

**Providing Health Care Information to
Refugees in Cairo:
Questions of Access and Integration**

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Introduction:

This paper began as an investigation into medical services currently offered to refugees in Cairo. The ultimate goal was to update the medical section of the Refugee Yellow Pages¹, an on-line information resource available through the Forced Migration and Refugee Studies department at the American University in Cairo. The impetus for this project was the idea that the provision of up-to-date listings of service providers was vital to refugees' access to social services, including health care. In the course of my research I discovered that while information does play a large role in an individual's ability to access health care, other barriers are in place in Cairo that nearly obscure any gains that could be made through updating the Refugee Yellow Pages. This paper will investigate the responsibility for health care provision, different health services currently available to refugees in Cairo, the access barriers faced by refugees, and the question of integration. It will address specifically the differences and similarities between the experience of refugees and nationals vis-à-vis the Egyptian health system and issues of refugee health care that may be difficult to resolve. Towards the end of the paper, I will suggest a multi-faceted plan of action to provide more accurate information resources that address not only available services, but also the barriers to quality care.

Methodology:

The sources that inform this paper are primarily written, most often in the form of Theses or past published and unpublished research findings on health care in Egypt for refugees and nationals. I have relied on the research of both Egyptians and foreign

¹ http://www.aucegypt.edu/academic/fmrs/Services_for_Refugees/Yellow_Pages/yellow_pages.html

researchers in Egypt, as well as accounts of interviews with refugees regarding their lives in Cairo. I was able to conduct only three informal interviews over the course of the three months in which this paper has been researched and hope that the issues presented in this paper can be investigated through more comprehensive interviews with refugees, Egyptians, and service providers in the future.

I was fortunate to have been able to interview two refugees: Mohamed “Fantastic”, a Somali experiencing several health problems, and Dr. Abdalrehim Hamid Abusibh, a Sudanese doctor practicing medicine informally in Cairo. I was also very grateful to Professor Elizabeth Coker for granting me the opportunity to correspond with her extensively and question her during a lengthy interview. Professor Coker’s work on health experiences of refugees in Cairo was especially helpful in my thoughts about this paper. Additionally, working papers and publications from the Forced Migration and Refugee Studies department at the American University in Cairo were most useful during my research, as was the very informative 2002 “Egypt Household Health Services Utilization and Expenditure Survey”, available to me in English through the Social Sciences Research Center at AUC. I would also like to thank Courtney Mitchell, head of the psychosocial team at AMERA, for her valuable suggestions and critiques of this paper in February, 2006.

My research was disadvantaged by my inability to read and speak Arabic, my relatively brief tenure in Cairo, and my lack of training as a health care professional, in either the clinical or policy divisions. In particular, I have been unable to provide adequate examination of national laws, as they were not available to me in English and I had no mechanism for translation. The text of these laws was related to me by staff

members at Africa and Middle East Refugee Assistance (AMERA), an Egyptian-run organization that works with refugees. AMERA had also updated the medical section of the Refugee Yellow Pages about two weeks before I began my study.² I have relied upon their findings and have not, due to time and language constraints, replicated their work. My reliance upon Egyptian friends to provide me with information slowed my research and there are several unanswered questions that remain due to missed appointments and scheduling conflicts. I hope to expand this paper in the future to incorporate other information that I have as yet been unable to verify and new findings that may arise from interviews with sources I have only just recently discovered, including a 2005 Thesis submitted to the University of Michigan department of Anthropology on the subject of refugees and healthcare in Cairo.

The Right to Health Care: Who is Responsible?

To date there is little clarity about who is responsible for health care. While some international legal treaties mention a state's responsibilities towards the health of its citizens, this is often considered only in reference to epidemics or curative care, without provisions for health education or preventative initiatives. Often preventative health responsibilities fall upon the individual, or professionally on the doctor who is entrusted with health promotion. Without government financial and institutional support, however, the individual often may not be able to afford the kind of care that could prevent minor ailments from leading to serious diseases. The case of urban refugees is even more difficult to define, as they are often viewed as a temporary population for many years of

² As of March, 2006, AMERA has updated medical listings and has adopted a more comprehensive approach to managing medical care, including the creation of a medical team to update the different venues for care in Cairo.

their lives and thus do not receive the same type of social services investment that nationals or otherwise stationary people might have access to.³

In an area where refugees have self-settled, as is the case in Cairo, these individuals are generally provided health care from four sources: 1) the State, acting in a legal capacity to provide services to those within its borders in the interests of public health, 2) UNHCR, acting within its mandate to enable refugees to access social services, 3) NGOs, acting professionally with specialization in health-related fields, and 4) religious-based organizations that provide low-cost medical care as a matter of charity and social justice. Who may lay claim to what services is also complex, as some providers cater only to recognized refugees and individuals who have sought or are presently seeking asylum (ex. Caritas), some to all who have entered Egypt within a given time frame (ex. Refuge Egypt), some according to nationality (ex. Refuge Egypt), and others who serve anyone seeking medical care (ex. Government services). The assumption of the financial burden of medical care is also variable, as in some cases the government or organization may fully or partially subsidize care, in others doctors may offer treatments for free or for reduced costs, and in still others the patient must pay in full.

While these responsibilities are often viewed as humanitarian duties, there is some legal precedent establishing the right to health care. In the case of Egypt this precedent can be found both in international laws to which the state is signatory and national laws that more specifically define the health care situation in Egypt.

³ This is in comparison with camp-based refugees, who often have access to a higher standard of health care than is available to nationals.

The consideration of health care as a human right was first mentioned in the 1948 Universal Declaration of Human rights. Article 25 of the Declaration considers health care in the context of the right to “a standard of living adequate for . . .health and wellbeing”, and, though it is not enforceable, it serves as a foundational philosophy for other treaties, such as the International Covenant on Economic, Social and Cultural Rights, to which Egypt became a signatory on 14 April, 1982.⁴ Article 12:1 of the ICESCR calls on states party to the Covenant “to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. Article 12:2 maintains that the state should take steps to “achieve the full realization of this right” including, in subsection (d), “the creation of conditions which would assure to all medical service and medical attention in the event of sickness”. The ICESCR unfortunately also is not easily enforceable, as the steps it calls for are incremental, rather than immediate, and no recommended timeline has ever been provided. Additionally, the ambiguous wording of the requirements, such as “highest attainable standard” of health and “the creation of conditions” to insure health, make implementation of the ICESCR almost impossible to monitor. What individuals living in developing countries, like Egypt, should expect in terms of health care is left decidedly unclear.

International instruments devoted to refugees are even less helpful in defining recommended health care services. In the 1951 Convention relating to the Status of Refugees (1951 Convention), there is no mention of “health care” at all. Presumably the Article 23 right according “public relief” at the same level as nationals could include health services, but the imprecise phrasing leaves the matter entirely to interpretation.

⁴ Status of the Ratifications of the Principle Human Rights Treaties, Office of the High Commissioner for Human Rights Treaties, <http://www.unhchr.ch/pdf/report.pdf> (June 2004).

Egypt's reservations to the Convention do not suggest it is likely for the government to take on any additional responsibilities not clearly required in the text.⁵

Egyptian national law addresses health care for both nationals and foreigners. Health care for nationals is governed by law 32 of 1975 and other decrees from the Ministry of health including decree 961 of 1975.⁶ Law 239 of 1997 made government hospitals accessible to foreigners as well as Egyptians at minimal fees that could not be altered by hospital physicians or staff on a case-by-case basis.⁷ According to government policy, free treatment is available to nationals in special need, as determined by a board from the Ministry of Health. In addition to these statutes, the Egypt's Constitution also considers the state's responsibilities regarding health care in Articles 16 and 17. Article 16 outlines general commitments of the state to guarantee health services, particularly in villages, "in an easy and regular manner" and Article 17 establishes state-sponsored health insurance guarantees.

As with other developing countries, Egypt has forwarded most matters concerning refugees to UNHCR. While UNHCR's efforts to address health care for refugees have often not addressed refugees in urban situations,⁸ some of the organization's policies can be applied to Cairo. The UNHCR in 1999 stated that "refugees ultimately are entitled to the same level of health care that the local community has access to and/or what they were used to in their home country" (Harrell-Bond 2004, 242). This policy addresses the

⁵ Egypt made five reservations to the treaty, including to Article 23. Shafie, 2004.

⁶ Meeting between NMH (UNHCR) and Haitham Helal (Egyptian Lawyer) regarding access of foreigners to medical facilities in Egypt (Sunday, May 30, 2004)

⁷ Ibid.

⁸ UNHCR's handbook for emergencies advises social workers that "whether refugees are in camps or spontaneously settled among local villages, community level services are essential" (Organization of Refugee Health Care DATE). This policy does not address refugees in urban environments, but other policies such as the use of host country health facilities via referrals, and compensation of those national structures for their services may be of use in urban settings.

ethical confusion that arises from attempting to standardize health care rights for refugees who enjoy the protection of asylum countries that are vastly different in their economic capabilities. A refugee gaining asylum in Canada, for example, would have access to a far higher minimum standard of care than a refugee in a developing country, like Egypt, whose medical program is unable to provide adequately for citizens. UNHCR further complicates its policy by stating that “if local and national health facilities can’t be strengthened to meet refugee needs alternative arrangements will be required” (Organization of Refugee Health, 74). This suggests that refugees might be entitled to more care than nationals, or at least could have access to special services provided for their benefit. “Should the standard of care be the same for refugees the world over” Harrell-Bond asks (242). While equalizing the medical provisions for refugees and their host population may be the best option for the sake of integration,⁹ in areas where refugees will be experiencing a significant decline in quality of care under the national system and putting severe stress on existing facilities this is not the best policy.¹⁰

The World Health Organization has offered some insight into the definition of “health”, defining it as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (Nygren-Krug, 2003, p. 7). The organization also states that investments that improve health in poor countries should not be perceived as altruism, but in terms of self-interest (8).¹¹ While this definition encourages a comprehensive approach to health, it does not address how such “health”

⁹ See Van Dame’s account of the refugee program in Guinea and the successful integration of Liberian refugees into the Guinean health system. Improvements made to the health systems in refugee affected areas continued to benefit locals even after the repatriation of refugees. Van Dame...

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¹¹ Nygren-Krug mentions especially a mathematical model for calculating a Hepatitis B intervention designed to cure migrants in their home countries, rather than waiting until they reached health care facilities in the UK. The study found that the resources needed to prevent 1 Hepatitis carrier in the UK could prevent 4,000 carriers in developing countries.

can be achieved, or what different economic and social classes may expect regarding their separate rights to health. Furthermore, in spite of its influence, these statements by the WHO cannot be implemented as legal standards and have not yet made their way into legally enforceable statutes.

Considering the weak legal requirements for the provision of health care to refugees, and the lack of resources in many asylum countries, it is not surprising that state governments often rely on NGOs, INGOs, and UNHCR to conduct medical outreach. This is especially true in scenarios such as Egypt where the national health system is already operating beyond its capacity and attention to refugee needs is overshadowed by a shortage in health facilities for citizens. Even so, conceiving of health care as an act of humanitarianism or charity, rather than a patient's right, may do more harm than good, as health care providers may be unwilling to meet patient demands for quality and timeliness if they perceive their work as volunteerism.¹²

¹² Sandra Jefferson (Jefferson, 1999) suggests that “the concept of community health workers and community participation...could legitimate low-quality health care for the poor—systematically denied access to superior modern health care systems”, p. 65.

Who is providing health care to refugees in Egypt?

The provision of health care for refugees in Egypt is confusingly pluralistic.¹³ Depending on their legal status, refugees may be entitled to care from a wide number of providers, including religious organizations, or they may be limited to low-cost government care. Refugees with independent funds, however, have access to a broad range of health care options, including refugee-specific programs as well as private medical facilities in Cairo. In general, medical care for refugees in Cairo may be facilitated by the government, the UNHCR, NGOs, religious institutions, private hospitals and clinics, or some combination thereof.

Refugees who have not received official status from the UNHCR, are not in the process of seeking asylum, or have had their applications rejected (“closed files”) generally only have access to the types of facilities available to Egyptians. This includes low cost options, like government hospitals and religious-based clinics (both Muslim and Coptic Christian), as well as higher-cost private hospitals and clinics. In rare cases, refugees have gotten jobs in Egypt that entitle them to health care allowances or formal insurance from their companies.¹⁴ Others who cannot afford or do not want to attend the low-cost clinics may provide their own health care through self-medication, including buying medicines to fit their symptoms from local pharmacies. African refugees may register independently with Refuge Egypt, the medical program at All-Saints Cathedral in Zamalek¹⁵ to receive a variety of low-cost services for a two year period. While the

¹³ See the attached chart for a full range of providers in Cairo.

¹⁴ Most refugees in Egypt work in the informal sector, if at all (Grabska, 2005).

¹⁵ In the literature this program is alternately referred to as “Refuge Egypt”, “All-Saints”, “Joint Relief Ministries (JRM)” or “the Zamalek Church”. For the remainder of this paper I will refer to it as “Refuge Egypt”.

services available at Refuge Egypt are reportedly of very high quality,¹⁶ it can be impossible for some refugees to complete registration, as interested parties must prove that they have been in Egypt less than six months by showing an entry stamp in their travel documents. For those without travel documents, or those who have entered into the country illegally, registration with Refuge Egypt will be impossible.

Officially recognized refugees and those seeking asylum through UNHCR are entitled to the help of that office in securing their medical services. UNHCR in Cairo serves a referral function, sending refugees to partner clinics, such as Caritas and Refuge Egypt, for primary care, as well as providing referrals (through Caritas) to private hospitals throughout the city. UNHCR is able to subsidize medical costs, including the cost of medicines, in most cases, and some medicines are available for free through charitable donations. For individuals with serious or chronic illnesses this is often a source of frustration for UNHCR and its partners. It is most common that the refugee and their community will be asked to provide some part of the funding, even in cases of life-threatening illnesses.

Refugee children who attend public schools in Cairo are entitled to health insurance under law 99 of June 1992 with the yearly fee of 8 LE per child (Nandakumar, 2000)¹⁷, and all children in Egypt are entitled to free immunizations from the Egyptian

¹⁶ The quality of care at Refuge Egypt has been routinely praised by refugees, both in my interviews and in the literature. See *Save the Children*, 2004 for an assessment of Refuge Egypt in comparison with other service providers.

¹⁷ The School Health Insurance Program (SHIP) devised by this law must provide preventative and primary services, including periodic medical exams, emergency care, school sanitation, health education, and food sanitation; curative care, including outpatient, dental, inpatient, surgery, and accommodations; and prosthetic equipment and prescription eye-glasses. The initiative is funded in part by client co-payments (8 LE per child each year), in part by a government contribution (12 LE per child each year), and in part by a national cigarette tax that is estimated to provide income that exceeds the government contribution. The payment structure was devised according to estimates made by the Health Insurance Organization that determined per-capita yearly health care costs for children to be 35 LE. While the system worked ideally in

government. Additionally, refugee schools such as those at Refuge Egypt, St. Andrews, St. Lwanga Education Center in Abbassiya, St. Joseph's Center for Basic Education in Maadi, Um Al Nureen Kindergarten in Arba wa Nuss, and Caritas Kindergarten in Garden City have their own medical clinics and are often able to provide medical services to their students for free or at a very minimal cost (*Save the Children*, 2004). Of these clinics, both Refuge Egypt and Caritas provide care for families of their students as well. Unfortunately, according to *Save the Children*, there are no services available for handicapped children, nor have any of the clinics undertaken systematic health promotion or education activities within the classrooms, either through printed media or presentations (*Save the Children*, 2004).

While it appears on the surface that there are many opportunities for refugees to receive health care services in Egypt, the number of different facilities, each with their own regulations, can be daunting for refugees and social workers. Coordination between service providers is often poor, despite occasional inter-agency meetings and the recently-proposed interagency medical working group.¹⁸ Unfortunately, there are no criteria for who is invited to the forum and groups that provide services to refugees, especially local Egyptian clinicians at government and mosque medical centers, are often

the 90's, the annual losses were predicted to increase to a rate of 351 million LE by the year 2000, due both to increased populations of school children and a lack of change in the co-payment rate per child. (Nandakumar, 2000).

¹⁸ While interagency meetings are sporadic, it seems when they do occur much is communicated between the larger players, with little emphasis placed on less formal care-givers and the expansion of medical services. The minutes from an Interagency working Group meeting on the 15th of May, 2000 attended by UNHCR, St. Andrew's JRM, IOM, the Australian Embassy, the Maadi Community Church, All-Saints JRM, the Canadian Embassy, the US Embassy, the Netherlands Embassy, Sacred Heart Church, the American University in Cairo, and Caritas discussed the following topics: a reduction of money for health care at Caritas provided by UNHCR; UNHCR's announcement that medical aid is only available for those with refugee status and those who are aided by UNHCR must go to Caritas doctors; the fast-track resettlement of refugees with chronic medical conditions, with \$500 pledge for emergency medical care from the US INS; All Saints announced it would turn new-comers with chronic conditions away; the public posting of UNHCR decisions was determined to have negative psychological effects; and issues relating to HIV and its effects on resettlement and legal status in Egypt.

left out of communication (Ismail, 3). While many actors wanted to coordinate their work, different organizations conceived of it in different ways. Some NGOs want to work with the government, while religious organizations often see themselves as separate from the government and are hesitant to coordinate programs(4). The lack of communication about individual cases can have dire effects on the health of refugees, as a sick individual may spend precious energy trying to find the right provider, often being turned away because of recent policy or service changes that were not reported to other organizations. Because many of these organizations are funded through charitable donations, the amount of services they are able to provide each year may fluctuate accordingly. Furthermore, changes in staff and leadership of government hospitals and clinics could result in the disenfranchisement of refugees, as new personnel may not be familiar with refugee-friendly laws or precedents and may take part in discriminatory practices. According to Iman Ismail, the ways of assisting refugees in Egypt as separate from local Egyptians may increase their alienation, and prevent their integration and enjoyment of rights(1).

What are some problems faced by refugees when accessing Health Care in Egypt?

Medical care services are very important to refugees in Cairo, but it is not easy for them to access health care in Egypt.¹⁹ The access problems encountered by refugees in Cairo can be discussed in terms of those faced by migrants, in general. According to Nygren-Krug (2003), “migrants face serious obstacles to good health due to

¹⁹In a recent study of refugees from Refuge Egypt (Briant and Kennedy, 2004) individuals indicated that medical services are the most beneficial social services offered to refugees and on average the majority of refugee budgets is set aside for health care. The study may not reflect the situations of all refugees in Cairo, however, as it was tailored only to those currently using the services of Refuge Egypt: Sudanese and other African refugees who registered with the program within six months of entering into Cairo.

discrimination, language and cultural barriers, legal status, and other economic and social differences”(4). According to Nygren-Krug the reason most given by migrants for not using health services is a lack of awareness or information. They are systematically ill-informed due to linguistic barriers and different educational backgrounds and perceptions of health care. For this reason migrants are particularly vulnerable to misdiagnosis and inappropriate treatment, especially concerning matters of mental health (28). Williams (2005) also notes common social and racial disparities in health that could apply to refugees²⁰, suggesting that socioeconomic status and neighborhood conditions have a direct impact on access to medical care and overall health. Williams considers psychosocial stress to be a serious health threat, and asserts that exposure to stress can be heightened among those living in segregated residences where there are limited opportunities for education and employment.

According to the literature, the health-related difficulties faced by refugees in Cairo may be broken into several categories, including 1) a lack of good information, 2) social and instrumental limitations on movement and transportation, 3) racist attitudes, 4) language, 5) monetary constraints, 6) poor health knowledge, and 7) poor quality care. Often these difficulties interact with one another to create an environment in which refugees would rather self-treat their illnesses than spend time and energy seeking out medical care.

Many of the problems refugees in Cairo experience when trying to access medical care are symptomatic of a lack of comfort and integration with the host society. In her study of Sudanese refugees in Cairo (Jefferson, 1999), Sandra Jefferson claims that

²⁰ Williams’s study was undertaken to observe racial and socio-economic disparities in health care between black and white populations in the United States.

“health status and health care problems are directly related to the lack of adaptation and the deficiency of...economic and social integration”. Individuals interviewed by Jefferson reported feeling uncomfortable walking on the streets in Cairo²¹ because they experience verbal and physical harassment. Common complaints are that Egyptians laugh at them, throw things, and children shout “Samara”.²² The situation is especially troubling for children, as one mother explained: “here in Cairo our children don’t want to go out. They are afraid the Egyptian children will call them names”(56). As accessing medical care in Cairo often entails a long walk in an unfamiliar neighborhood²³, the discomfort felt by many refugees on the street in Cairo can cause them not to seek health assistance at all. One third of the Somalis interviewed by Al-Sharmani indicated the local pharmacy as their primary health care provider (27).²⁴

In addition to negatively affecting health-seeking behaviors by hindering refugees from traveling to medical clinics, street harassment has even been identified by some as a source for their illnesses. As one Sudanese woman said, “worry is the cause of so many diseases” (55). Among the Somalis the suffocating social situation in Egypt causes an ailment known as “buufis”, a term used by Somalis to describe the painful obsession with traveling to and resettling in western countries (Al- Sharmani, 27). One woman described her condition, saying “when I think of my life here and our problems, when I think of resettling and how I can’t get it, my head hurts so much...my body aches. It feels like there are worms crawling all over my body” (Al-Sharmani, 27).The connection

²¹ “sometimes our problems start when we have to walk out on the streets of Cairo” (Jefferson, 55)

²² A word in colloquial Egyptian Arabic meaning “black” and used in a derogatory fashion against Africans.

²³ See chart for a distribution of services.

²⁴ Others use inexpensive clinics, such as local neighborhood clinics and Islamic clinics that cater primarily to Egyptians. A very small percentage used the clinic at Caritas, and even fewer went to the clinic at refuge Egypt (Al-Sharmani, 27).

between environmental stressors and disease has been confirmed in women who experience depression and hypertension²⁵ (26). As Coker (*Travelling Pains*, 2004) notes, “the extreme cultural, social and geographical fragmentation experienced by southern Sudanese refugees in Cairo were experienced as part and parcel of bodily ills and physical pain” (Coker, 17).²⁶ Coker discusses at length the issue of “somatization” of the social environment and the difficulties faced by doctors in treating a-symptomatic patients. According to the medical director of Refuge Egypt, more refugees complained of “inexplicable pains and sicknesses” than diagnosable diseases (19).

While many refugees attributed their illness to the social and environmental situation in Cairo²⁷, other refugees experienced illnesses that aligned with their past migrations. Coker found that somatic pains were “historicized, moving through the body” according to changes in physical locations during migration (20). The source of these “traveling pains” is often a traumatic experience that cannot be forgotten, such as one woman who said “since my husband and two children were killed I have remained unhealthy until now” (21). Patients afflicted with these illnesses often perceive them as incurable, and find their best solution to be “withdrawal” (22). Thinking, worry, and anger manifested themselves in headaches, heartaches, high blood pressure, muscle pain and stomach ailments (23-24). Coker notes that “many of the refugees were literally immobilized by pain” that reflected their “sense of helplessness in a foreign culture” (33).

²⁵ Some Sudanese women express frustration at life in Cairo, specifically the hostility of Egyptians towards them that manifests itself in something as simple as buying groceries: “often we go to the ‘sook’ to buy vegetables and when we return home we discover the vegetables are often the ‘bad ones’”. (Coker, 26)

²⁶ Another stress upon Sudanese may be their inability to behave in ways they are accustomed to from home. Large gatherings, traditional singing and dancing are not allowed by Egyptian landlords and neighbors, and Sudanese feel psychologically cramped by their loss of freedom in this way (Coker, 408).

²⁷ Complaints of Cairo-related causes of illness include cold winters, dust, pollution, “impure food”, and the crowded environment. (Coker, 22)

Western medicine has not historically dealt with socially-rooted illness, where pain is not an organic ailment of the body, but is a product of relationships between an individual and his surrounding social and physical environment.²⁸ Doctors and patients in Cairo were frustrated by their inability to communicate with one another: the doctor claiming to see nothing wrong with the body, and the patient adamantly asserting his illness. The feeling of not being understood compounds the stress of the medical visit, in which “the refugee is forced literally to bare his body to the gaze of a powerful member of the host society” (Coker, *Dislocated Identity*, 402). Coker found the distrust of Egyptian medical staff to be “universal” among the Sudanese she interviewed (411). Suspicions were largely based on Sudanese perceptions that doctors give them the wrong medicines and over-medicate in situations such as childbirth (411). Organ stealing anecdotes have also spread among the refugee community. Coker views these stories as a form of “urban legend” that arises to describe the “fear and resentment of the powerful ruling class” experienced by the refugees (413). Additionally, such stories may describe the real opportunities offered to refugees to sell organs in financial emergencies (413).

There is also evidence of poor treatment of refugees from the very NGOs that are designed to provide them with medical services. Reports from refugees²⁹ suggest that overworked and under-resourced organizations often send sick individuals on wild-goose chases for medical services that will never be provided. Additionally, many refugees have been turned away from medical procedures by doctors who say their pain is mental.

While this may indicate the kind of somatic disorders discussed by Coker, Doctors

²⁸ Compare Western Medicine’s approach to “depression” with the traditional healing techniques of Somalis in which healers perform cures by reading verses of the Koran to the afflicted individual (Al-Sharmani, 27).

²⁹ The following anecdotes come from personal interviews with AMERA staff and the organizations in question will not be named.

apparently have not been able to comfort suffering refugees, who most often feel that they are being unfairly deprived of expensive services, such as MRIs, that could potentially provide a cure.

Whether or not the health-seeking anecdotes told by refugees are true, they indicate the real lack of trust and communication between doctors and their refugee clients and the impact this situation can have on the quality and results of health care. Though it seems clear that refugees are not experiencing positive relationships with their health providers, specific examples suggest that in some cases this has less to do with any sort of discriminatory intent on the part of the doctor, and far more to do with cultural differences in conceiving of proper treatment for specific ailments. One example of this is the use of cesarean section deliveries. The method is not commonly practiced in Sudan, and can be very frightening for women are not familiar with the procedure. Many Sudanese women believe cesarean sections are dangerous for the baby and assert that several deaths and injuries to infants have occurred during such procedures (79). Part of the problem is the doctor's failure to give adequate medical information to their patients, or to engage in pre-treatment counseling and question-and-answer sessions. One refugee noted "doctors were only concerned with giving medication" (81) and did not provide any other information. A Refuge Egypt medical administrator disclosed that "most of the displaced women were not given prior notice or informed by the attending mid-wife of a possible Cesarean birth" (88-89). The lack of education regarding Cesarean section has sparked legends in which "the [doctors] remove the womb so that our women will never give birth" (Coker, *Dislocated Identity*, 415).

Social stigmas attached to certain medical conditions and a lack of basic health knowledge also contribute to the poor health care reported by refugees. Many Sudanese still understand medicine according to traditional beliefs and maintain that health is determined by an energy force that must be kept in equilibrium (44). Under this system, the spiritual roots of illness are very apparent, and causes of illness are understood as envy or other traits that negatively describe the sick individual (46). TB patients in particular are often stigmatized, and thus attempt to keep their illness secret from roommates and family members. The secrecy can have a negative impact on treatment, especially directly observed therapy (DOT), which requires that a doctor or another person observe the patient ingest medications (107). Medical professionals unaware of the social stigmas of disease may inadvertently harm the patient's likelihoods for survival by enlisting the aid of family and friends in the curative process. While many medical practitioners are aware of the confidential nature of AIDS and STDs testing, it is important that doctors also understand that in cultures where sickness is viewed as a punishment for a person's thoughts or actions sharing illness information that does not address the myths and misconception of disease etiology could have negative social and health effects for their patient.

The misinformation and lack of communication between medical personnel and refugee patients causes refugees to believe that the medical care they receive is sub-standard and discriminatory. One refugee stated "Receiving medical care can often become a degrading and humiliating experience" (65). Additionally, many refugees feel they get inadequate care because they do not understand the medical terminology used to describe their illnesses. This problem was especially severe among illiterate refugees

who felt totally powerless in the medical situation (66). Under these circumstances, it is likely that misdiagnosis and misunderstandings about how to take medicines will be commonplace.

In addition to feeling uncomfortable with this unfamiliar environment in Cairo, refugees also face financial barriers to health care. In spite of the promises suggested by the Four Freedoms agreement, Sudanese in Egypt are not eligible for any type of health insurance (61). For those not seeking recognition as official refugees, the primary options for low-cost health care are government hospitals, whose services are often considered inadequate and rife with linguistic and cultural barriers (25). Additionally some refugees reported being refused from hospitals when they could not pay their fees upfront. This has been a particular problem for pregnant women who have been turned away from hospitals during labor when they cannot pay the delivery fees. Others were frustrated by long wait times and commented that “they may lose a day’s work” (66) waiting for medical care.

For refugees who must choose between providing breakfast for their children and school transportation (58), spending money on accessing health care providers can be an unaffordable luxury. It is not surprising with all of the barriers to medical care that Sudanese refugees often self-medicate with remedies available from pharmacies or through traditional healing techniques. One woman reported using traditional healing techniques on her sick children because she could not afford missing work to take her children to the doctor. On previous occasions she had scheduled appointments, only to find there was no doctor present upon her arrival (81).

The combination of cultural, linguistic, and financial barriers to medical care can have an overall negative impact on refugee health in Cairo, as those who are sick may forgo proper treatment and rely on pharmacy “cures” or self-medication that do not contain their illnesses. In spite of many assertions to the contrary, it seems probably that most negative health experiences reported by refugees have more to do with poor communication than any harmful intentions of Egyptian doctors. One way of measuring this is to compare the refugee experience of medical care in Cairo with that of Egyptians. Problems found to affect both groups will be determined not by foreign or refugee status, but by difficulties endemic within the Egyptian medical system.

What are some problems faced by Egyptians when accessing Health Care in Egypt?

Although Egyptians do not face the same kinds of racial and linguistic barriers, their access to medical care in Cairo is subject to similar difficulties as faced by refugees. Egyptians seeking medical care in Cairo are also daunted by countless medical options, ranging from low-cost to extremely expensive options that provide strikingly disparate levels of care. Egyptians also complain of long wait times, difficulties reaching medical facilities in emergencies, low-quality care, and humiliating treatment. Anecdotes regarding organ-stealing and dishonest medical practices are also present in the Egyptian society, suggesting that the discomfort of receiving health care in Egypt is not only felt by refugees.

Egypt is currently in the process of implementing a multi-phase Health Sector Reform Program (HSRP). The program, launched in 1996 seeks to improve affordability, sustainability, quality, and satisfaction, and will provide universal coverage

in basic primary care and to support public health programs.³⁰ A 1998 article by Ismail Sallam further vindicates the health system in Egypt, noting substantial improvements in neonatal mortality, viral hepatitis, and the national death rate between 1981 and 1997. Sallam further asserts that 60% of health clinics in hospitals provide health services for free in cases of need and that any patient who is unable to pay for surgery is allowed to have it for free in specialized centers operating under a state-controlled program, though it is unclear how often this happens in practice.

While improvements, both realized and planned, in the Egyptian medical system should be applauded, the present reality of health facilities for Egyptians remains disheartening. Kandela (1998) notes that “for the ordinary person in Egypt, health care remains both inaccessible and chaotic.” A combination of unemployment and lack of health insurance create situations where individuals must appeal to the government and wealthy sponsors through newspaper advertisements in the hopes of receiving medical treatment (Kandela, 1998). While it may be true that health care is provided for free in some cases, Kandela suggests that this is only the case when individuals appeal to the Minister of Health for special considerations, a process that is likely to compromise efficient access to care. Financial problems do not only affect patients, but also frustrate medical staff. Nurses, whose jobs often carry negative cultural stereotypes³¹, receive pay as low as 300 LE³² a month in government hospitals and often are forced to supplement their salaries by requesting tips from patients (Kandela, 1998). Lack of supervision for doctors and nurses also contributes to professional corruption. Medical workers have

³⁰For more information see (Sallam, 1998) and (Egypt Household Health Service Utilization and Expenditure Survey, 2002).

³¹Nurses are often considered “women with loose morals”, according to Kandela.

³²Around 50 USD.

been reported to steal machinery and surgical instruments from government hospitals to resell or use in private practices. More disturbingly, Kandela reports incidents of unsupervised doctors using patients for surgical experimentation (Kandela, 1998).

Recently, the 2005 Conference on People's Health in Egypt mentioned a feeling of frustration among health care workers that they "give more than they take" and see public services as a burden, rather than a duty.³³ Lack of feedback and accountability was also mentioned as a major problem in the Egyptian medical system. Lack of salary and work benefits, combined with crowded work conditions and lack of resources are creating an environment in which medical professionals are dispassionate about their work and have little incentive to create good relationships with their patients. Dr. Alac Shukrallah called the situation in Egypt a "health crisis" and noted extreme forms of corruption among medical staff that lead to bad service and accusations of doctors "using patients as experimental animals" and "taking body parts from patients" to sell or use in private practices. Part of the problem may be blamed on the existence of privatized health care and government health centers as parallel systems in Egypt. The low salaries of government jobs, compared with higher pay in private practices, encourage government workers to moonlight in private practices and to steal equipment and drugs from the government.³⁴

The pluralistic nature of the health system in Egypt may engender more problems than benefits. Government facilities exist alongside private practices, and non-profit with for-profit organizations.³⁵ During the Mubarak administration, there has been a rise of

³³ This was mentioned in the conference by Professor Helmi El-Hadidi, Former Minister of Health.

³⁴ This idea was presented at the 2005 Conference by Professor David Sanders, University of the Western Cape.

³⁵ See Egypt Household Health Service Utilization and Expenditure Survey (2002).

religiously-based clinics as churches and mosques step in to fill the service gap left by the government (Roushdy, 1990). While these providers usually have a very high-ranking according to patient satisfaction, their existence could arguably provide the government with a convenient way of avoiding its health service responsibilities.

The lack of communication between patients and health service providers, and the lack of government accountability mean that many public health problems are not addressed on a national level. Living conditions for most people in Cairo pose serious threats to their health due to causes that are part of government responsibility according to “developed” country models. Lack of housing for a growing population, lack of basic water sanitation, pollution, and poor or nonexistent trash collection all contribute to poor personal hygiene and environmental threats to health. Hopkins notes the effects of pollution and garbage on people in Cairo and the discomfort felt by locals in making complaints to the government (Hopkins, 2003). Lead, particulate matter, and microbiological diseases are mentioned as some of the leading causes of illness in Egypt, and 78.1% of Cairenes think that air pollution strongly affects their health in negative ways (Hopkins, 22). Despite the discontent with environmental conditions in Egypt, only 7.8% blame the government for not addressing the issue and only 3.9% have ever made complaints to the government (24-26). As Hopkins noted, Egyptians “feel overwhelmed and unable to effect their situation”(27).

The Egypt Household Health Service Utilization and Expenditure Survey of 2002 found several problems faced by Egyptians seeking health care and health maintenance. Significant differences between health provision and environmental conditions were noted between upper and lower Egypt, and it was recorded that over 70% of the

population in lower Egypt had unfavorable housing conditions (18) and 73.7% do not seek health care when they are ill (59). Reasons given for not seeking medical care included the cost, low quality of services, including “humiliation”, long waiting times, misdiagnosis, geographical inaccessibility of health centers, shortage of doctors, lack of time, and the choice of self-medication. The survey found that 32% of those interviewed always chose to self-medicate during an illness, using pharmacies or personal remedies for their care (59). A similar percentage of individuals with chronic illnesses also self-medicated, with 40.2% explaining that they did so because of the lack of affordability of professional care (60).

While 77% of Egyptians are covered by health insurance, the majority of this group is made up of children who receive school health insurance and new borns who receive specialized insurance from the government for the first years of life (63). As nearly half of Egypt’s population is made up of school age children (0-19 years old), it is not surprising that the percentage of people with health insurance appears remarkably high (11). This percentage will shift as the children age, however, although maintenance of the current trends in population growth may maintain the appearances of high-levels of coverage. Of those who are not covered, only 46% are willing to be insured (68) largely because of an unwillingness to pay premiums. While premiums in Egypt range from 6.7 LE a year for school health insurance to 92 LE a year for syndicate health insurance, uninsured Egyptian adults set 8 LE as the premium they would be willing to pay on average (67-68). Currently the majority of health care expenditures come out of the household budgets, with annual expenditures among the lower-income classes ranging between 123-188 LE a year per capita (81). Interestingly, individuals with no

formal education spent the most on health care, with yearly expenditures in the lowest income bracket reaching nearly 300 LE per capita (80). On average, a single health care experience can cost 11 LE for doctor's fees, 31 LE for medications, and 6 LE for transportation. The expenses can be overwhelming for 44% of those surveyed who choose not to take prescribed medicines because of their high cost (89).

While those who can afford private clinics in Egypt seem satisfied with the care they receive, low-cost run by the Ministry of Health received low marks from patients (99). While many patients complained about poor services, 89% perceived their health status as the same as others in their age group or better. This is surprising given the health complaints and difficult living conditions of many Egyptians. Zagloul (2001) notes a general trend of the poor in Egypt to be less satisfied with health care (83) and Osman (1998) notes that 13% of Egyptian children under 5 are severely stunted (105), so the apparent level of contentment with health status seems confusing. Khattab (1999) explains that many Egyptians, especially among the poor and uneducated, tend to see chronic diseases as part of their natures (14), and would thus not consider their health in terms of "better" or "worse" than others, but view ill health as a function of human mortality. This seemingly defeatist or fatalistic approach to health behavior, coupled with the relatively high quality of health care received by high income Egyptians may combine to inflate the percentages of positive personal health status views.

In addition to statistical data which suggests Egyptians as a population may not be happy with the quality of government medical care, there have also been personal reports of the dangers posed by poor health services in Egypt. According to one source, the traffic problems on Egyptian streets increase the likelihood of death in emergency

situations. This possibility was exemplified by an old man who died in an ambulance after waiting for over six hours in traffic while the motorcade of a high-ranking political figure passed through a downtown area.³⁶ The poor efficiency and neglect on the part of emergency medical staff has also been the cause of death for some Egyptians. One father recounted the death of his daughter in the following way:

“I had a phone call to tell me that my daughter had had an accident. It took more than half an hour to locate her at Kasr El-Aini hospital. She was lying unconscious in a pool of blood on a trolley. A man in jeans was standing beside her holding a bottle of intravenous solution. He told me he had to do this because there were not stands to hold the bottles. An assistant professor then examined her with his cigarette ash everywhere. He asked for oxygen but was told they did not have any, so I asked for her to be transferred to another hospital. She died a couple of days later” (Kandela, 123).

Are refugees integrated?

While refugees and local Cairenes may continue to view each other with hostility, it appears that within the context of access to medical care the two groups share equal frustration with the structural insufficiencies of Egypt’s health system. While Egyptians do not experience the same kinds of social barriers as refugees, both groups express similar frustrations over the lack of efficiency and competence of health professionals, difficulty in accessing medical care, high costs of care, and unhealthy environmental conditions. While many refugees attribute poor treatment and long wait times in medical facilities to racially-based discrimination on the part of Egyptian medical staff, it seems in many ways they suffer no more than poor Egyptians.

Social barriers to care, including perceptions by refugees that Egyptians do not “understand” them, have been re-enforced by the practices of both the Egyptian government and by the UNHCR. According to Shafie (2004) “the Egyptian government...does not publicly address the refugee issue” (34-35) and when the

³⁶ Personal communication with the author.

government does consider refugees it “opposes the suggestion of integration of refugees into Egyptian society and the presence of refugees is seen as temporary until they get resettled in a third country” (17). The lack of public knowledge surrounding refugee issues translates into hostility, largely based upon the perception that refugees are the source of unemployment and negative behaviors, such as prostitution. Portrayals of refugees in Egyptian media often reinforce such perceptions (35). More disturbing are the negative influences on Egyptian perceptions of refugees created by UNHCR. One advertisement campaign at the UNHCR Cairo office “portrayed refugees in a refugee camp and asked for donations to provide refugees with tents”(35). This fundraising policy separates local images of “refugees” from the actual refugee population living in urban centers like Cairo and encourages the perception that Africans in Cairo are illegal migrants here to take Egyptian jobs. Public support for initiatives such as the January 2003 operation “Track Down Blacks”, which arrested hundreds of refugees and foreigners in Maadi (35), is just one symptom of hostilities and lack of understanding on the part of many Egyptians.

Apart from clear disadvantages and negative stereotypes faced by refugees in Cairo, many of their frustrations arise from systemic problems with Cairo’s infrastructure. Issues such as poor standard of living, inadequate garbage collection, pollution, traffic, crowded clinics and long wait times, and poor treatment of patients by medical staff can be blamed more on mismanagement of the state than on the ill-will of Egyptians towards foreigners. Unless the HSRP makes gallant strides in the coming years, it is unlikely that Egypt’s structural problems will be solved anytime soon. While both nationals and refugees do have some options, in terms of religiously-based or NGO

sponsored health care programs, opportunities for good quality care at low cost will remain an impossibility for those who can not benefit from nongovernmental service providers. For many refugees, as well as Egyptians, these structural problems cannot be solved.

Conclusions and Recommendations:

While it is clear the many problems with health care in Egypt affect refugees and economically disadvantaged nationals equally, and may not be easily addressed, a review of the literature suggests some small steps that could be taken to improve the situation, albeit minimally, for all involved. Recommendations include 1) improving the Refugee Yellow Pages/establishing a center for information updates and distribution, 2) launching health education programs that seek to disseminate accurate information regarding wellness and disease, and 3) encouraging greater communication/coordination between medical service providers in Cairo. While many of these are not new ideas, and some are already beginning to occur, the suggestions require some elaboration.

1) The medical section of the Refugee Yellow Pages is a potentially valuable source of information, but more effort must be done to make refugees and service providers aware of its existence. In addition to calling attention to the resource, work must be done to update the pages regularly to chart policy changes, prices, and contact information in coordination with information maintained by service providers. The webpage should also include a map and simple directions to each location so refugees and NGOs can easily locate services. Ideally, the web page should also display user reviews of medical services, including both positive and negative commentary on refugee

experiences, which could be used to construct an assessment of facilities in terms of waiting areas, medicine availability, cleanliness, record-keeping, and child-friendliness.³⁷

In 1991 Anita Fabos developed The Counsellor's Handbook of Resources for Refugees and Displaced Persons and mentioned the need to establish a permanent resource center to update the handbook each year (Ismail, 6). While the handbook was turned into a more accessible online tool, a suggestion made by Ismail in 2001, no resource center was established for the purpose of keeping entries up to date. I reiterate the need for such a center and suggest that center workers should not only update information about service providers, but should work with local doctors and NGOs to provide health updates, a message board where reviews of medical clinics could be posted, and should establish a general information posting on health risks in Egypt and how to best avoid them.

2) Education initiatives should be undertaken for refugees, service providers, and humanitarian workers to touch upon issues of refugee health experiences in Egypt and problems with the Egyptian system in general. Refugees should understand that many of their frustrations regarding the medical system in Egypt are experiences by nationals as well, and that some of their negative impressions of Egyptian doctors may be more related to structural problems in the medical system than to racially-based hostilities. Service providers, especially doctors and nurses, should receive some training in refugee health issues, including misunderstandings due to different health perceptions, the social stigmas of illness among some refugee communities, issues surrounding somatic complaints and how best to address them, and the difficulties faced by refugees in accessing services in Egypt. Refugees should be involved in a dialogue with Egyptian

³⁷ See *Save the Children*, 2004, p. 74 for an example of this.

health professionals to design a brief training program that will address the concerns of all parties. Humanitarian workers should not only receive information regarding the situation of health care in Egypt for nationals and refugees, but should also receive training regarding somatic illnesses, social stigmas of illness, different health behaviors among different cultures, and issues affecting their own health and effectiveness, such as stress-management.

3) Better communication should be a goal for all service providers in order to increase opportunities for networking and burden-sharing. Non-governmental service providers should organize and pressure the government to increase its commitment to health services for refugees and nationals. Service providers should also make themselves open to feedback from refugees to help them improve the quality of care, both in terms of doctor-refugee relationships and the effectiveness of health advice.

While many of these recommendations may be thought of as wishes, even dreams, rather than projects that can realistically be implemented, it would be defeatist to consider all as such. In spite of the real difficulties in making improvements within the existing structure, many current initiatives address some of the issues discussed in the paper. Ismail's recommendation in his 2001 paper helped to establish the Refugee Yellow Pages, and projects undertaken at present by Refuge Egypt in Arba wa Nuss to improve the relationship between Egyptians and Sudanese have already begun to produce positive results. The establishment of a large health center in Arba wa Nuss, with funds donated in part from the American actress Angelina Jolie³⁸, is representative of what could be accomplished from cooperation between service providers.³⁹ I hope that the

³⁸ See coverage at <http://www.angie-jolie.com/unhcr/unhcr301203.html>.

³⁹ The Arba wa Nuss project was sponsored by both Refuge Egypt and the Coptic churches.

suggestions in this paper will continue the momentum of positive change for the benefit of Egyptians as well as refugees.

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