We don't have the Arabic mentality. We take it easy. It's an education class.'

'There is all this secrecy in Egypt about sexual issues. This is the Egyptian mentality. At home we discuss these things with women.'

Four interviewees even said that they preferred having women present and that mixed sex groups were beneficial. The only exception was one young woman who had been brought up in Egypt and did not feel comfortable discussing sexual topics with men.

In fact the only issue that was mentioned as causing any problems among the men was age differences. Two of the older respondents said they did not feel comfortable in discussions with younger men. Another man said that religious differences had caused some arguments in the groups discussions and they did not feel comfortable with this.

Suggestions for improvement

The interviewees were told that this was the first time that health education classes had been run in this way for refugees and that we would like their honest option about any improvements to the program. Participants were also asked their opinion on the handouts and mix of lectures and group discussions. Almost all the refugee praised the program and most could offer only suggestions for minor improvements. Several (5) said the program should be upgraded and continued, perhaps with more money and for other refugees. It is of course not surprising that people were fairly reluctant to criticize the program directly to the people who had organized it. Nevertheless, the participants did offer some important suggestions for improvement.

Security problems at the Liberian/Sierra Leonean Center in the months before the program meant that many of the classes were moved to classrooms at the University. Although there was concern whether the familiar location of the Center would mean that the groups would feel comfortable, the opposite was true. The mood among this

group of refugees was that the decision to hold the classes at the University campus had helped them feel relaxed and safe, as illustrated by one respondent:

> *'The way you conducted the program was very nice. We felt very free. Nobody harms us or asks us questions.'*

Everyone seemed to be happy with the 50/50 mix of lecture and group discussion. Almost all were pleased with the handouts, saying that they were good and easy to read. Many said that they would keep them and refer to them later:

> *'They have become something I would refer to later if I forgot some of the things I learned from the classes.'*

> *'I think the papers were very good. I group them and keep them. Maybe I forget something and look it up. I will remember the papers ... if I have a woman and forget to use a condom they will remind me.'*

A few comments were made about the logistics: for example that sessions should be longer than 2 hours (3 hours or all day); that the technical quality of the films could be better; that the food should be served in the middle not at the start; that the schedule should be made clear at the start of the program; and that the handouts had been late sometimes.

Two interviewees did not like the mix of religion and medical topics that came up, for example when discussing FGM:

> *'The only thing…I was not happy about the religious discussions because it is based on conflict – people argue and there is no benefit.'*

On the other hand, so many of the interviewees were effusive in their praise, both when asked and spontaneously, that it seems to be genuine. Similarly, the mood from informal interactions with the participants throughout the course was that they were genuinely enthusiastic about program and this may be attributed to their thirst for knowledge and the desire of the urban refugee for anything to wile away the time that cannot be spent at college or work. One refugee summed up the benefits of the program as follows:

> *'You have done an excellent thing to us by bringing us together. We have been at home frustrated and demoralized. I was in a situation of hopelessness, I was involved in too much self-thinking but when I heard that the FMRS has invited us to attend a Health Education Program, I was very grateful to notice that. I said in my heart to myself, I have been thinking here that I have become useless but in fact there are some people out there who are thinking about us. For me that was a very special invitation. It has generated a new kind of thinking in me….it is of confidence in myself that, the other refugee and I are not abandoned by everybody as I used to think.'*

Discussion and implications for future programs

Method of outcome evaluation

Evaluating the success of health education projects such as this generally consists of basic, quantitative 'knowledge-attitudes-practice' (KAP) questionnaires. However, Crane and Carswell (1992) emphasized the importance of information to be gained from a more time-intensive qualitative approach, which can uncover details about the meanings attributed to information learned, as well as the logistics involved in putting the knowledge into practice. Because this was a pilot project designed to provide a model for future programs, qualitative methods were relied on exclusively to provide an index of outcome.

Relevance of health-related topics to refugees' health needs

The participants in this pilot project were young healthy men who had not experienced serious health problems in the past. The early needs assessment indicated that loneliness, multiple stresses due to fear for their future and the ongoing conflicts they encountered daily, and unfamiliar weather and food were their biggest health concerns. Because of this, the program was specifically geared to include active discussions of these issues and others that were brought up, such as sexual frustration which was\thought to lead to health problems.

The lack of appropriate sexual outlets as a health need led naturally to discussions of unsafe sexual practices, such as resorting to prostitutes, which provided a context for the lectures concerning protection against unwanted pregnancies and STDs. Prior to this program, many of the participants were unaware of various birth control methods or of the importance of using condoms for protection against HIV or other STDs. At the beginning of the program, many participants possessed inaccurate or incomplete knowledge about HIV. Our program consisted of several sessions devoted to this and related topics, all of which seemed to have an impact on the participants' knowledge about this illness and its prevention, as measured by exit interviews.

FGM was an area which was not identified as a health need by the participants themselves, but which was included as a main focus in one of the seminars. Through this (often graphic) presentation, participants indicated that they became aware of the health problems associated with FGM, a topic that most of them had not previously considered.

Proper nutrition was a big concern for these young men, most of whom found themselves alone, with no one to cook for them or make sure they ate properly. In one session devoted to mainting a balanced diet with very little money, the participants were taught to prepare a healthy meal using only affordable foods that could be found in Egypt. While this made an impression on the participants, the symbolic associations of certain foods that can only be found in their home country means that while the refugees might have learned to eat healthier, they continued to be dissatisfied with their diets in Egypt.

Dealing with stress is a major psychosocial issue for this group, as for most, if not all refugees in similar situations. These young men are terrified for their futures, have little earning potential in Egypt, and many are uncertain whether or not they will be granted refugee status and eventually resettled. In addition, they deal with regular

harassment from locals and fears of arrest. Therefore, the session that dealt with coping with stress was well-received, and gave the participants opportunities to share their experiences and exchange ideas for coping strategies.

There were some areas that might have been expanded. This group was particularly concerned about their levels of physical activity and often expressed the desire to find places and ways to participate in sports and other exercise. The stress and coping segment turned out to be important, and specific techniques for managing anger might have been useful for this group.

In summary, the program was able to address the major areas of health needs as identified by the organizers and the participants. This was accomplished through the very open-ended and flexible nature of the program. As needs were expressed, the organizers tried to respond with a session, or program segment, to address it. It is very likely that when this model is used with other refugee populations, different needs will be identified by participants. For example, a larger female component would obviously change the focus, perhaps to include more on women's and children's health. An older population might require more information about dealing with acute and chronic illnesses and accessing affordable health services. Therefore, as a model for future programs, we suggest that the curriculum development include the active input of participants. Furthermore, the heavy emphasis on discussion was important both to give the organizers feedback about the effectiveness of the sessions, and to allow the participants to place the material into a personal context.

Evidence of learning and behavior change as a result of workshop participation

It is difficult to assess actual behavioral change using only interviews, as the participants were probably eager to show what they had learned in the program (indeed, some saw the exit interview as a sort of 'test'). However, while there can be learning without behavior change, there can be no behavior change without learning, and so the program accomplished, at the very least, the first step towards developing more healthy behaviors for the refugee participants.

In order to facilitate the translation of the theoretical aspects of the program into concrete behaviors, we encouraged participants to tell personal stories relating to the topic of the discussion, and then provide alternatives incorporating the new material. For example, participants were taught to negotiate the use of condoms with partners who might be reluctant, or to visualize scenarios in which they practiced positive coping strategies to deal with intentional provocation by host country nationals. In fact, this group excelled at using narrative strategies, and were always ready and able to contextualize information with a metaphor or story. Similarly, in the exit interviews they displayed their learning through narrative techniques aimed at demonstrating a situation (real or otherwise) in which the new information would be used. In the case of the utilization of health care services, many participants demonstrated the impact of peer narratives and discussions by saying that they would not be more likely to utilize Egyptian health care services in the future, but would even be less likely to, having interpreted the stories told in the discussions and the presentation as meaning that these services are dangerous (a common belief among refugee populations in Egypt in general).

The fact that the participants could contextualize the information they learned suggests that, it is likely to be translated to behavior change, at least where this is

possible and/or convenient. In order to ascertain the long-term benefits of these projects, more follow-up and outcome research is needed.

Unexpected benefits of the program

One of the most important benefits of the program as a whole was the fact that it gave the participants a place to gather, a forum for discussion, and some intellectual stimulation. These particular refugees do not work or go to school, nor do they have any real social support generally. They are inhibited from gathering in large numbers (as this is discouraged by the Egyptian security) and therefore spend their days bored, frustrated and lonely. For this reason, programs such as this are highly valued in the community. Refugees are especially vulnerable to psychosocial stressors that can lead to drug and alcohol abuse, suicide, crime and stress-related physical and mental illnesses. This in itself is an argument for continuing the program, possibly to include different educational topics.

Project sustainability

One of the main goals of this project was to develop a model for health education delivery that could be used in the future with refugee populations in Cairo. A key finding of the present study was the importance of adapting every program to the specific needs of the target population. Inflexible programs are much less likely to reach a wide variety of recipients (Crane & Carswell, 1992). Therefore, the health education program that we propose takes as a point of departure the need to, first and foremost, listen carefully to the unique health challenges facing a given group or community of refugees, and to act accordingly. Age, gender, marital status, cultural beliefs and practices, and religious affiliation all affect attitudes and practices regarding health and health care. Programs such as this are only useful to the extent to which they are made meaningful to the people they are meant to serve. This does not mean that we propose to create completely new health modules each time. Health information, materials, lecturers, etc. can be recycled and improved upon continually. However, the choice and use of these materials, as well as the structure of the groups themselves must remain flexible and responsive.

On other hand, several important (structural) issues arose during the project that have implications for the sustainability of the project as a whole:

Staffing is an important issue for the ongoing success and sustainability of the program. Continuing programs require the ongoing involvement of at least one, if not more, dedicated staff members and funds must be available to retain them (Crane & Carswell, 1992). At the present time, little funding exists for refugee training programs. They are generally time-limited, earmarked for ‘start-up’ programs that have nothing available for their continuation if they prove to be successful. Because of this, and the scarce funding that is available, programs may be staffed by highly motivated student volunteers, for example, who move on to other things once the project ends and the funding dries up. Therefore, finding the capital to maintain well-trained staff, preferably from the refugee populations themselves, would serve to increase the sustainability potential of refugee educational programs.

Participant motivation is a very important factor in the success of any project. The refugee participants must find it worthwhile to attend the sessions. In the present case, the participants were young, largely unemployed people who were highly motivated

to gather and to learn new information. In addition, they were compensated for their travel to and from the sessions, and provided with food and drink. Future programs with different refugee groups will have to consider such factors as work considerations and family obligations, none of which were important to the present group. In addition, different educational levels in some of the other refugee groups may mean that different training methodologies will have to be utilized in order to gain the same level of participant satisfaction.

Finally, qualified speakers as well as educational supplies are obviously pivotal for the success of such a program. In the present case, the speakers gave their time free of charge; however, an ongoing program would require some financial compensation for the amount of time and effort necessary to put together a comprehensive workshop for a specific group. This problem might be partially mediated by training qualified health education personnel to present the material themselves. However, this leads to the second major obstacle, which is finding appropriate educational materials and supplies. Proper educational materials are not only expensive, but virtually impossible to find in many parts of the developing world. Furthermore, what exists may not be culturally appropriate or available in translation (if necessary). For example, while there is much on 'reproductive health' education available on the Internet, much of it was found to be far too sexuality explicit for a conservative society such as Egypt. Therefore, time and care must be dedicated to developing appropriate educational materials that will suit the needs of the various refugee populations who might benefit from the program.

Recommendations

Based upon the outcome of this pilot project, it is recommended that the following steps be taken to continue the health education project for refugees in Cairo:

1. Develop flexible 'content modules' for different health education topics that can be easily accessed as needed. These should be developed under the supervision of experts, and should include material than can be easily translated into the various languages of the refugee groups in Egypt.
2. Train refugees from each community to administer the health education programs. If this project is going to be sustainable in the community as a whole, it must be extended to other refugee groups, and must include individuals from each of these groups as facilitators and educators.
3. Maintain ties with the health care community in Egypt. A major issue raised in the pilot program was the mistrust the refugee community has for the Egyptian medical practitioners. One of the most positive aspects of the program was bringing in experts from the community to deliver presentations. The involvement of the Egyptian medical fraternity in future programs would help to build trust and confidence. While we cannot rely exclusively on this, this contact is important and should be sustained.
4. Create ongoing programs for groups who demonstrate a need. One outcome of this pilot project was the obvious need for ongoing services and activities for the Liberian/Sierra Leonean refugees. If, during the course of the program, an obvious need is identified that cannot be addressed in the short time available, then every effort should be made to address the need, with trained refugee health educators as administrators.
5. Find ongoing funding for the above-mentioned projects. Efforts must be made to convince potential funders of the importance of these projects, and the need to find them on a longer-term basis.

Annex 1: The health education seminar series – description of individual sessions

The program and topics

Days	Topic
Session 1	Introduction. *Health and Well-being.* Focus Group Discussion: *Needs Assessment - Identifying problems about health, access to health services and risk-taking behavior*
Session 2	*Conception, Fertility, Anatomy, Physiology, Female Genital Mutilation*
Session 3	*STD's – HIV/AIDS: Origin and Transmission*
Session 4	*Video. Negotiation and Communication Skills – Initiating sex, slide show on contraception*.
Session 5	Focus Group Discussion: *Reflections on the previous three sessions.*
Session 6	Focus Group Discussion: *Gender Norms, relationships.*
Session 7	*Video on HIV/AIDS. What is AIDS? Origin, Transmission and Prevention*.
Session 8	*Nutrition – Introduction to Dietary Health, adapting to a new food culture. Cooking Egyptian Style – buffet.*
Session 9	*Small budgets and healthy diets. Nutrition, stories and myths about food, Market Simulation*
Session 10	*Sleeplessness, Depression, Keeping Fit Mentally – Stress and Coping Strategies for living in Egypt*
Session 11	Conclusion. *Accessing health services – learning to trust health professionals and utilizing services*

Reproduction, sexual anatomy, fertility and contraception (family planning)

The program

The lecturer was a medical doctor working at Al-Azhar University and an expert in FGM and experienced working with Somali refugees. The lecture covered basic reproductive anatomy and physiology: the sex organs, how conception occurs, the ideal time in a woman's life for reproduction and contraceptive methods. Small group discussions afterwards focused on sexual frustration, finding sexual partners in Cairo and the different sexual mores in the refugees' home countries and in Egypt. Individual interviews after the program probed their knowledge of contraception.

Objectives

- To discover more about the sexual attitudes and practices of refugees in Cairo, especially with regard to relationships with local people and prostitution.
- To give participants an opportunity to discuss their views about relationships and share problems of refugees, such as sexual frustration.

- To give participants knowledge about reproductive anatomy and physiology, conception and fertility.
- To give participants knowledge about family planning and contraception.

HIV/AIDS

The program

This topic was covered in two lectures, and was discussed in-depth in other sessions and informal discussions. The lectures provided a natural history and pathology of HIV/AIDS, showed how HIV is transmitted, taught participants to identify common signs and symptoms, and sought to raise awareness of prevention strategies and improve negotiation and communication skills with partners.

HIV/AIDS was a important topic to the refugees and was discussed during several previous and subsequent seminar sessions including those on family planning, access to health services, FGM and mental health. Because it is such a large and complex issue an additional seminar session was also planned with the help of a health consultant from the UNFPA. The session began with a series of video clips that presented HIV in terms of personal risk, prevention, stigma and impact on personal life. A question and answer session followed covering the history and pathology of HIV. Individuals were then asked to identify factors that place them at risk of HIV infection and performed a written exercise on 'How I failed to get infected with HIV'. Posters from the National AIDS Program were displayed around the seminar room and prizes were given to individuals who answered questions correctly. An information sheet identifying HIV, its symptoms and prevalence was also distributed.

Objectives

- To provide a natural history and pathology of HIV/AIDS;
- To show how HIV is transmitted;
- To identify common signs and symptoms;
- To raise awareness of prevention strategies and improve negotiation and communication skills with partners.

FGM

The program

The lecturer was a medical doctor working at Al-Azhar University and an expert in FGM and experienced working with Somali refugees. The lecture covered the different types of FGM and where they are practiced and the complications that can results. He also explained that it was culturally-defined, not Islamic practice. A film was shown with graphic details of the operation being carried out on a young Somali girl. Questions and comments were invited from the participants and later the refugees broke into smaller groups to discuss the issue among themselves.

The use of explicit visual material (including slides showing the effects of STDs plus HIV/AIDS) and videos depicting FGM made information easier to digest, although a few of the female participants reported feeling disturbed by the graphic illustrations. However, the doctor's used of medical terminology in his presentations made it difficult for some to understand the seminar.

Objectives

- To give the participants detailed information about the methods and practice of female genital cutting/ mutilation.
- To promote discussion and debate among the participants about the purpose and validity of FGM.

Nutrition

The program

Two sessions were devoted to nutrition. The first involved a cooking demonstration given by a local nutritionist from the National Research Center in Cairo. A range of foods were cooked using cheap local ingredients at a cost of less than 2LE (less than 0.5 dollar) to illustrate possible additions to one's diet. Food was shared and consumed among the group. A talk on hygiene, sanitation in the kitchen and how to get the most from vitamins on a limited budget was also given, concluding with an informal discussion of the foods typically eaten by refugees in Cairo.

The second session was led by one of our facilitators who was conducting his own study on the nutritional status of refugees in Cairo. He delivered a lecture on the major macro and micronutrients, their affect on the body, the foods in which they are found and the consequences of mal/under nutrition. Group discussions were then held to identify some of the myths and reputed effects of foods on the body. Posters depicting a variety of fresh produce available here in Cairo were displayed around the room. Handouts showing the five food groups and their recommended intake, lists of major micronutrients, macronutrients and common diseases related to malnutrition were also given to participants.

Objectives

- To broaden participants knowledge of local ingredients and their nutritional value;
- To dispel myths and suspicions about local foods.
- To provide ideas on efficient food management, food processing and safety.

Stress and coping

The program

The lecturer was Assistant Professor in Psychology at the American University in Cairo. She presented a talk with handouts about the different types of stress and coping mechanisms. The participants then separated into smaller groups to discuss what stresses they faced as refugees in Cairo to share ideas about how they coped with this.

Objectives

- To inform refugees about the different types of stress and how to cope with it.
- To promote discussion and sharing ideas about experiences of stress as a refugee and ways of dealing with it.

Access to health services

The program

The lecturer was the medical director of the largest provider of health care to asylum seekers (unrecognized refugees) in Cairo: an Anglican church-sponsored clinic. The session was in the form of a lecture punctuated by discussion questions with the group. There were two activities where participants were divided into smaller groups. In the first, they read and discussed two real-life case studies: one about the diagnosis and access problems faced by a refugee with TB and another about a doctor asking for money to record a negative result for a refugee with a positive HIV test. Later the groups acted out a role-play where refugees, doctors and community health specialists put their case to a fictitious minister of health.

The lecturer talked about the work of the refugee clinic and the exponential increase in demand from the growing population in Cairo, coupled with financial limitations that mean that attendance at the clinic has to be limited. The group was given lists of clinics with the lowest consultation fees and again discussed getting dedicated help from one Egyptian clinic for their community. The lecturer also discussed the need for job creation strategies in Cairo to help refugees with financial difficulties, so that they can afford medical treatment when they need it.

Objectives

- To raise awareness of what health services are available for refugees in Cairo.
- To facilitate an exchange of ideas between health service providers and refugees.
- To reduce cynicism and build trust about health care services in Egypt.
- To give refugees a better understanding of the common problems faced by refugees and poor Egyptians.

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