

**The American University in Cairo**

**HIV Services for Refugees in Egypt**

*An Evaluative study*

**A Thesis Submitted by**

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**To**

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## **Abstract**

Refugees are a higher risk population for HIV infection due to the absence of proper medical attention and socioeconomic stability during flight and at the country of asylum. Cairo is home to refugees from high conflict regions where sexual violence is prevalent, thus calling for a strong HIV focused care program. This study IS a small scale evaluation of the HIV and AIDS services targeting refugees' in Cairo at Refuge-Egypt's VCT clinic. This evaluation aims to assess refugees' access to preventive methods, testing services as well as the integration within the Egyptian national services.

This study takes a qualitative approach to evaluate HIV and AIDS services available to refugees in Cairo. I collected primary data using in-depth interviews to navigate through informant's personal experiences with Refuge-Egypt medical services and the HIV program in particular. I employed the concepts of comparison and scanning for a full apprehension of refugees' experience with the program. The study uses indicators developed by the UNHCR to assess HIV/AIDS services targeting refugees, I opted to use this set of indicators to compare implementation activities to aspired polices in relation to the Egyptian national program to create a holistic view for the current situation.

This research highlights the challenges that face refugees' willingness to receive HIV and AIDS related services including HIV clinic's location, refugees' knowledge of the program in addition to social and medical stigma associated with HIV and AIDS. The findings provide a holistic image of HIV as a medical concern as well a social phenomenon. Informants' feedback on the medical program in Refuge-Egypt suggested a number of issues that affects their ability to access health services at the clinic. The clinic's physical location in Zamalek Island is a highlighted limitation for refugees' ability to receive services they need. The language is another concern that informants express as most of the workers at the clinic speak Arabic or English, which exclude a good percentage of the refugee population in Cairo. This study shows that refugee-focused HIV and AIDS services are integrated with the national program on the policy level however, implementation is restricted by various socioeconomic deterrants that excludes refugees from national services whether due to the poor nature of such services or refugees' self-exclusion.

## Chapter 1

### Introduction

#### **1.1. Refugees and HIV**

AIDS is surrounded by three *S*'s in Egypt, "Shame, silence and stigma"  
Kozman, Catholic Relief Services.

HIV, one of the most deadly epidemics in our world today claiming two million lives annually (WHO, 2010), is transmitted primarily through infected blood. HIV was diagnosed in the 1980s and the majority of the new infections are in underdeveloped countries in Asia and Africa (UNAIDS, 2007). Factors that increase the risk of infection include unprotected sex and using contaminated piercing tools, which explains high infection rates in poor countries where dire socioeconomic conditions influence individuals' access to quality healthcare.

Conflict induced displacement entails conditions where basic health care is not accessible and sexual violations are a fact of daily life. For refugees and asylum seekers HIV is a daily risk. In camps situations as well as urban settings, HIV is not given priority of medical attention despite the immediate hazard due to the long incubation period. Though refugees were included in the high-risk groups in 2005, UNAIDS does not include refugee population in indicators' reports on par with other

groups<sup>1</sup>. It is noticeable that most of the refugee population is concentrated in underdeveloped countries, where health care systems are burdened by nationals' needs. Therefore, call for further attention to study refugees' access to HIV related services is crucial. Though the Middle East is considered a low-prevalence area for HIV, the United Nations estimates that 380,000 people in the region are infected. According to the U.N., 25,000 people died of the disease in 2007. Egypt has recorded 2,500 cases based on testing; of these, 1,600 people are still living. The U.N. estimates that the true number of infected Egyptians is 9,000 (CRS, 2009).

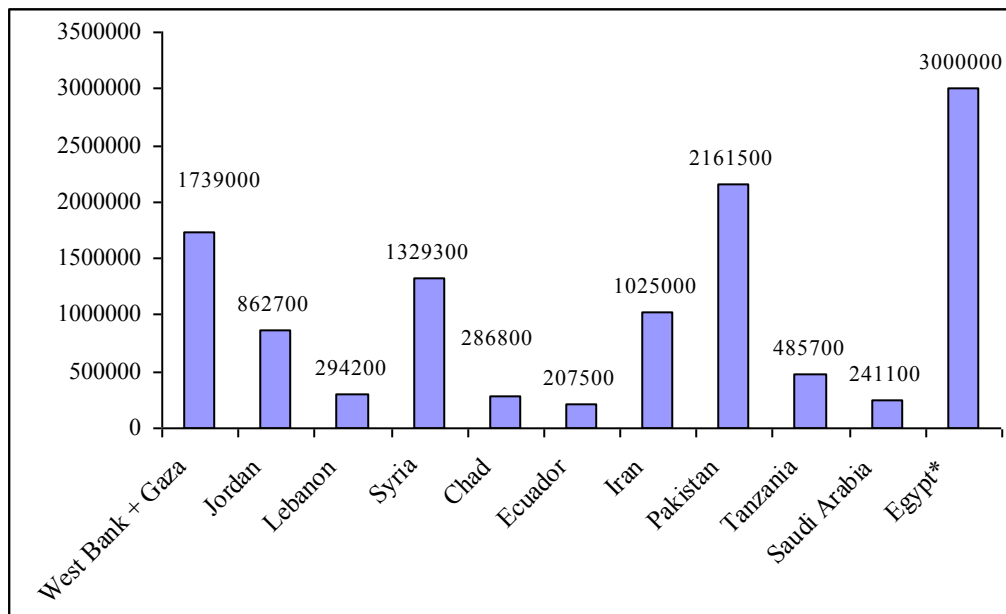


Figure 1.1 Number of refugees to host country populations, 2006

Source: Source: USCR (2007), *World Refugee Survey*

\* Approximate

<sup>1</sup> See UNIAD's most recent report in 2008, where refugees are highlighted as risk group yet are not included in indicators' charts.

Egypt is a state where nationals have the right to free education and health care yet the quality and availability of state supported care systems are poor in general. Suffice to say that 14.7% of Egyptian children between the age of 6 and 18 have never joined education or dropped out before finishing secondary education which makes the 66% literacy rate reasonable (UNDP, 2009).

Refugees have no hope to integrate in Egypt regardless of the time they spend in Egypt. A good example is the long standing Palestinian refugee population. Egypt is host to 50,000 Palestinian refugees the majority of which are 1967 refugees from Gaza and the West Bank. While the UNRWA is not functioning in Cairo, the UNHCR does not provide protection to Palestinians in Cairo. Therefore, they face security as well as legal challenges as the Egyptian government prevents them from legally integrating (Ishtay). Generally, refugees in Cairo are dependant on UNHCR's support system. UNHCR's implementing partners Caritas and Refuge-Egypt offer partial health care and educational support (Yoshikawa, 2007). At the same time, the UN refugee agency is promoting self reliance and informal local integration so that refugees become independent from organizational support (Sperl, 2001). There is reluctance among the policy makers and civil society to pay required heed to issues related to the population groups such as MSM, FSWs, and IDUs. Egypt receives millions of tourists, in addition refugees from countries with high HIV prevalence and illicit drug use rates. There are persistent stigmatization of HIV/AIDS in the society like Egypt and a lack of effective STI/HIV/AIDS education programs and other preventive measures. These circumstances warrant deeper understanding in the dynamics of refugee and HIV in Egypt.



## 1.2. Refugee Status and Protection

The Convention Relating to the Status of Refugees (here after the 1951 Refugee Convention) is the key treaty to define both the term refugee and member states' commitment towards refugee population<sup>2</sup>.

Worth further brief exploration is the term “protection”. According to 1951 Refugee Convention, protection is not limited to protection from deportation but is extended to secure refugees' access to and enjoyment of social as well as economic rights. In articles, 23, 22 and 17 the 1951 convention requires signatory states to provide access to public relief, education and gainful employment. These three sets of rights crystallize protection as a measure reaching beyond guaranteeing physical safety alone – “protection” should fundamentally assure human safety, security and dignity.

The 1951 Refugee Convention did not mention the right to health separately, but this study builds on the assumption that healthcare is implicit in the rights to social security. The Article 24 - *Labour legislation and social security*, in its paragraph (b) *Social security* explicitly mentions maternity, sickness, and disability in a list of

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<sup>2</sup> The 1951 Geneva Convention defines a refugee as a person who “owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it” art. 1(2)

contingencies that should be covered by a social security scheme to which refugees should have an access.

It should be further taken in consideration that the right to health is confirmed through various human rights treaties. In article 24, the Declaration of Human Rights grants the right to adequate health care. International Covenant on Economic, Social and Cultural Rights goes further to demand the right to the “highest attainable standard of physical and mental health<sup>1</sup>.” This right is further confirmed through special groups-focused treaties like migrant workers, women and children. These bodies of human rights treaties do not only confirm access to health care as an integral part of human dignity and a basic human right but also an essential component to protection.

For the purpose of this study refugee status is a legal condition as acknowledged by the UNHCR based on the definitions provided in the 1951 Geneva Convention and on the 1969 Organization of African Unity (OAU) Convention. To be able to evaluate program design it is important to use the same definition used by the UNHCR being the definition used in program design as well as internal evaluations to ensure inclusion in UNHCR’s services. I chose to exclude failed asylum seekers and Palestinian refugees to limit the scope of the study to Persons of Concern to the UNHCR (PoC).

Egypt is known for legal protection of refugees, allowing legal assistance to refugees in prison and cooperation with UNHCR’s regional Cairo office nevertheless the government is very reluctant to allow for an economic and social integration of refugees through full legal integration (Sperl, 2001). Egypt made reservation on

refugees' access to social security and relief when it ratified the Refugee Convention. Presumably, the intention has been to protect and reserve the scarce resources and services for Egyptian nationals.

Having pointed out the reservations of Egypt to the Refugee Convention, it must be however also stressed that according to the national law 239 of 1997 foreigners have the right to access public hospitals<sup>3</sup>. Thus, it might be argued that in access to healthcare, although not in other aspects of social protection, the refugees are in the same situation as the Egyptian citizens seeking state supported services<sup>4</sup>.

What is the actual situation, whether and how are refugees integrated into the public healthcare program is a question that merits further research. This particular study focuses on one facet of the refugee experience HIV/AIDS prevention and access to assistance in Cairo.

It has been argued by researchers and policy actors alike that Egyptian Government does not see Egypt as a country where refugees should settle and locally integrate but rather as a transit country where refugees would be protected from the immediate danger and through the assistance of international agencies either repatriate back to the country of origin once the conflict ends or be resettled into another (third) country (Shafie, 2004). Indeed, Egypt never fully assumed responsibility for the refugees: In

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<sup>3</sup> For more information on the Health care options available for refugees please refer to Appendix I

<sup>4</sup> Egyptians who do not have medical insurance through social security, or an adequate private income, face the hardship of securing the needed resources to address chronic illnesses. Nationals who cannot afford quality medical services, are forced to seek medication in under equipped and overworked public hospitals (UNDP, 2005)

1954<sup>5</sup> , Egypt delegated Refugee Status Determination (RSD) as well as socioeconomic services to the UNHCR.

### **1.3. HIV a medical condition with social implications**

HIV/AIDS is a medical condition like many other blood borne and Sexually Transmitted Infections (STI). It can be argued that the fatal nature of the infection is the reason for this attention but this argument can be defeated by the simple fact that other fatal infections are not given the same attention one of them is Hepatitis C that drains developing countries' resources<sup>6</sup>. Another argument is that HIV and AIDS are associated with certain behaviors which are often frowned upon and/or criminalized in many societies. This argument frames HIV as a social/ethical concern rather than a medical one. In such manner it explains the stigma and social pressure associated with HIV. Academic studies indicate that social factors at play are the major reasons for the negative attitudes associated with HIV and AIDS (Devine, Plant & Harrison, 1999; Block, 2009). Stereotypes about HIV transmission plague many countries in the Middle East, and Egypt is no exception. Evidences are not scarce that many people

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<sup>5</sup> Please refer to Egypt's agreement with the UNHCR in Appendix II

<sup>6</sup> According to the WHO, developing states have higher Hepatitis prevalence rates than developed states. Egypt has the highest Hepatitis C infection prevalence in the world.

lose their jobs when the HIV positive status has become known. Evidence is not scarce that surgeons often refuse to operate upon HIV positive patients

This study is concerned with the factors affecting refugees' access to HIV and AIDS related services rather than the development of HIV/AIDS related medical research. I analyze the socioeconomic dynamics influencing refugees' decision to seek HIV and AIDS relating services.

#### **1.4. Rationale and Significance of the Study**

This study compares the progress of a HIV program targeting refugees in Cairo with the targets set by the UNHCR and the Egyptian national HIV/AIDS plan of action. This research studies the HIV/AIDS support program managed by Refugee-Egypt, a UNHCR implementing partner, which offers Anti Retroviral treatment (ART) and Voluntary Counseling and Testing services (VCT).

Academic studies do not address HIV/AIDS services targeting the refugee population in Egypt. Despite the abundance of academic literature targeting social and legal aspects of refugee's life in Egypt, medical services especially HIV services have not been given sufficient attention.

The issue of HIV and AIDS services targeting refugees came to my attention during my work at Africa and Middle East Refugee Assistance (AMERA-Egypt), where I

encountered a number of HIV positive cases and touched their daily challenges. As a psychosocial worker, I worked closely with the UNHCR's implementing partners to secure medical services for these individuals. At the same time, my involvement with the refugee community in Cairo gave me the insight on refugees' access to health care in general and the relation with the Egyptian community. The study assessment takes a qualitative form, attempting to analyze the existing policies, in-field implementation activities, and their impact in direct relation to service recipients.

### **1.5. The Objective of the study**

The objective of this thesis is to study the HIV and AIDS services targeting refugees in Egypt. The study aims to find out the factors affecting refugees' willingness to access HIV and AIDS services and to existent out reach efforts. This evaluation study combines targeted audience's feedback and policies to reach a true image of the current program. HIV and AIDS services targeting refugees in Egypt is a blind spot in the academic studies that has not been addressed before. Through this study I want to reach a realistic view of the services provided in comparison to the United Nations' refugee agency (UNHCR) HIV and AIDS polices.

This research attempts to identify the strengths and potential weaknesses in the HIV and AIDS refugee-focused program at Refuge-Egypt. This study will address a much-needed concern in the field of rights based advocacy. It will examine the current plan of action and the policies implemented to offer an insight based on refugees' day-to-day experiences.

I start the study with the hypothesis that both the religious affiliation and the physical location of the programs present major challenges to refugees' access to services in addition to the existing tension between refugees and the national medical system. This hypothesis is based on my professional experience and the academic knowledge gained through my study at the CMRS.

## **1.6. Organization of the Thesis**

The second chapter discusses the methodology I used to conduct my research. I offer a background on evaluative studies as a tool to measure programs' progress and various manners in which they can be used. Then I talk about data gathering and data analysis. In this study I used two sources for data, desk research and primary data collected through one-on-one in-depth interviews. I also discuss the tools I used to analyze primary data.

The third chapter analyzes available academic and organizational literature on HIV/AIDS in the Middle East and Africa in relation to forced displacement. I use organizational and academic reports to establish the risk of HIV infection during the all phases of refugees' flight from their country of origin to the country of asylum. Then I discuss refugees' inclusion in national public health care and HIV prevention and treatment in Egypt. In chapter four, I talk about policies framework and the development of HIV policies in Egypt in the light of national health care system and Egypt's commitment to international policies. I also discuss other parties at play especially NGOs and international agencies involved in the services provision and policies mapping in relation to refugee population in Cairo. Chapter five is the evaluation's outcome. I use the UNHCR's set of goals and indicators to compare Egyptian National policies, Refuge-Egypt's implantation activities and refugees' feedback on the services. I also identify a number of challenges that limits refugees' access to services in general and HIV/AIDS in particular.



## **Chapter 2**

### **Methodology**

This evaluation is based on service recipients' responses to services within the framework of the goals established in UNHCR's strategic plan for HIV and AIDS. All Saints Cathedral is home to Refuge-Egypt, a UNHCR implementing partner for asylum seekers. The HIV/AIDS program at Refuge-Egypt is a recent development in a refugee-focused healthcare system. Though the testing program is running for six years, the VCT program is less than one-year old.

This chapter focuses on the methodological background of the study. The principal aim of the assessment is to find out the challenges and difficulties faced by HIV positive refugees in their pursuit of medical attention as well as other non-medical services including social support.

Evaluative studies are a form of qualitative studies. They aim to judge ongoing programs to measure the subjective impact and the progress of a program. Usually, program targets are set by policy makers while planning for the program. These targets represent the vision adopted by policy makers to achieve their goals to start a program. Once the program is introduced, it creates a change in their lives through the services offered. This change is the impact of the program. It can be either identical to the targets drawn by program's designer or different from it. Hence, the need for ongoing evaluation arises to address and analyze both the targets and the impact in relation to

the objectives of the service provided and its recipients to assess the development and progress of the program.

One approach to health program evaluation is empowerment evaluation. It focuses on service recipients' personal voices (Secret, Jordan, & Ford, 1999). David M. Fetterman introduced it as a method to “help people help themselves” and it aims to improve programs through community involvement in program design and process development. An external evaluator coaches the evaluation to help stakeholders to recognize gaps. Program workers and beneficiaries discuss the strategic plan and implementation efforts. Thus, clients are given a sense of ownership and a space to be heard. Fetterman argues that empowerment evaluation is most helpful in programs targeting minorities and isolated groups (Fetterman, 1994). Empowerment evaluation seems to be the best approach in the case of refugees-focused programs in Cairo. However, it demands program administrators' involvement and openness to the outsider evaluator, which is a lacking condition in the case of academic research. In my experience, program administrators are too busy to meet with researchers regardless of the research topic hence the hardship to implement this approach.

Case study qualitative research methodology is another approach that I considered for this study. Though not meant for evaluation, this approach allows the researchers to reach an understanding of an unexplored phenomenon based on contextual observations (Jack & Baxter, 2008). Case study qualitative research is limited to the study and explanation of one issue; based on the findings of this study I can use this methodology for future research to understand the HIV testing decision-making process.

For my current study, I considered the following: I need to reach a full understanding of the program through a matrix of issues. Further, I need to understand the policies and their objectives that shaped the design of the current program. Finally, I need to understand whether and how the program works for its target group: the asylum seekers and refugees.

## **2.1. Primary Data**

Qualitative research methodologies give the researcher the space and the freedom to explore the field through informants' narratives and personal experiences. I collected primary data, using in-depth interviews. My objective had been to hear informants' personal experiences, assuming that sharing informants' narratives offers them a sense of empowerment and voice of their own; therefore, guaranteeing a personalized medical experience. My practical first hand experience gives me insight into the inner dynamics controlling the relation between refugees and service providers.

I collected data from interviews with service providers to understand their perspective on current policies on HIV/AIDS and their translation into practice in Egypt. On the level of service recipients and audience targeted for the outreach activities, I conducted in depth interviews with refugees to better understand the recipients' personal experience in receiving HIV related information and medical care.

I interviewed medical workers using semi-structured interviews to know the execution of the plans of action. I made sure to suspend my judgment throughout the interview especially when informants express personal opinions on high-risk population. I interviewed three doctors.

I divided members of the refugee community into two groups. The first group is for refugees who receive medical services from Refuge-Egypt, this group consisted of 8 refugees. I interviewed five community focal points at AMERA- Egypt, who advocate for refugees medical and social rights. They are two Somalis, one Eritrean, one Amharic Ethiopian and one Oromo Ethiopian. I chose to interview these individuals due to their close contact with the refugee community including refugees living with HIV. All informants meet the minimal age of 21 years old to assure their full understanding of legal rights as adults.

Before the start of the interview, I secured oral consent of the interviewee. Before doing so, I read a statement to explain the study and the need for the interviews in the context of academic integrity<sup>7</sup>.

I used an audio recording device to store the data. It is crucial to the study that informants feel safe and uninterrupted during the interview considering the type of issues that will be discussed.

## **2.2. Data Analysis**

A set of indicators is employed to scale the data collected in the field. Overall, the UNHCR has a list of seven goals related to refugees-focused HIV and AIDS services, which are set to guide program design and sustainability of HIV interventions within

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<sup>7</sup> The statement illustrates clearly that the informant can refuse to answer any of the questions or withdraw from the interview at any point at their convenience. All interviews were held in secure conditions and informants' identities are protected through using codes, unmarked files in a separate electronic saving unit (an external hard drive) in an encrypted folder. The real identity (names, nationality and ethnic group) of the participants' will be kept separate from other data used for the study. I did not ask informants to sign a consent form to protect their anonymity hence they all will be above 21 years old.

the refugee community and the host population. These goals are designed for a UNHCR long-term plan of action of 2008 to 2012, with interim assessment after 2009. These strategic goals cover all areas of care and protection concerning HIV and AIDS service provision in addition the well being of HIV positive refugees in the host community. I will use the most relevant selection of these goals and corresponding strategies as indicators against which I compared and analyzed the policy and practice of HIV-related prevention and assistance to refugees in Egypt. To assess the existing policy responses, I primarily use Egypt's National HIV/AIDS and STI Surveillance Plan to identify the national health policies and areas of attention.

Data is induced from informants' contribution to research process through the interviews conducted (Mills, Bonner & Francis, 2006). Therefore, it gives informants an empowered independent voice to contribute to the body of knowledge.

Data induction in the grounded theory approach depends on on-going comparison between interviewees in one stage then comparing findings and interpretations. Comparison gives the researcher a three dimensional perspective that involves not only one informant's understanding of the research question but also involves a second opinion as provided by other informants and the researcher herself. Therefore, create a cognitive matrix that maps the relation between all involved parties and in a result a holistic portrait of the issue of concern (Mills et al., 2006; Scott & Howell, 2008).

In my work with data, I utilized two elements from the grounded theory; comparison and identifying core indicators to analyze informants' narrative. After collecting data, I scanned it for recurrent themes and took notes while comparing data sources and

contexts. Careful scanning for thematic codes enables the theory to formulate in a comprehensive manner. This understanding is based on interrelations among patterns and thematic groups (Bowen, 2006; Kelle, 2005). The process of scanning and coding allowed me to place refugees' narratives in the center of the evaluation process on which the outcome stems.

### **2.3. Challenges**

To contact refugees living with HIV I worked on three levels; first I recruited 4 research assistants from three refugee communities; one Sudanese and two Amharic Ethiopians and one Oromo Ethiopian to locate informants. Through Africa and Middle East Refugee Assistance (AMERA-Egypt) AMERA- Egypt I found one HIV positive client who was willing to be interviewed. However, his medical conditions were getting worse; I was not able to talk to him anymore. I found out later from a community connection that the informant preferred to return to his country of origin to be with his family and to receive better medical treatment away from the stigma and the limited medical services in Cairo.

The research methodology plan was approved by the Internal Review Board (IRB) of the American University in Cairo. The IRB however had concerns about the interview process and informants' selection. Thus, I had to reformulate the interviewing process to include a recoded consent form instead of a written one to protect informants' identities. Interviews were conducted in AMERA's office, in a private room.

I usually took ten to fifteen minutes before the start of the interview to create a safe space for the informants, in many cases acknowledging the hardship of living in Cairo

and providing some advice on resources facilitated the interviewing process. Throughout informants' recruitment and interviews, I have, to my best knowledge, adhered to academic integrity and ethical standards.

## **Chapter 3**

### **Literature Review**

This chapter reviews available organizational reports and academic literature to discuss the prevalence rate of HIV among forcibly displaced population and the high risk of infection due to the nature of flight. The literature review focuses on refugees as a vulnerable group, with a particular focus on urban refugees as a largely neglected group within international mapping by UNHCR and strategic planning in the host community by governments. Special attention is paid to the discussion of social stigma and the general conception of certain high-risk populations as members of “immoral” groups facing various social and cultural challenges.

#### **3.1. HIV/AIDS Prevalence and Population Movement in the Region**

Currently there is an estimate of 33.4 million persons living with the HIV infection globally (Rawley, 2009). Sub-Saharan Africa represents the highest HIV/AIDS prevalence in the world with 67% of the world’s people living with HIV more than 50% of them are women (UNAIDS, 2006). In 2006, the number of new infections among adults and children in sub-Saharan Africa is 50% of the world’s prevalence with 2.8 newly infected individuals. This percentage explains the increase in the



numbers of people living with HIV despite the rise in the numbers of deaths. The increase in deaths can be attributed to lack of Antiretroviral Therapy (ART)<sup>8</sup>.

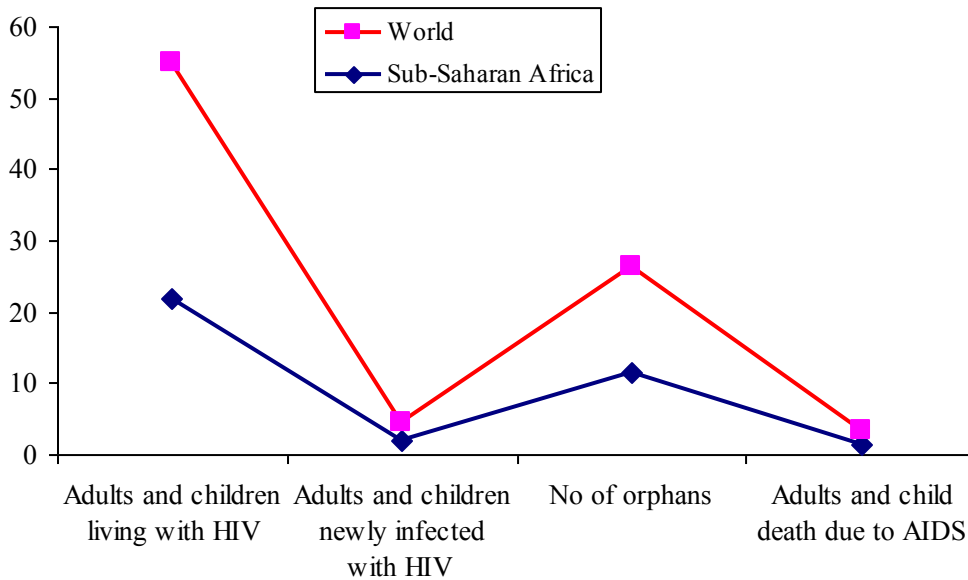


Figure 3.1. HIV/AIDS Sub-Saharan Africa versus World 2009 (in million)

Source: The World Bank. HIV/AIDS - HIV/AIDS Regional Update - Africa. Web. 27 Nov 2009. \*15 years old, \*\*15-49

The number of AIDS deaths dropped from 2.1 million in 2006 to 1.5 million in 2009 despite in the decrease in the number of adults living with HIV by 2.7 million. The decrease in mortality rates can be explained by the progress of ART treatment. Unlike Sub-Saharan Africa, there is an absence of accurate statistics on HIV in North Africa, leading to a vague vision of the overall situation.

<sup>8</sup> ART is the only available treatment for HIV, it is meant to keep the number of viruses to the minimal while boosting one's immunity level. The treatment consists of three types of antiretroviral drugs (ARV).

Table 3.1. Sub-Saharan Africa vs. Middle East and North Africa (millions)

<b>Region</b>	People receiving ART,*	People needing ART	ART Coverage (%)	People receiving ART**	People needing ART**	Art coverage ** (%)
Sub-Saharan Africa	2.9	6.7	44	2.1	6.4	33
Middle East and North Africa	0.01	0.068	14	0.007	0.063	11

Source: The World Bank. HIV/AIDS - HIV/AIDS Regional Update - Africa. Web. 27 Nov 2009. \*Dec. 2008; \*\* Dec 2007

Despite the low infection numbers given by Middle Eastern States, experts believe that there are high chances for an HIV/AIDS epidemic in the Middle East (Sufian, 2004). Governments tend to dismiss investing in HIV interventions relying on the "low rates" of infection, ignoring scanning at-risk groups as well as other preventive measures.

The context of the MENA's population structure means that impact will not be limited to a medical condition on individuals' level but will result in strong economic dysfunction. Much-ignored factors in HIV prevalence in the MENA region include unemployment and the increase in youth in the demographic balance. Low rates of prevalence can be deceiving in case of low testing rates. The case of the MENA is a good example with 0.3% regional prevalence. The World Bank acknowledges the economic hazards of a potential HIV epidemic in the MENA region if further prevention methods are not taken. Despite the low prevalence rate recorded, four interrelated risk factors present in the region discredit these rates. There is an increase in the number of youth combined with low employment rates and poverty while on the other hand, there is a prevalence of sexually transmitted infections and low reported

condom use. These factors collectively pose a high potential for the infections' transmission from high-risk behavioral groups to the general public (World Bank, 2005).

The constant prevalence of internal conflict and war in the region is a push factor for the forced displacement of people from sub-Saharan Africa to MENA. Increasing numbers of refugees use Morocco, Libya and Egypt illegally to cross the Mediterranean to Europe (de Haas, 2005). There are 21 million documented migrants in the region (UN-Habitat, 2000) this number does not include undocumented asylum seekers who wish to escape persecution in their country of origin. While the MENA region is considered a low prevalence region with the estimate of 1.8% prevalence among adults (UNAIDS, 2006). However, being a destination as well as a passageway for migrants en route to Europe, it is difficult to keep track of population movement within and from the MENA region, as many displaced individuals are undocumented.

The number of people living with HIV in forced displacement situations is estimated to be 20.8 million. Four million infected persons of concern to the UNHCR live in sub-Saharan Africa alone (UNHCR, 2007). Forced displaced populations represent 59.9% of the population movement in the MENA region (World Bank, 2005) thus increasing the risks of infection due to the nature of the forced displacement in addition to the absence of adequate testing services upon entry. There is a gap in information regarding refugee's access to HIV<sup>9</sup> treatment and the prevalence rates within the displaced population. UNHCR acknowledges the hardship of including

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<sup>9</sup> Refugees are not one of the reported groups in UNAIDS' reports, see UNAIDS brief for the MENA Region, 2007.

refugees and IDPs in countries' HIV/AIDS national plans to praise refugees' "innovative" methods to gain access to ART (UNHCR, 2007).

### **3.2. Refugees as one of the HIV infection vulnerable groups**

The majority of the infected persons of concern to UNHCR are located in the Global South in medium to low income countries, where access to ARV treatment is limited by nationals-focused public health systems (WHO, 2008). In many cases refugees have to struggle further restricted by their stigmatization and self-exclusion from the host communities. The reasons for and the nature of forced displacement is a strong challenge to correctly assessing HIV/AIDS prevalence rates.

*Sexual and gender based violence* as a major risk factor: The high prevalence of sexual violence and sexual coercion is one of the major causes of HIV infections in sub-Saharan Africa. Rape is widely used as a weapon of war as well as opportunistic sexual violence in post conflict situations as seen in various situations, as documented in the DRC, Burundi, the Darfurian conflict, Liberia and Cote d'Ivoire. This explains the higher proportion of women living with HIV in comparison to men in sub-Saharan Africa (Buss, 2009). The systematic use of rape in warfare increases the threat of HIV infection especially in high prevalence countries (De Lary & Klot, 2007). UNAIDS is becoming invested in refugees and migrant-focused programs due to the "large numbers of migrants and mobile people (refugees included)." Such individuals' high risk of infection has 'far-reaching consequences' (UNAIDS, 2001). However, this attention is focused mainly on refuge camps and is not extended to refugees living in urban settings (UNAIDS, 1997). The UNAIDS' "Refugees and AIDS," a document

that defines the scope of UNAID's effort with the refugee population, refers to refugees in refugee camps and makes no mention of urban populations.

***Long incubation periods*** as a contributing factor of HIV's long incubation period delays preventive interventions (UNAIDS, 2003). Which explains international NGOs disregarding the immediate danger of HIV infection during the process of forced displacement despite the high risk of sexual violence amongst displaced people.

***The loss of traditional support of social networks:*** During flight refugees are detached from their families and their social network. Emotional, social and physical insecurity places victims of forced displacement in a situation of disfranchisement. This situation forces families to resort to "unconventional" methods to reach basic needs. Women are coerced to trade sex for protection and food either during the flight or in the country of asylum (Piot, 2001). These conditions increase the chances of exposure of various STIs and blood borne infections including HIV.

***The loss of income and sexual coercion:*** As in most developing countries, heterosexual sex is the principal mode of transmission within Sub-Saharan Africa and the Middle East (French et al., 2006). The conditions of forced displacement and the absence of traditional support networks force individuals to trade sex for income or protection, thus placing them at a higher risk of HIV infection.

In principle refugees leave their country of origin to seek international protection from persecution, in many cases such individuals are not able to cross international borders via legal means due to restrictions imposed by the country of origin of visa requirement from the receiving state. To escape persecution, many asylum seekers pay

smugglers to facilitate crossing international borders (Morison and Crosland, 2001). Hence, they face high risk of being trafficked to sexual enslavement.

### **3.3. Vulnerability in the context of asylum country**

Relation between HIV and mobility is complex and far more interwoven with factors of social network support, socioeconomic status and HIV prevalence in the host state (IOM, 2002).

***Social exclusion:*** In the context of Egypt, refugees face a considerable amount of pressure when seeking health care, employment as well as accessing other socioeconomic rights. These pressures are rooted in xenophobia AND racism as much as self exclusion. On one hand, there is a stressful relation with the host community and on the other there is refugees' wish to maintain their private space to ensure personal empowerment. SOME refugees refuse to enroll their children in Egyptian schools or use public hospitals in fear of racism as well as children adopting an "Egyptian" identity.

***Stigma:*** Stigma is a social process by which individuals are discriminated against because of their behavior, race, gender, or any social practice that is seen as deviant in their community. Stigma reduces one's social role and acceptance therefore stigmatized individuals or groups are excluded from mainstream activities and duties as expected from individuals of equal status due to "deviance" (Goffman, 1963). Stigma, as a collective social marker, serves three functions in the relation between the community and the stigmatized individual (group) to protect the collective perceived

identity of the community. In relation to racial discrimination, stigma is used to dominate (*keeping people down*); while in the case of deviant behaviours stigma is used to enforce traditions (*keeping people in*); and in the case of disabilities and illnesses stigma is used for physical protection (*keeping people away*) (Phelan, Link, & Dovidio, 2008).

The influence of stigma varies in relation to individual's socio-economic status, which explains the role of class and social affluence with respect to exposure to stigma. In the case of refugees, social stigma can be seen within a framework of various other social factors including labeling, stereotyping, power structures and culture. The most highlighted form of stigma is that against deviation from "moral" values. The collective consciousness guards strictly traditional norms and values from those who represent a threat to the status quo, hence the exclusion and ostracization endured by refugees<sup>10</sup> (Person, Bartholomew, Gyapong, Addiss & van den Borne, 2009).

Stigma associated with HIV is recognized to be the hardest form of social isolation as it involves a mixture of shame, contempt and anger not only towards HIV positive people but also to people linked to the illness. High HIV prevalence differs in its conception from one community to the other. Block (2009) argues that a community

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<sup>10</sup> Stigma is not only imposing on the "other", some forms of stigma are self-imposed. In Van Brakel's article on HIV related stigma (2006), he categorizes five types of stigma; enacted stigma, perceived (or felt) stigma and self (or internalized) stigma, discrimination and attitudes towards the affected people. While negative attitudes and discrimination can be present in the work place, health care services and the public space, enacted stigma is rather present within one's community (family). Perceived stigma and self-stigma are enforced by one's fear of others' forms of stigma thus limit access to services to avoid potential stigma.

judges a person living with HIV based on the way they were infected. Religious communities see HIV/AIDS, as a divine punishment for a sinful act be it homosexuality or drug abuse. HIV stigma is used to protect the morality of the society in ways of the community's sense of righteousness and core values (Devine, Plant, & Harrison, 1999) hence the isolation facing high risk groups and marginalized communities (refugees). Devine et al argue that media and educational material that focuses (labels) high risk groups are to blame for creating such a collective identity for people living with HIV. Even the use of categories like "high-risk groups" not only link HIV with "immoral/high risk activities" but also stigmatize members of such groups regardless of their HIV status.

In reaction to this collective shame loaded attitudes, individuals living with HIV construct an "HIV" identity where the individual embraces the negative aspects implied by stigma "I am HIV" . Self-exclusion from the community and services is rooted in self-stigma. Members of high-risk group are reluctant to be tested due to fear of further stigma. The test result is not only an indicator for a medical conditions but rather a confirmation to "sinful life style" they are leading. Delay in testing extends to receiving services related to HIV including counseling and protection methods. Fear of disclosing one's positive HIV status is an obstruction to reaching out to HIV positive individuals who avoid seeking medical care. One argument to overcome the fear of stigma is to offer anonymous testing services to encourage individuals to seek help. However, the anonymity of the testing might hinder further care (Chesney & Smith, 1999).



HIV/AIDS positive refugees are subject to social, economic and security challenges. Since the 1980s, when HIV/AIDS was first diagnosed, it became associated with “immoral” social behaviors like drug users, sex workers and homosexuals. At the same time, these practices are criminalized in many countries (Giri, 2007).

A growing number of the refugee population in Africa find their way to urban centers, some coming directly from international borders while others escape refugee camps. Despite the increasing numbers of urban refugees, many succeed in staying hidden on the margins of cities (Sommers, 2000). Unlike refugees residing in camps, reception centers or in formal settlements, urban refugees are not the center of service providers and funding agencies’ attention. Urban refugees face the challenges of job hunting and livelihood sustainability in addition to their fragile legal status. Urban refugees remain marginalized on a policy level due to the self-reliance approach adopted in the UNHCR Urban refugees’ policy (Landau, 2004). Mobility and lack of documentation are not the only factors that raise challenges in documenting the prevalence of HIV in the MENA region. The stigma surrounding HIV as an illness brought from countries of immoral sexual behaviors limits testing and prevention interventions in the region. The majority Muslim region witnessed resistance to high-risk populations’ interventions. All Middle East countries screen blood donors and some test all individuals seeking health care in hospital, as in the case of Saudi Arabia however, high-risk populations are not particularly targeted for services due to the stigma associated with high-risk activities (Obermeyer, 2006).

### **3.4. The urban refugees in Egypt**

Egypt hosts 112,605 persons of concern to the UNHCR (UNHCR, 2009). This population puts Egypt among the highest five countries hosting urban refugees in the developing world. <sup>11</sup>Considering the conditions of the Egyptian economy and public services, putting emphasis on self-reliance and local integration will only increase refugees' isolation and motivation for irregular movement to reach social security. The Egyptian government is generous in addressing refugees' protection needs nonetheless, other socio economic rights are not equally addressed, particularly access to employment (Sperl, 2001)

Refugees are the “outsiders” who present a threat to the collective sense of identity hence excluding refugees (the racially/ ethnically different) from the community (van Brake, 2006). This dehumanization of refugees extends to policy makers who choose to design programs and interventions without consultation with the refugee community. The social stigma is seen in political, social and economic exclusion from the mainstream Egyptian services provision both at the legal and societal levels (Grabska, 2006). One can argue that enacted stigma on policymaking and implementation levels create a double burden on the refugee population in Egypt. This combines with self-stigma to prevent individuals from accessing social support services and medical treatment.

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<sup>11</sup> Self-reliance policies aims to encourage refugees to develop independent means to support themselves away from the UNHCR's support system.

Elizabeth Coker (2004) draws attention to issues of trust, power relation, and misinformation in the relation between refugees and the medical establishment. These issues as well as identity formation in exile plays an influential role in the relation with the host community and the legal establishments i.e. Egyptian state and UNHCR (Al-Sharmani, 2006).

The refugee population in Egypt has limited access to medical services due to lack of information, mismanagement of medical establishments and refugees' fear of mistreatment and abuse. The research argues that refugees are subject to the same maltreatment and limited resources as poor disadvantaged nationals, yet the refugees' situation is worse due to social misconceptions, racism, and inadequate access to information (Eidenier, 2005).

Many young refugees in Cairo believe that HIV virus is transmitted through kissing, sharing a cup or toilet seat. However, sharing a syringe and mother-to-child transmutation are not perceived as method of infection. Some sex workers reported that asking a client to use a condom implies that they are “dirty” while many of the participants did not know how to use a condom (Coker et al, 2003). Some medical workers did not recognize vaginal secretion and semen as routes of HIV transmission (Adebajo et al, 2006).

### **3.5. Refugees in Public healthcare and HIV treatment in Egypt**

With less than 0.1% HIV prevalence rate, international organizations consider Egypt a low prevalence country. However, this information can not be trusted due to the gaps in the surveillance system (IMPACT/Egypt, 2007).

Sandy Sufian compares Egypt's HIV programs to the other Arab states in the region. She argues that Egypt does not offer effective prevention measures other than the HIV advice hotline, which is a weak preventative method without the support of on ground campaigns and information sessions for the at-risk groups (Sufian, 2004).

In the Egyptian context, though, refugees are theoretically integrated within the national medical system. They have limited access to healthcare rights. The work of Coker, Grabska and Al-Sharmani support the notion that a set of socioeconomic factors determine refugees' ability and willingness to receive health care from an Egyptian establishment. Issues of trust and agency come first due to the racial tension between refugees and the host community. The Egyptian government is "generous" regarding legal protection despite its "fundamental unwillingness" to allow refugees' local integration and nationalization. Despite Egypt's cooperative attitude on the policy level with UNHCR's Cairo office in regards to access to refugees in person and case referral, the state is determined on keeping refugees within the premises of temporal measures. This "guest" status limits refugees' ability to enjoy livelihood and social stability (Sperl, 2001).

The MENA's place as a passageway for migrants and refugee alike offers a fertile space for migration and refugee studies that remains unexplored especially on access to healthcare. The wide spread of conflict-induced sexual violence in sub-Saharan Africa is well documented however often ignored in refugee-focused programs planning and advocacy. The relation between individuals' readiness to access HIV testing services and stigma is yet to be confirmed in the Middle Eastern context. The work of Chesney et al. and van Berkel hypothesize that the social and moral stigmas hinder individuals' willingness to seek HIV services. Within the refugee population social isolation, distrust of Egyptian medical establishments as well as legal insecurity are established through academic research however it is not inclusive of medical stigma of contagious infections like HIV, hepatitis C or renal failure.

## **Chapter 4**

### **Policy Framework and Actors Involved**

#### **4.1. The system of public health in Egypt**

The Ministry of Health and Population (MoHP) is the governing body for health services provision for the public sector facilities as well as the private practices. The MoHP plans and executes health care programs in cooperation with international organizations like the WHO, the UN agency for women and Children (UNICEF) and the UNAIDS. This cooperation takes shape on the policy level as well as the implementation level as the case with UNAIDS' consultation on the HIV and AIDS services in Egypt.

Since the establishment of the republic in the early 1950s, Egypt adopted welfare policies aiming to address social and economic inequalities and to provide universal access to health care and education. However, this vision became hard to implement due to Egypt's economic status. The system failed the very people it aimed to support, poor people working in the informal economy especially in agriculture and manual labor, were dependant on the welfare system. The current status of the system leaves them no choice but to seek private options for quality health care and education (UNDP & The Egyptian Institute for Planning, 2005).

Egypt stands at the 123<sup>rd</sup> rank in the global human development index in a list of 182 countries and holds the 103 rank on the gross domestic product (GDP) per capita in a list of 181 countries (UNDP, 2009). These economic and developmental indicators not only confirm Egypt's status as a developing economy.

Egyptians who do not have medical insurance or an adequate income face the hardship of securing the needed resources address chronic illnesses. Nationals who cannot afford quality medical services, are forced to seek medication in under equipped and overworked public hospitals. The UNDP Human Development Report for 2008 recognizes the important role of community services organizations or local NGOs that provide medical services for minimal fees. According to the UNDP such organizations supplement the needed health care provision. Nonetheless, NGOs have to expand their services to reach better coverage. The following chart shows the types of health care available in Egypt.

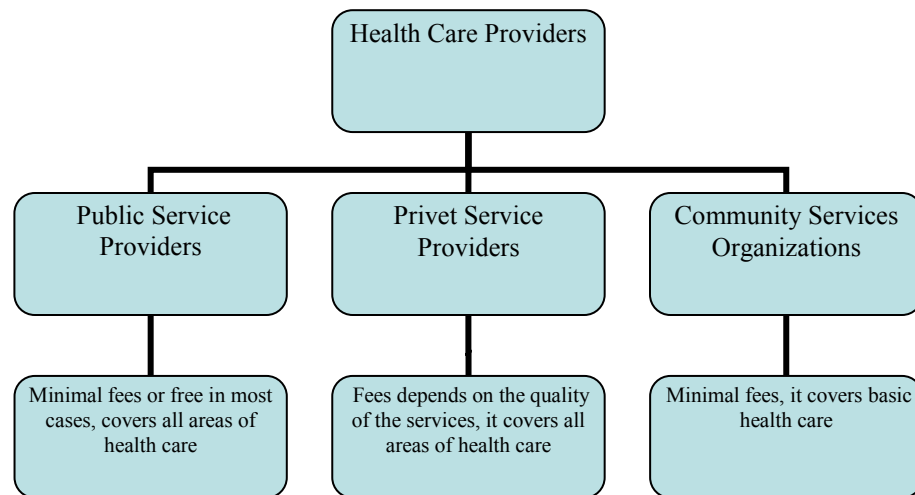


Figure 4.1: Health Care Types

As illustrated, the national health system in Egypt is overwhelmed by the national overpopulation; hence, there is no space to integrate non-citizens into the system.

Under Egyptian domestic law, government hospitals and clinics are open to nationals and foreigners equally "at minimal fees that could not be altered by hospital physicians or staff" (Eidnier, 2005). This generous provision allows non-citizens equal access to medical services; nevertheless, the conditions of the Egyptian health system itself are obstacles to reach this resolution. As Eidenier (2005) concludes, "the national health system [in Egypt] is already operating beyond its capacity and attention to refugee needs is overshadowed by a shortage in health facilities for citizens." Poor medical facilities are not the only reason failed-asylum seekers do not integrate fully into the Egyptian national health care system. There is the factor of distrust between the medical facilities and failed asylum seekers, such distrust is enhanced by rumors of organs theft, children theft and fears that doctors will harm them on purpose.

As for private clinics and hospitals, high quality medical treatment is rather expensive, especially for major surgical operations, especially cancer related treatments and organ transplants. While cheaper alternatives are available on the private sector, quality wise, it is on the same level as state hospitals. The third type of medical establishments is religious based charity clinics. These clinics are more expensive than government facilities; nonetheless, they offer comparatively better treatment, due to the charity funding they enjoy. Egyptian religious-based charities offer a range of medical services depending of the funding. They also refer their patients to government hospitals or hospitals within their network. Due to the charity nature of these establishments, they can fund partially or fully the necessary medical procedure. However, some of these organizations limit their services to their religious base (Muslims/Chirstian). As seen above, failed asylum seekers have restricted access to



health care services due to the hardship of the livelihood conditions and the overwhelmed Egyptian medical system.

#### **4.2. HIV Public Health Policy and National HIV Program**

In 1986, Egypt started a HIV testing service that was limited to testing without medical treatment. Under this program, nationals seeking employment abroad and foreigners seeking “formal” employment in Egypt are required to attach negative HIV test result to their employment documents. Blood donors are also tested for HIV. In its early phase, the program did not include off site testing. Testing services were only available through the Ministry of Health Central Laboratories (MOHCL). This program did not include refugees in its plans. Foreigners, including refugees and asylum seekers, who tested positive for HIV were deported from Egypt. At this time, many HIV positive refugees were resettled to other countries.

In 2004 Egypt started its first voluntary counseling and testing (VCT) program. The outreach plans designed with IMPACT/Egypt program targets needle users and street children. The IMPACT/Egypt team used the ABC approach<sup>12</sup> “Abstinence, Being faithful, and using Condoms” to educate Intravenous Drug Users (IDU) on HIV. According to a 2007 IMPACT/Egypt report, abstinence is introduced as the first preventive measure, followed by commitment to one partner and if clients fail to follow that, they are offered advice on using condoms. The report states that 35,592 condoms were distributed to VCT clients, IDUs and clients seeking help for Sexually

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<sup>12</sup> The ABC approach highlights abstinence as a preventive method in the first place, then keeping to one partner (being faithful) thus leaving protected sex to be the least advertised protection. This approach ignores safe sex as a method of protection and blood transmission as a route of infection.

Transmitted Infections (STI) during the project period between 1999 and 2007. This is a promising number however; the report does not document usage rates and changes in risky behaviors.

In 2001, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) was held to discuss the impact of epidemic. Upon this session, the UNGASS set five goals to reduce infection rates and to curb the impact of HIV/AIDS. These goals focus on prevention information availability, limiting mother to child transmission, ARV treatment availability, increase the efforts to find a cure/vaccine for HIV and to provide special care for HIV orphans (UNGASS, 2001). A more recent UNAIDS number estimates that 209 persons received antiretroviral treatment in December 2007 while 2,200 individuals were denied access to treatment (WHO, 2008). These UN numbers did not specify if the entire populations residing in Egypt including refugees and illegal migrants.

The most widely reported routes of transmission in Egypt are mainly unprotected sex (both homosexual and heterosexual) and needle drug users. In addition to such acknowledged modes of infection renal dialyses comes in with 19% of Egyptians living with HIV (MoHP et al., 2005). Commercial sex workers are a hidden community due to the criminal nature of “selling sex” in the Egyptian legal system. Hence, limiting their access to adequate education on Sexually Transmitted Diseases

(STD) and preventive methods despite the active market for commercial sex (IRIN, 2006)<sup>13</sup>.

Men who have sex with men are ostracized by their community and targeted by the Egyptian government. The police detain openly homosexual men under the accusation of “habitual practice of debauchery” and for being, suspect HIV positives. In detention, men are abused and tortured (HRW, 2008). Human rights reports criticize the Egyptian government for targeting homosexual men under the claim that they are HIV/AIDS positive (HRW, 2008; Scott, 2008). Needle drug users are another group involved in high-risk criminal activities however, the presence of three drop-in centers put them in a better situation in comparison to other high-risk groups.

Until 2004, refugees were not included in the NAP, which excludes them from further services offered through the UNAIDS initiatives for Egypt including ARV provision and social services. Despite this exclusion, HIV positive refugees are required to have their confirmatory test at the central laboratory of the Ministry of Health and report the result to the Egyptian government. There are 6 sites offering antiretroviral treatment to nationals as at 2007, in comparison to only one in 2005. The number of adults receiving antiretroviral treatment is less than 500 persons (UNAIDS, 2008). These

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<sup>13</sup> For more on commercial sex workers access to HIV prevention programs please refer to Souad Orhans’ thesis on the topic, “Men Selling Sex In Cairo And Alexandria Perspectives On Male *Sex Work And Aids In Egypt*” submitted to the Department of Sociology, Anthropology, Psychology & Egyptology at the AUC in 2008.

numbers are not a definite estimate and require clarity, as it does not indicate if this number is of nationals only or includes non-citizens as well.

#### **4.3. Refuge-Egypt's Role in Service Provision**

The UNHCR funded HIV/AIDS refugee's program started in 2003, at Refuge Egypt clinic only for testing. Refuge-Egypt provides VCT services and ARV treatment. This encouraged the Sudanese Development Initiative (SUDIA) an NGO run by the refugees, to start a HIV/AIDS program. This program eventually stopped in response to donors' interest in needs-based assessments thus diverting funds to conduct assessments (Grabska, 2006). Therefore, All Saints clinic is the only HIV/AIDS service provider fully dedicated to the refugee population in Cairo. Since Refuge-Egypt started the testing program in 2003, 3,216 persons had the HIV test at their clinic and only 107 were found to be HIV-positive.

In June 2008, a pilot project started to dispense free antiretroviral treatment for a limited number of refugees at Refuge Egypt's clinic. The Refugee Egypt program offers HIV voluntary testing (VCT), social support for HIV-positive persons (microfinance and job placement), medical support and community outreach. It is hosted within the premises of All Saints Cathedral in the Zamalek Island.

## **Chapter 5**

### **Assessment outcome**

#### **5.1. Assessment Indicators selection**

The UNHCR recognizes health care as an integral part of protection as seen in its plans of action and interventions. The UNHCR has a long-term plan of action of 2008 to 2012 to address HIV and AIDS infection. The plan is scheduled for an interim assessment after 2009. This plan sets a list of seven goals to guide program design and sustainability of HIV interventions within the refugee community and the host population. These strategic goals cover all areas of care and protection concerning HIV and AIDS service provision.

In this section, I use indicators based on the UNHCR's goals to analyze the policy and practice of HIV-related service provision to refugees in Egypt. To assess the existing policy responses, I primarily use Egypt's National HIV/AIDS and STI Surveillance Plan in combination with Egypt's 2010 progress report to the UNGASS to generate an updated view of the national policies (see the following tables).

The first column of those tables has a list of UNHCR's set of indicators to evaluate the progress of a goal's implementation; the next column is represented by the Egyptian NAP (this column is based on Egypt's general policy towards refugees and HIV/AIDS to represent the state's side in service provision). The third column is for the actual practices implemented by the UNHCR's partner, the Refuge-Egypt. In the last column

is on refugees' narratives to provide a "first-hand" experience to measure the gap between policies and implementation.

## **5.2. Protection**

UNHCR provides legal status to persons who cannot "avail themselves to the protection of their country of origin" as stated in the 1951 Geneva Convention. However, the UN refugee agency is not an instrument of implementation. It is mandated to refugees' protection using advocacy on the policy level (UN High Commissioner for Refugees). In most cases, it is upon the host state to conduct the RSD interview and implement the 1951 Geneva Convention however, in some cases, as in the case of Egypt, a state delegates such duties to the UNHCR. In 1954 Egypt signed a protocol by which the government acknowledges the importance of the UN agency, promises to support its activities, and delegate all refugee related concerns to the UN agency<sup>14</sup>.

The Refugee Convention secures multidimensional protection to refugees not exclusive to legal protection. It establishes refugees' access to primary education, health care and social security on par with nationals or most favored aliens. Egypt made reservations to the rights to employment, health care, education and rationing. These reservations remain enacted; however, Egypt's ratification for later human

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<sup>14</sup> See Appendix II "Agreement Between The Egyptian Government And The United Nations High Commissioner For Refugees" 1954.

rights agreements and treaties gave access to some basic rights<sup>15</sup>. The right to health care is a basic human right that is confirmed by other human rights treaties that Egypt ratified like the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, both treaties confirm the right to health care to the “best attainable level” (Yamin, 2005). Yet legal tools are not the sole ground on which individuals access rights. In the Egyptian context, a matrix of socioeconomic issues limits refugees’ access to health care within the national system<sup>16</sup>.

UNHCR’s protection mandate is inclusive to health care as an integral part on individuals’ security and well being and basic human rights. The HIV and AIDS strategic plan defines protection in relation to HIV’s prevention, treatment, care and support programs. Egyptian government is “generous” regarding legal protection however Egypt’s “fundamental unwillingness” to allow refugees’ local integration and nationalization keeps refugees within the premises of temporal measures. This “guest” status limits refugees’ ability to enjoy livelihood and social stability (Sperl, 2001).

Before 2008, when the ART program started at Refuge-Egypt, HIV positive refugees were promoted for resettlement to a third country based on their medical condition and the absence of the treatment in Egypt. This is an internal UNHCR policy, hence the

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<sup>15</sup> Egypt’s ratification to the African Child Charter allowed refugee-children access to primary education on par with nationals and other treaties like the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights assured a wider access to socio economic rights.

<sup>16</sup> See Appendix I for the factor affecting refugees’ access to health care.

lack on information on the number of refugees resettled on HIV-related medical grounds or the countries which received such cases.

Unlike other foreigners, refugees are not subject to deportation based on their HIV status. Egypt does not enforce HIV testing upon admission on refugees and asylum seekers. Though refugees are eligible to receive ART on the same level as Egyptians, they are limited to one VCT center in comparison to 23 for nationals, nine of which are mobile units (NAP, 2010). The national HIV plan is inclusive of sexually transmitted infection within the VCT clinics.

Protection is defined in terms of legal protection and access to treatment. There are no reports of Egypt deporting refugees based on their health status. At the same time, there are rumors within the refugee community of refugees repatriating to seek medical treatment and social support. As for access to treatment, while ART is free treatment, the majority of the refugees I interviewed have to commute for at least an hour to reach the clinic and spend an average of 10 to 15 LE on transportation<sup>17</sup>.

Table 5.1: Protection Evaluation

<b>UNHCR indicators</b>	<b>Policy (NAP/national law)</b>	<b>Practice</b>	<b>Refugee Experience</b>
Protection from mandatory testing	No such policy	No such practice	Many refugees were not aware of the service availability in the first place
Access to ART on the same level as nationals	Service is available for refugees free of charge same as Egyptians	One ART center versus 23 centers for nationals	Reports of community members repatriate to the country of origin to seek treatment

<sup>17</sup> The Clinic is located in the Zamalek Island, it is not accessible by most public transportations.



HIV status of an asylum seeker does not constitute a par to accessing asylum procedure , nor constitute grounds for refoulement	UNHCR is the apparatus conducting and deciding on RSD interviews	Irrelevant to RSD process	No reports of the topic
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### 5.3. Coordination among the UN bodies and the Egyptian government

UNHCR’s coordination with other UN bodies should maximize the engagement for the benefit of the refugee population. UNAIDS, national efforts on HIV and AIDS is in itself a joint program of UN agencies including the International Labor Organization and the UNICEF this diversity of collaborating agencies is an acknowledgement of HIV’s wide impact. This indicator aims to measure the coordination and integration of refugees HIV and AIDS services on three levels a) UN agencies, b) National policies and c) international efforts.

UNHCR works closely with the World Health Organization (WHO) in providing VCT services for refugees. This cooperation resulted in “Policy Statement on HIV Testing and Counseling in Health Facilities for Refugees, Internally Displaced Persons and other Persons of Concern to UNHCR” with the purpose of enhancing and supporting VCT services for the refugee population. In the Egyptian context, UNHCR and UNAIDS advocated for the inclusion of refugees in the national policy and the

Egyptian funding proposal to the Global Fund through which ART became available for the refugee community in Egypt<sup>18</sup>.

Though refugees were not included in the 2004 HIV Surveillance plan, they were integrated into the testing service. The start of the ART services in 2008 marked refugees' integration within the national plan of action through the cooperation between the NAP and UNAIDS and UNHCR. Refugees are integrated on two levels of service provision testing and treatment. Testing wise, refugees are included in the national VCT scheme. They receive free of charge rapid testing at the VCT unit in Refuge-Egypt and the confirmatory test the Ministry of Health central laboratory on same level as nationals<sup>19</sup>.

It is important to notice that the UNHCR and UNAIDS has succeeded in integration HIV and AIDS refugees' VCT and ART services into Egypt's plan of action and services provision; however, limiting these services to one site might affect the impact of the program for accessibility reasons. As for AIDS related medical concerns refugees are referred to the two public hospitals of ElAbassya and the Embaba where they receive services free of charge. However, issues of distrust and racism in addition to lack of information present a negative influence on refugees' access to medical services through the nation system (Coker; Grabska; Popinchalk).

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<sup>18</sup> For more information see Egypt's inclusion of refugees in the proposal to Global Fund, submitted 2006, [http://www.theglobalfund.org/grantdocuments/6EGYH\\_1310\\_638\\_full.pdf](http://www.theglobalfund.org/grantdocuments/6EGYH_1310_638_full.pdf)

<sup>19</sup> Informal interview with Dr. Ehab Abdelrahman the head of the Egyptian NAP.

Table 5.2: Coordination and Integration

UNHCR indicators	Policy (NAP/national law)	Practice	Refugee Experience
Policies integration	Included in VCT as well as ART services	Limited to one site	Accessibility challenges that jeopardizes the implementation of the policy
Inclusion in donor proposal	Refugees were included in the funding proposal to the Global Fund.	Free VCT and ART services for refugees through Refuge-Egypt and hospitalization in public hospitals	Social stigma and racism limit refugees' readability to access national medical services.
Advocate to ensure inclusion of refugees and IDPs in HIV National HIV/AIDS Strategic Plans	Refugees are included in the NAP's strategic plan	There are 22 spaces for ART therapy for refugees (only 9 are in use)	Refugees are unaware of the service
Ensure that PoCs are included into participatory assessments and age, gender and diversity analysis as part of HCR's operations management cycle	Egypt did not conduct such assessment on the national level yet for the "HIV/AIDS Biological & Behavioral Surveillance survey", refugees were not included.		

#### 5.4. Prevention

The aim of this goal is to curb HIV's infection rates and morbidity among the refugees population. The community's feedback is much needed on information dissemination methodology and availability of preventive methods. The UNHCR supported program at Refuge-Egypt does not plan information sessions<sup>20</sup> or provide information materials through the VCT center. Informants from the clients' groups did not know about the VCT service despite their frequent visits to Refuge-Egypt for medical as well as other purposes that indicate a deficiency in prevention methods. Despite the availability of information posters in UNHCR's implementing partners' clinics<sup>21</sup>, refugees from the clients' group suggested that the posters and booklets are the least helpful communication tools.

Currently, Refuge-Egypt does not conduct HIV-focused outreach sessions in fear of social stigma, which prevents information session on HIV and AIDS. During the registration process, social workers do not explain available services to their clients. The interview does not include an orientation section to educate refugees on services provided through All Saints whether medical or social. One interpreter indicated "They don't explain about the services provided through all saints, that is what AMERA does" thus denying refugees information on VCT services. Nonetheless, in some cases

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<sup>20</sup> Refuge-Egypt used to conduct information session at schools, CBOs and within Youth Mentorship at All Saints Cathedral however this tradition stopped in 2009. Currently, outreach sessions are not planned but offered per demand from the community.

<sup>21</sup> Both Caritas and Refuge-Egypt clinics have a number of HIV awareness posters in various languages.

clients are told to come back to register for clothes or food packages if the social workers “feels” the client is in need.

Refuge-Egypt is fundraising for an HIV prevention program focused on female sex workers. The primary goals of the program are to provide an alternative income generating activity for refugee women involved in prostitution. The UNHCR focal point is advocating for this project to be included in the quick response program through the UNDP. This program is designed to target commercial sex workers, thus excluding their clients and women in coercive sexual relations<sup>22</sup>.

One important limitation to VCT services is refugees’ legal concern of deportation. Due to the lack of information, the refugee communities are unaware of the special protection they enjoy against deportation. According to community, focus points, many refugees worry they will be deported if found HIV positive, such concern needs to be addressed in special information sessions and upon registration with the UNHCR office.

According to these strategic indicators, HIV is treated primarily as an STI hence disregarding other modes of transmission. In the Egyptian context, cumulatively 29% of the documented HIV infected cases were through nonsexual activities<sup>23</sup>. Medical research in the 1990s warned against renal dialysis being a dangerous route of infection causing 65% of the documented HIV positive cases in Egypt in 1991(Hassan et al.). In 2010, renal dialysis remains a considerable route of infection with 8.9% of

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<sup>22</sup> The program is designed to relocate “women at risk/ sex workers” to provide them with vocational training and alternate income generating activities.

<sup>23</sup> According to the percentage of modes of transmission in Egypt, IDU 4.6%, mother to child 1.8%, blood/blood 5%, renal dialysis 8.9% and 8.7% remain for unknown reasons(NAP-Egypt).

the overall documented HIV positive cases in Egypt (NAP-Egypt). Ignoring blood a route of infection does not only limit much needed efforts and resources to the field of STI but also confirm the social stigma associated with HIV and AIDS.

Table 5.3: Prevention

UNHCR indicators	Policy (NAP/national law)	Practice	Refugee Experience
Ensure that UNHCR's PoC have access to cultural appropriate HIV information materials on prevention and treatment in a language and format they can understand	Refugees are not included in the outreach activities or prevention programs conducted by the NAP	There are posters in various languages hanging in Refuge-Egypt and Caritas	In the absence of interpersonal communication, posters remain ineffective
Ensure access to programs for prevention and treatment of STIs	Blood donors are scanned for HIV and STI	Condoms are distributed only through family planning clinics	No record of STI focused activities outside family planning programs except for the rape response program
Increase access VCT for UNHCR's PoCs.		Only "low profile" one VCT site	Legal concerns and location limit accessibility.
Ensure establishment of linkages between the HIV, STI and TB programs.	These programs are not linked within the national plan	No established link between the TB and HIV programs	HIV positive refugees who suffer from TB are usually referred to Embaba hospital
Increase HIV prevention education and access to condoms, harm reduction, STI and VCT services for most at risk populations amongst UNHCR's PoCs		Refuge-Egypt is using the ABC approach  no special program for most at risk population	Social stigma and legal fears limit members of high risk population from coming forward to seek services
Increase access to Prevention of Mother to Child Transmission programs for UNHCR's PoCs	Prenatal HIV testing is in the initial phase on the national level	All pregnant women who receive prenatal care through Refuge-Egypt are tested for HIV	

Ensure post exposure prophylaxis is available to all survivors of rape amongst UNHCR's PoCs	This service is not included in the national plan	STI services available in family planning clinic	
Ensure access to male and female Condoms	limited dissemination for condoms among high risk groups	Condoms are available only for married couples through the family planning clinic	Men who have sex with men, sex workers and un married couples are excluded from this service

### 5.5. Care, Support and Treatment

Refugees are eligible to the same medical treatment as Egyptians. Within HIV related health care, refugees are seen as a high-risk group together with street children<sup>24</sup> this status supports their access to all available medical services. However, in practice refugees are limited to one fixed ART site (Refuge-Egypt) unlike nationals who receive VCT services at 24 sites and ART from six distribution sites in five governorates.

As for opportunistic infections, refugees are referred to national hospitals, the Embaba hospital for TB and chest infection and elAbassya hospitals for immunity related infections. The nature of medical treatment and the relation between refugees and nationals receiving the same medical treatment is unexplored. The immunity diseases unit at elAbassya hospital is an isolated ward in a separate building away from the main compound. Patients are kept in studio-like rooms with a bathroom<sup>25</sup>, fridge and a washing machine. This setting is uncommon within Egyptian hospitals. It is arguable that these arrangements enforce patients' feelings of isolation and self-exclusion.

<sup>24</sup> See Egypt's proposal to the Global Fund

<sup>25</sup> Personal visit in 2007.

Primary data, suggested that refugees living with HIV feel reluctant to seek treatment at Embaba hospital and elAbassya hospital because “people go there to die<sup>26</sup>”.

This goal is fulfilled on the policy level however on the implementation level, there are a wide of range of limitations that hinder refugees’ integration within the national services.

Table 5.4: Care Support and Treatment

UNHCR indicators	Policy (NAP/national law)	Practice	Refugee Experience
Provide treatment for opportunistic infections for People Living with HIV who are POCs for UNHCR	Refugees are integrated in the national scheme	Refuge-Egypt refers refugees to Embaba and ElAbassya hospitals	Limited by feelings of distrust between refugees and national health care
Ensure PLHIV have access to supplementary feeding programs	The national program does not include providing nutrition packages	HIV positive refugees receive food packages from Refuge-Egypt once/month	The long commute and transport expenses limit this service
Ensure that UNHCR’s PoCs have access to ART at level similar to that of the surrounding population	ART is available to refugees on par with nationals	ART is available through Refuge-Egypt	Nationals receive ART through 24 VCT centers while refugees receive it from one site

## 5.6. Durable Solutions

Durable solutions being the term used to solutions meant to end refugees’ legal dependency on the protection system. The UNHCR supports three durable solutions,

<sup>26</sup> Informal interview with psychosocial officer at AMERA-Egypt, she explained that HIV positive clients do not seek medical treatment until later AIDS stages leading to high rates of mortality at the hospital.



local integration, voluntary repatriation and resettlement to a third country. Due to Egypt’s reservations on the 1951 Geneva Convention regarding the rights to employment and access to social services, local integration is not a viable choice for refugees living in Egypt.

Durable solutions are not a part of the HIV/AIDS care program. However, HIV positive refugees who face severe social stigma due to their medical condition are highlighted for resettlement in a third country<sup>27</sup>. At the same time, there are various community reports on HIV refugees’ repatriating to their country of origin to escape social stigma and to seek better medical attention.

Table 5.5: Durable Solution

UNHCR indicators	Policy (NAP/national law)	Practice	Refugee Experience
Advocate for and establish local integration and repatriation policies and programs that include appropriate prevention and treatment interventions for HIV/AIDS	Egypt has a firm stand on disapproving local integration	Refugees have access to basic rights on par with national and informal labor market	“informal” local integration deprives refugees of legal protection especially for labor law and social security

<sup>27</sup> Informal interview with UNHCR focal point.

## 5.7. Capacity Building

This goal focuses on UNHCR and partners' staff, in this case partners are Refuge-Egypt and Caritas being the two partners offering medical treatment for refugees in Egypt. The NAP held four, two-day, training sessions to build partner NGOs capacity in respond to HIV and AIDS. Refuge-Egypt had 55 staff members, an average of 10 staff members attended the training. Though medical staff had to attend the training, social worker attendance is based on personal interest despite being the clinic's frontline.

Registration officers/social workers are the ones to decide on refugees' acceptance in the support program. During the registration process, clients are interviewed about their livelihood in Cairo and the reason on which they left their country of origin in a very similar manner to RSD interview conducted by the UNHCR office. As indicated by community focal points, the interviewer assumes that all clients are lying to seek resettlement.

A minor client, the interviewer made fun of her asking her if she is the daughter of Meles Zenawi. He asked me if she is my girl friend. They are usually hard on Ethiopian women. Once, my client started crying during the interview but the interviewer interrupted her by saying you don't have to cry I know it is a lie, you don't have to lie to get resettlement. (Ethiopian interpreter)

Registration staff is not trained to identify protection needs or legal concerns that their clients might face. According to refugees and community focal points that I interviewed, the registration interviews at Refuge-Egypt include asking about the reasons of flight and the number of countries a client has been through before reaching

Egypt. This training is not repeated on annual basis despite the high turn over of the medical staff in Refuge-Egypt, to date four doctors has taken over the VCT center. Based on my interviews with two medical staff who ran the VCT center, medical stigma is prevalent especially toward high risk groups.

According to the UNHC’s plan, refugees are supposed to take part in healthcare program design to address their needs. Sharing program design and implementation methodology of empowerment to service recipients, such training was not conducted and refugees do not have a say in the health care service provision.

Table 5.6: Capacity Building

UNHCR indicators	Policy (NAP/national law)	Practice	Refugee Experience
Train UNHCR and partner staff on HIV protocols, prevention and treatment	Not relevant to national policies	The NAP conducted 4 training sessions for refugee-focused NGOS	Indicators show that staff is not educated on refugee issues as well as prevalence of stereo types and medical stigma.
Build capacity of HCR’s PoCs to participate in design, implementation, monitoring and evaluation of HIV programs	Not relevant to national policies	No monitoring and evaluation-focused trainings conducted	Evaluations should help service provision and address present gaps

### 5.8. Assessments, Surveillance, Monitoring and Evaluation and Operational research

Refuge-Egypt does not conduct regular organizational evaluations. The program’s development remains undocumented. The clinic’s annual report includes has a small

section on the number of individuals tested for HIV, but does not reflect on the numbers or the motivation for testing<sup>28</sup>.

Monitoring and evaluation are essential parts of program design being the main indicators to program's progress and development. It is only through field suggested indicators that health care programs can grow inclusive of population needs. The HIV program for refugees is comparatively new that can explain the absence of published progress reports. Nevertheless, basic indicators and statistics are much needed to present a clear image on the current situation and the needed steps.

Table 5.7. Assessments, Surveillance, Monitoring and Evaluation and Operational Research

UNHCR indicators	Policy (NAP/national law)	Practice
Collect, analyze, and respond to essential HIV-related data on routine basis using standard case definitions.	Not relevant to national policies	Non published
Improve UNHCR programs through joint HIV assessment and monitoring missions.	Not relevant to national policies	No information on such missions
Evaluate HIV control programs on a routine basis.	Not relevant to national policies	No available information
Conduct HIV operational research, as indicated, to guide program implementation or to address identified programmatic problems.	Not relevant to national policies	No available information

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<sup>28</sup> Talking to one medical staff, I found out that most of those tested for HIV are women seeking prenatal care. HIV testing is mandatory to receive these services.

## **5.9 Service limitations**

### **5.9.1 Accessibility Challenges**

According to interviews with informants in the refugee group and the community focal points group, perceived and enacted racism were both part of refugees' experience at Refuge-Egypt. Though undocumented, racism within the Sudanese community creates racial tension that prevented at least one informant from seeking any services at the southern Sudanese-dominated NGO.

All Saints is a cathedral, whether Refuge-Egypt controlled by Church's regulations or point of view in service provision is not the point of argument rather it is the perception refugees have of the institution. The religious perception is enhanced by the setting of the waiting room in both the reception and waiting area for the clinic where Biblical media is on display. Feedback from the community focal points group suggested that religious Muslims refuse to receive services from a Church, also they reported hardship for women who wear the niqab (face cover) and women who wear the hejab (head scarf) during the registration interview. Hence, confirming to clients' worries.

### **5.9.2 Clinics' Physical location**

Refuge-Egypt is located in All Saints Cathedral in the posh Zamalek island, except for few mini-buses there are no-public transportation that go through the island. The closest metro stop is 20 to 30 minutes walk at the downtown Naser stop. A taxi from downtown to Zamalek costs between 5 to 7 Egyptian pounds hence clients' preference

to walk. As for refugees who live in Naser City the commute should take about two hours depending on traffic.

“For me one pound is lots of money, if I have this amount of money we take a taxi but if we do not, we walk across the bridge.... and because she is pregnant, it would take more than one hour” (Male informant on taking his wife to the prenatal care clinic)

All informants indicated that the commute to All Saints is too expensive. According to one informant who takes the bus to Zamalek from the working class neighborhood of Boulak, taking the bus in the morning is not a problem as the traffic is better however the wait between seeing the doctor and receiving social services is the “deal breaker”. Coming early to the clinic allows her to see the doctor for prenatal care before noon but the wait for the food package keeps her until early afternoon where the traffic becomes heavier. While living in Boulak which is relatively closer saves on the transportation money, the mother of three ends up spending around 3 to 4 pounds for lunch from the Cafeteria located within the premises.

Oromo community focal point reported that many times clients would refuse coming back to receive services as the cost of the transportation is more expensive than the service they want to receive. He gave the example of the food package saying that sometimes to receive the food package a clients needs to come few times to register and actually receive it. For those who live in Maadi or Naser City the commute expenses and the physical effort invested in the trip can costs more than seeing a doctor for free or receiving a small box of food.

### **5.9.3 Religious affiliation**

Refuge-Egypt provides a great opportunity for people to see Jesus Christ at work (Refuge-Egypt website)

While a place of worship for Christians the All Saints Cathedral serves Muslims and Christians equally. During my work at AMERA many of my Muslim Somali clients refused to go to All Saints to receive services including health care, education or food supplies.

“It would be better if the clinic is outside the church, Southerners (Sudanese) would think it is only for them coz they are Christians, giving UNHCR aid through the church allows people to think that this money is from Christians to Christians” (Muslim Female, Sudanese informant)

Christian Ethiopian community focal point, told me that he does not mind the Christian setting or showing Christian movies in the waiting room. However he knows that some clients do not like it yet they do not complain because “They would not say because these people go there for services, they can not complain about it, they don’t feel it is their place to complain”. Refugees are burdened by being in receiving end of the support equation as well as the present racial and religious tension makes them unable to voice their concerns.

### **5.9.4 Stigma**

I believe if you are a refugee and a single mom, all you have is your community and if they refuse to shack you and talk about you, like this women I am talking about, she tried to commit suicide. (female Somali interpreter)

Data based on clients’ feedback suggest that social stigma related to HIV/AIDS is limited to “illegal” heterosexual intercourse. All informants indicated basic knowledge of HIV’s routs of infection however, sexual activities were highlighted as the main

mode of transmission. This knowledge is based on media awareness campaigns especially on television. A 40 years-old Sudanese man told me “being respectful would prevent the illness”, being respectful meant to avoid “dirty women” the same attitude was confirmed by other informants in this category. When asked how they would behave around an HIV positive person all informants with the exception of one showed comfort by saying shaking hands or even hugging is not a method of transmission.

People think that this is stigmatizing that someone with this disease is not a good person, they can not protect themselves from the illness because they had sex, unprotected sex or adultery, they also think it can be contagious to them and it can be transmitted to other people so they don't want them in the community (Female Somali interpreter)

Data gathered from community focal points suggests contradictory to the clients' group. Female Somali interpreter who worked with the community for more than 3 years, narrated the story of three HIV positive women. Two of them managed to keep their status a secret to live normally with their community while the third one was found out. The Somali community rejected the third woman, a single mother; people would not shake hands with her. She tried to commit suicide and was hospitalized in a psychiatric hospital. Currently she is on anti-depressants awaiting resettlement. The same attitude is echoed within other communities. Interprets involved with Ethiopian and Eritrean communities, reported that social stigma associated with HIV is too bad Eritreans and Ethiopian tend to repatriate hoping to get the social support they need with their families despite the risk of persecution.



The reason for the apparent contradiction between clients' and interpreters' outcome can be explained as refugees' wish to present themselves as educated people with no prejudice.

Generally, condoms are only offered through the HIV clinic for the use of HIV positives themselves or the family planning clinic in the cases when women can not start their contraceptive plans due to medical issues. People can buy condoms from the pharmacy if they need it. (Medical Staff, Refuge-Egypt VCT clinic)

Other high-risk groups including commercial sex workers and needle drug users are not offered preventive methods including condoms or clean needles through the clinic. Another note worthy issue is the absence of regular outreach information sessions. In 2008 Medical staff Eura mentioned out reach sessions offered to young people during Church's youth retreat, which did not only exclude Muslim youth for the service but also Christians who do not worship at All Saints. No informants in clients' group knew about VCT services offered through the clinic, this was confirmed through interpreters' group feed back that their communities do not have any information on HIV/AIDS.

### **5.9.5 Lingual challenges**

My clients do not speak the language(Arabic), and all workers are Sudanese, if you are Sudanese you are in a better place at least you speak the language but Somalis who don't speak the language.....you feel excluded (Female-Somali interpreter)

Numerically, Arabic speaking refugees represent a majority of the refugee population in Egypt however, other lingual minorities should be taken in consideration. The interpreters' group feedback suggested a demand representative for major languages i.e. Somali, Oromo and Tigrinya. Data suggested that this person would not be a

better interviewer because of the language but also due to cultural reasons would provide better understanding for clients' needs.

### **5.9.6 Ethnic group**

Workers are mean to us, I try my best to avoid them to avoid the humiliation. I am from the north and all the NGOs are controlled by southerners, I worry they can be racist, I wasn't able to get a job because I am from the north, I tried to get a school job like my old job in Sudan but all the schools are controlled by southern Sudanese. (40 years-old Sudanese male)

Informants from clients' group suggested intra-Sudanese racism between Northern and Southern Sudanese refugees. This racism is indicated through general behavior and tension between southern and northern within the Cairo community that is viewed in the microcosm of Refuge-Egypt. While clients did not state specific incidents that took place in the clinic or in the social services section, they used stressful language to describe the relation between "Arabs" and "Southerners". Usually terms like them or these people are used to refer to southern Sudanese.

As seen these limitations affect refugees' access to services at All Saints, lingual, commuting and racial factors are suggested to be the strongest influences on clients' readability to access services. These factors in addition the absence of an effective outreach program can explain the low rates of HIV testing and request for VCT services. In addition to these factors, interpreters' group suggested the presence of legal fears of deportation associated that prevents individuals' willingness to get tested.

## **5.10. Discussions**

As seen from the previous section, there is distance between UNHCR's set goals and refugees expectations from the medical program. When the UNHCR's plan explains prevention program structure and activities' implementation, methodology is not included. The absence of clear program design indicators ignores the impact of structure on programs' quality.

Though, HIV testing is integrated in prenatal care services at Refuge-Egypt's clinics, advising on HIV risks and testing is limited to the VCT clinic. There is a need to integrate HIV into the whole body of medical services instead of limiting it to one clinic and one implementing partner.

Refugees' concerns were focused on exclusion from services due to their ethnic background as in the case of Northern Sudanese refugees who feel excluded by the majority Southern Sudanese staff and Muslim clients who exclude themselves from the services from the Christian oriented program. Refugees who need to commute for hours are restricted by their financial resources. The UNHCR's plan of action asserts prevention as an important part of the VCT activities. It focuses on availability of ARVs, preventive methods and VCT services, thus ignoring physical accessibility as an important factor in service provision

The UNHCR used advocacy to integrate refugees in the national ARV program policies and implementation yet refugees remain limited to one VCT center to receive this service. The VCT program can introduce mobile clinics to serve refugees residing on the outskirts of the city on par with the national program to increase refugees'

accessibility to VCT services. At the same time, increasing the number of refugee-oriented VCT units within implementing partners' medical network.

Refugees' feedback suggested the need for information sessions and trained community focal points to spread knowledge on HIV and AIDS as many of the refugees can not read in Arabic or English. Refugees and community focal points confirmed to the need for multimedia tools like documentaries and interactive media to reach the community especially young people. Prevention is not only a medical concern; it is a matter of proper outreach methodology to educate the community on methods of transmission and prevention as well as living with HIV and AIDS.

Medical and social stigma was suggested strongly through informants in the medical staff group and community focal points group. HIV can be introduced as a blood borne disease to overcome the moral stigma on one hand and to include other routes of infection including renal dialyses on the other. At the same time, educate medical staff (doctors and supporting staff) on interpersonal communication and suspending personal judgment to create a "high-risk" groups friendly environment within the clinic.

The tension between Egyptian community and refugees affects refugees' access to basic health care services. Positive steps are needed to elevate the tension between refugees and national service providers to reach full integration within the national health care scheme. Start outreach programs to target "high risk" population.

The VCT clinic at Refuge-Egypt is a relatively new program that suffers from staff high-turnover and the absence of monitoring and evaluation unit. Thus, calling for

contentious staff training and strong program structure to follow on the program development and maintain organizational memory.

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## **Appendix I**

### **Medical Services Available For Refugees**

UNHCR-Cairo has two implementing partners to offer medical and socio-economic support to refugees and asylum seekers. The two NGOs provide services to refugees and asylum seekers based on their legal status. On one hand, Caritas-Egypt for blue cardholders, yellow cardholders (*prima facie* recognition) and minors, and on the other Refuge Egypt (All Saints Cathedral) serves yellow card (asylum seeker) and asylum letters holders. Each NGO registers and supports refugees according to their internal mandate and in accordance to the funding offered through the UNHCR as well as other funders. The presence of external funders allows NGOs to start their own support programs like Project 15 at Caritas and food assistance in case of All Saints.

#### **Refuge Egypt (All Saints Cathedral)**

Refuge Egypt is also known as “All Saints Cathedral” or, among refugees, as “the Zamalek church.” Refuge Egypt is a Christian development organization that operates out of All Saint's Cathedral Episcopal Church in the aristocratic Zamalek Island. Refuge Egypt's refugee programs offer medical services, in-house inexpensive language classes, vocational training, job placement, clothing, and food packages for vulnerable cases. The program targets Sub-Saharan African Refugees excluding any other asylum seekers in Egypt. Another restriction on the program is that to receive their services, a refugee must register with the program within their first year in Egypt. Any delay jeopardizes their chances to join the program. The medical program offers HIV/AIDS services, TB clinic free of charge and prenatal care for minimal fees these services are open to all refugees/asylum seekers regardless of their legal status. However, all other medical services, including subsidized surgeries and medical tests are limited to individuals registered with their program.

#### **Caritas-Egypt**

The other NGO is Caritas-Egypt, which serves recognized refugees, both blue cardholders and yellow cardholders. To register, refugees need to wait for the UNHCR to fax their file Caritas-Egypt. It may take up to four weeks in waiting for the UNHCR to process the fax, and few more weeks for a scheduled registration interview, in addition to at least 3 weeks for the committee to make a decision regarding the case. During this rather long waiting period, a refugee is given no explanation or fixed dates for when they will receive the needed documents. Under-staffing factors to this delay in the

registration process. However, after registration, refugees can access medical services, socio-economic services, vocational training, and job placement opportunities.

The UNHCR funds Caritas under two projects. The first is Project 25, under which Caritas provides medical assistance to recognized refugees. A refugee can see a doctor at Caritas, yet in certain cases where an expert opinion is needed, refugees are referred to one of the specialist doctors in Caritas' network. In addition, Caritas refers refugees to receive medical tests or physiotherapy through their network of laboratories, hospitals, and clinics.

This project does not provide full funding for medical treatment or examination, the percentage that Caritas' contribution is subject to alteration depending on Caritas' annual medical services budget.

In case a refugee needs a surgical intervention, a Caritas-UNHCR joint committee decides if they are going to fund the operation. Caritas is revising their budget every fiscal year and changes the amount of funding they allocate to each of the services provided, depending on the funding they secured. The other project is Project 15, under which Caritas offers very limited support to asylum seekers holding a special reference letter from the UNHCR. These applications are considered by a Caritas committee that decides on case-by-case bases.

The UNHCR does not fund programs to supports failed asylum seekers<sup>29</sup>. Individuals with closed files need to seek medical treatment as foreigners in Cairo through public government hospitals, private clinics and religious-based charity clinics.

### **National Health System**

The national health system in Egypt is overwhelmed by the national overpopulation; hence, there is no space to integrate non-citizens into the system. According to Emily K. Eidenier's paper "Providing Health Care Information to Refugees in Cairo: Questions of Access and Integration," under Egyptian domestic law, government hospitals and clinics are open to nationals and foreigners equally

"at minimal fees that could not be altered by hospital physicians or staff"<sup>30</sup>. This generous provision allows non-citizens equal access to medical services,

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29 However, through advocacy individuals holding closed files were able to receive UNHCR funded medical services.

<sup>30</sup> Eidenier, E. K., "Providing Health Care Information to Refugees in Cairo: Questions of Access and Integration, American University in Cairo, May 28, 2005.

nevertheless, the conditions of the Egyptian health system itself are obstacles to reach this resolution. As Eidenier concludes, "the national health system [in Egypt] is already operating beyond its capacity and attention to refugee needs is overshadowed by a shortage in health facilities for citizens."

Poor medical facilities are not the only reason-failed asylum seekers do not integrate fully into the Egyptian national health care system. There is the factor of distrust between the medical facilities and failed asylum seekers, such suspicions are enhanced by rumors of organs theft, children theft and fears that doctors will harm them on purpose<sup>31</sup>.

As for private clinics and hospitals, cheap private medical establishments are on the same level as government hospitals quality-wise. Even for nationals receiving high quality medical treatment is rather expensive, especially for major surgical operations, especially cancer related treatments and organ transplants.

The third type of medical establishments is religious based charity clinics. These clinics are more expensive than government facilities; nonetheless, they offer comparatively better treatment, due to the charity funding they enjoy. Egyptian religious-based charities offer a range of medical services depending of the funding. Services start from clinics that offer primary medical care to specialists who donate their time. They also refer their patients to government hospitals or hospitals within their network. Due to the charity nature of these establishments, they can fund partially or fully the necessary medical procedure. However, some of these organizations limit their services to their religious base. As seen above, failed asylum seekers have restricted access to health care services due to the hardship of the livelihood conditions and the overwhelmed Egyptian medical system.

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<sup>31</sup> In Coker's paper, she mentions the fear that doctors will conduct operations in a way that affects female fertility.

## **Appendix II**

### **Egypt's Memorandum of Understanding with the UNHCR**

#### **TRANSLATION ON**

#### **AGREEMENT BETWEEN THE EGYPTIAN GOVERNMENT AND THE UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES**

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#### **PREAMBLE**

CONSIDERING that the Egyptian Government is desirous to continue the international co-operation within the United Nations in favour of refugees who are within the mandate of the United Nations High Commissioner for Refugees;

CONSIDERING the big number of these refugees in Egypt;  
The Egyptian Government and the High Commissioner agree on the following:

#### **Article 1**

Without prejudice to the Egyptian legislation and, in general, of all sovereign prerogatives of the Egyptian Government, the High Commissioner for Refugees is authorized to establish a Branch Office in Cairo in view of assuring, in the interest of the refugees within his mandate, and in agreement with the Egyptian authorities, the closest possible cooperation with such authorities for the implementation of the tasks mentioned in article 2 below.

#### **Article 2**

The tasks entrusted to the High Commissioner Delegation in Egypt will be in particular, the following:

- a) Cooperate with the governmental authorities in view of undertaking the census of and identifying the refugees eligible under the mandate of the High commissioner:
- b) Facilitate the voluntary repatriation of refugees;



- c) Encourage, in cooperation with the Egyptian Government, and the international organizations competent in immigration matters, the initiative leading to resettle, in every possible measure, in the countries of immigration, the refugees residing in Egypt;
- d) Help, within the limits of the funds received to this effect, the most destitute refugees within his mandate residing in Egypt;
- e) Insure the coordination of the activities undertaken in Egypt in favour of refugees under his mandate, by welfare societies duly authorized by the Government.

### Article 3

The contacts between the Branch Office of the UN High Commissioner in Egypt, the Government and the Egyptian administrations will be ensured, in a general way, by the intermediary of the Ministry of Interior.

### Article 4

The nomination of the Representative of the High Commissioner will be submitted to the agreement of the Egyptian Government. The High Commissioner will consult the Egyptian Government concerning the nomination of the other eventual members of his Office.

### Article 5

The Egyptian Government undertakes to give to the delegation of the High Commissioner all facilities necessary to the exercise of its functions. The Egyptian Government will give to the Delegate of the High Commissioner the same favourable treatments as those given to other United Nations Missions and Specialized Agencies. The list of the staff members of the Delegation of the High Commissioner in Cairo called to benefit from the same treatment given to staff member of the other Delegations of the United Nations and Specialized Agencies in Cairo will be established by common agreement between the Government and the High Commissioner.

### Article 6

The Egyptian Government will grant to “bona fide” refugees, residing in Egypt, who fall within the High Commissioner’s mandate, residence permits according to the regulations in force.

### Article 7

The Egyptian Government will grant to said refugees, when they will have to travel abroad, travel documents with return visa, of a limited, but sufficient, duration, except if reasons of public security prevent it.

### Article 8

The present agreement will enter in force as soon as the Egyptian Government notifies the United Nations High Commissioner for Refugees of his approval of the agreement, in conformity to its constitutional procedure.

In witness whereof the Representative of both Contracting parties have signed the present Agreement.

Made in double copies in French language.

Cairo, 10 February 1954.

UNHCR Cairo  
Unofficial translation  
Date

### Appendix III

## **Questionnaires**

### **HIV/AIDS Program for Refugees in Cairo**

**Questionnaire No:**

**Date of interview:**

#### **Dear respondents:**

The primary purpose of the research is to identify the lacking of the services ...

This interview is part of my research on HIV related services for refugees. This research will study the existing HIV/AIDS program serving the refugee population in Cairo. The outcome of this research should highlight the ongoing programs and provide an insider perspective for the current efforts. The data to be provided will absolutely be used for research purpose.

#### **Informant's consent:**

- Your participation in this study is completely voluntary.
- All the information you are going to share is protected with academic integrity
- You can ask me to rephrase any of the questions or give further explanation if it is not clear.
- If any of the questions makes you feel uncomfortable, you can refuse to answer this question.

The data concluded from this interview will be used strictly for academic purposes. If you have any questions/concerns you can contact my supervisor (Dr. AKM Ullah at [aullah@aucegypt.edu](mailto:aullah@aucegypt.edu)) or the director of CMRS (Dr. Ray Jureidini at [rayj@aucegypt.edu](mailto:rayj@aucegypt.edu)) or me at mobile: 0107100187 email: [rehamhussain@aucegypt.edu](mailto:rehamhussain@aucegypt.edu)

## **I- Service recipients questions**

### **1- HIV/AIDS related (for service seekers)**

- a. Do you know about HIV/AIDS (what kind of disease is that).
- b. Can you tell me some more on how does this spread/transmit and how does it not transmit?
- c. What are major sources for you to have information on HIV/AIDS?
- d. Can you tell me about the services offered here? Did you receive any of them? Could you please tell me what are those?
- e. If you have not received any services from here would you be interested in receiving any?
- f. Did you attend any information sessions about HIV/AIDS in your neighborhood? To you, was it helpful? If it is, could you tell me more how helpful was it. Do you have any suggestions on the location of the sessions?
- g. Did you see any outreach material related to HIV/AIDS awareness before? (Posters, brochures, documentaries, news articles). Were they informative? You benefited from them? How? Do you have any suggestions on the content of the leaflet and posters and how best they could be distributed to those need most?

### **2- VCT (Questions for HIV/AIDS positives)**

- a. Could please tell me when were you detected? You may feel free to share your experience of the day you were tested and detected. It would be helpful for me if you explain more on why did you get tested and was it done discreetly?
- b. How was that dealt immediately by the doctor? Were you prescribed any medicine or anything? If so, please explain more.
- c. Are you under any medication at this moment? What are those? How are they managed?
- d. Did the doctor tell you what to do if you got sick? Which hospital/clinic to go to and if you need any special papers/ letter to take with you?
- e. Has your status been disclosed? How was that disclosed and to whom. Please describe how different is your time now than before disclosure?
- f. Did the clinic provide any medical training or advice on the best practices to manage your day to day activities?
- g. Do your doctors conduct a home visit to talk to you and your friends about your medical condition? If yes, is that comfortable with you? If

no, please could you tell us what way you want the doctor to deal with this?

- h. Have you been or are you a member of any support groups? If yes, please would you share your experiences of being a member of a support group, either good or bad?
- i. Do you have any suggestion for the program that they can launch for offering better services?

#### **4- General Services (Question for service seekers)**

- a. How often do you have to come here? Is there enough transportation between where you live and the clinic? Is it expensive to come here? How do you feel about coming to a church to receive assistance? How the staff treat you? (doctors/supporting staff)

## **II- Question for service providers**

### **1- Administrative related (head of administration at Refuge-Egypt Clinic)**

- a. How many staff members do you have in your program?
- b. Do you coordinate with other NGOs to implement your program?
- c. What are the services you offer in the clinic?

### **2- Program design ( UNHCR's HIV/AIDS focal point)**

- a. Would you please tell us something on the background of the HIV/AIDS refugee program of your organization? (The Goals/targets; the program design; activities; Plan of action (time frame); funding (reports/allocation), and other UN agencies involved)

### **3- Outreach activities ( Head of HIV/AIDS outreach )**

- a. Could you please explain the purpose of the sessions that your outreach programme holds and how is this generally conducted? (target audience, size of the session, duration, schedule,
- b. How is the schedule determined, how is the audience selected, etc.,)
- c. Would you please tell me some more on how is the achievement normally assessed? (I mean in terms of its success or failure)
- d. Could you please tell me more on the content of the sessions? In a society like here sex education is still a source of embarrassment, in this circumstance how do you incorporate sex education in the sessions (if you do)? (how is this taken, accepted or)
- e. Do you dispense any contraceptives? If you do, do you also demonstrate them with their effective uses?. Any reported problem in doing so? Could

you elaborate what kind of? How do you normally then overcome such problems?

- f. Do you communicate with the Egyptian national HIV/AIDS program? What is the nature of this communication and what is the outcome? (does this help? What kind of help of constraints you encounter and how is this resolved)
- g. Tell me what are the procedures you adopt after a patient is detected HIV+ (like counseling, medication etc). It is a challenge to deal with this situation, what are your standard procedures to deal with this?
- h. In case of non-HIV/AIDS related medical complications, where do HIV/AIDS positives go to receive medical treatment?

**Appendix IV: IRB Approval Letter**