

*“Pains of Conflict and Refuge”*  
**Mental Health and Psychosocial  
Wellbeing of Refugees in Egypt**  
Situation, Policies and Practices

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**Declaration:**

Where other people's work has been used (from a printed source, internet or other sources) this has been carefully acknowledged and referenced in accordance with departmental requirements. This thesis ""Pains of Conflict and Displacement" MHPSS for Refugees in Egypt Situation, Policies and Practices" is my own work.

**Signature:**

A handwritten signature in black ink that reads "Muhammad Al-Zawawy". The signature is written in a cursive style with a clear, legible font.

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**Dedication:**

I dedicate this work to the refugees who are suffering outside of their countries, to those who are suffering from human rights abuses in their own countries and to the Martyrs of January 25<sup>th</sup> revolution who sacrificed themselves for a better tomorrow for their country and their people. I would like to dedicate this work as well to the most important person in my life, my sweet daughter Laila, My all, whom I had to leave in her first year to accomplish my studies.

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**Disclaimer**

The author of this thesis recognizes that Israel the *de facto* existence of Israel as a state. However, his referring to Israel in this thesis does not in any way acknowledge its right to exist in its present form, that is, while it continues to lay claim lands that historically belong to the state of Palestine.

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## Abbreviations

AMERA	Africa and Middle East Refugee Assistance
AUC	American University in Cairo
CMRS	Centre for Migration and Refugee Studies
CSOs	Civil Society Organizations
EGP	Egyptian Pound
EIPR	Egyptian Initiative for Personal Rights
EMRO	Eastern Mediterranean Regional Office (WHO)
GDP	Gross Domestic Product
GoE	Government of Egypt
GSMHAT	General Secretariat of Mental Health and Addiction Treatment
HIS	Health Information System
IASC	Inter-agency Standing Committee
IAWGs	Inter-agency Working Groups
IGOs	Intergovernmental Organizations
IMC	International Medical Corps
IOM	International Organization for Migration
MENA	Middle East and North Africa
MH	Mental Health
MHPSS	Mental Health and Psycho-Social Support
MoHP	Ministry of Health and Population
MoE	Ministry of Education
MoHE	Ministry of High Education
MoMP	Ministry of Man Power
MOU	Memorandum of Understanding
NGOs	Non-Governmental Organizations
OAU	Organization of African Unity
PHC	Primary Health Care
PoC	Persons of Concern (to UNHCR)
PS	Psycho-Social
PSTIC	Psycho-Social Training Institute in Cairo
PTSD	Post Traumatic Stress Disorder
RSD	Refugee Status Determination
SGBV	Sexual and Gender Based Violence
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
UNHCR	United Nations High Commissioner for Refugees
UNICEF	UN Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
USD	US Dollar
VOT	Victims of Trafficking
WHO	World Health Organization

## Glossary:

From IOM Glossary On Migration, 2<sup>nd</sup> edition, 2013 (IOM 2013).

**Asylum:** “A form of protection given by a State on its territory based on the principle of non-refoulement and internationally or nationally recognized refugee rights. It is granted to a person who is unable to seek protection in his or her country of nationality and/or residence in particular for fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion”.

**Asylum-seeker:** “A person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status under relevant international and national instruments. In case of a negative decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other related grounds”.

**Country of transit:** “The country through which migratory flows (regular or irregular) move”.

**De facto:** “Existing as a matter of fact; having effect even though not formally or legally recognized”.

**De facto refugees:** “Persons not recognized as refugees within the meaning of the UN Convention Relating to the Status of Refugees, 1951 and Protocol Relating to the Status of Refugees, 1967, and who are unable or, for reasons recognized as valid, unwilling to return to the country of their nationality or, if they have no nationality, to the country of their habitual residence”.

**De jure:** “Existing by right or as a matter of law”.

**Displacement:** “A forced removal of a person from his or her home or country, often due to armed conflict or natural disasters”.

**Economic migrant:** “A person leaving his or her habitual place of residence to settle outside his or her country of origin in order to improve his or her quality of life. This term is often loosely used to distinguish from refugees fleeing persecution, and is also similarly used to refer to persons attempting to enter a country without legal permission and/or by using asylum procedures without bona fide cause. It may equally be applied to persons leaving their country of origin for the purpose of employment”.

**Exodus:** “Movements in groups (isolated and sporadic) out of the country of origin. Mass exodus is a movement in large numbers or of a section of the community at a given time”

**Externally displaced persons:** “Persons who have fled their country due to persecution, generalized violence, armed conflict situations or other man-made disasters. These individuals often flee en masse. Sometimes they are also referred to as ‘de facto refugees’ ”.

**Forced displacement:** “In the law of armed conflict, the individual or collective movement of civilians in the interior of an occupied territory. In the terms of Art. 49, Geneva Convention Relative to the Protection of Civilian Persons in Time of War, 1949 and Art. 85, Protocol Additional to the Geneva

Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts, 1977, forced displacement constitutes a war crime, unless it is justified by imperative military reasons. In a more general sense, forced displacement – or displacement – is the involuntary movement, individually or collectively, of persons from their country or community, notably for reasons of armed conflict, civil unrest, or natural or man-made catastrophes”.

**Integration:** “the process by which migrants become accepted into society, both as individuals and as groups. It generally refers to a two-way process of adaptation by migrants and host societies, while the particular requirements for acceptance by a host society vary from country to country. Integration does not necessarily imply permanent settlement. It does, however, imply consideration of the rights and obligations of migrants and host societies, of access to different kinds of services and the labour market, and of identification and respect for a core set of values that bind migrants and host communities in a common purpose. Local integration is one of the three durable solutions to address the plight of refugees. It may also be applied to victims of trafficking and unaccompanied children”.

**Involuntary repatriation:** “The return of refugees, prisoners of war and civil detainees to the territory of their State of origin induced by the creation of circumstances which do not leave any other alternative. Repatriation is a personal right (unlike expulsion and deportation which are primarily within the domain of State sovereignty), as such, neither the State of nationality nor the State of temporary residence or detaining power is justified in enforcing repatriation against the will of an eligible person, whether refugee or prisoner of war or civil detainee. According to contemporary international law, prisoners of war, civil detainees or refugees refusing repatriation, particularly if motivated by fears of political persecution in their own country, should be protected from refoulement and given, if possible, temporary or permanent asylum”.

**Non-refoulement:** “Principle of international refugee law that prohibits States from returning refugees in any manner whatsoever to countries or territories in which their lives or freedom may be threatened. The principle of non-refoulement is considered by many authors as part of customary international law, while for others the two requirements for the existence of a customary norm are not met”.

**Prima facie:** “Latin expression meaning “at first sight”; on first appearance but subject to further evidence or information. It provides sufficient proof to establish a fact or raise a presumption unless disproved or rebutted. In the migration context, an application for immigrant status may undergo preliminary review to determine whether there is a prima facie showing of all the basic requirements (often as a condition for receiving financial assistance or a work permit)”.

**Protection:** “The concept of protection encompasses all activities aimed at ensuring full respect for the rights of the individual in accordance with the letter and the spirit of the relevant bodies of law, i.e. human rights law, international humanitarian law and refugee law. Human rights and humanitarian organizations must conduct these activities in an impartial manner (not on the basis of race, national or ethnic origin, language or gender)” (Inter-Agency Standing Committee). Protection given to a person or a group by an organization, in keeping with a mandate conferred either by international instruments, in application of customary international law, or by the activities of the organization. Such protection has as its aim to ensure respect for rights identified in such instruments as: 1951 Refugee Convention, 1949

Geneva Conventions, and 1977 Protocols, right of initiative of the International Committee of the Red Cross, de facto protection by the International Organization for Migration, International Labour Organization Conventions, and human rights instruments”.

**Refugee:** “A person who, “owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, 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. (Art. 1(A)(2), Convention relating to the Status of Refugees, Art. 1A(2), 1951 as modified by the 1967 Protocol). In addition to the refugee definition in the 1951 Refugee Convention, Art. 1(2), 1969 Organization of African Unity (OAU) Convention defines a refugee as any person compelled to leave his or her country “owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country or origin or nationality.” Similarly, the 1984 Cartagena Declaration states that refugees also include persons who flee their country “because their lives, security or freedom have been threatened by generalized violence, foreign aggression, internal conflicts, massive violations of human rights or other circumstances which have seriously disturbed public order.”

**Refugee (mandate):** “A person who meets the criteria of the UNHCR Statute and qualifies for the protection of the United Nations provided by the High Commissioner, regardless of whether or not he or she is in a country that is a party to the Convention Relating to the Status of Refugees, 1951 or the 1967 Protocol Relating to the Status of Refugees, or whether or not he or she has been recognized by the host country as a refugee under either of these instruments”.

**Smuggled person/migrant:** “A migrant who is enabled, through providing financial or material benefit to another person, to gain illegal entry into a State of which he or she is not a national or a permanent resident”.

**Stateless person:** “A person who is not considered as a national by any State under the operation of its law” (Art. 1, UN Convention relating to the Status of Stateless Persons, 1954). As such, a stateless person lacks those rights attributable to nationality: the diplomatic protection of a State, no inherent right of sojourn in the State of residence and no right of return in case he or she travels”.

**Trafficking in persons:** “The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation” (Art. 3(a), UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the UN Convention against Transnational Organized Crime, 2000). Trafficking in persons can take place within the borders of one State or may have a transnational character”.

**Victim of human trafficking:** “Any natural person who is subject to trafficking in human beings”.

**Vulnerable group:** “Any group or sector of society that is at higher risk of being subjected to discriminatory practices, violence, natural or environmental disasters, or economic hardship, than other

groups within the State; any group or sector of society (such as women, children, the elderly, persons with disabilities, indigenous peoples or migrants) that is at higher risk in periods of conflict and crisis”.

## Abstract:

Refugees often suffer from mental trauma due to loss of homes and loved ones, as well as having witnessed war and violence. The threat of trauma is often exacerbated by a lack of financial assets. Moreover, refugees face difficulties integrating into a new society, including language and cultural barriers, limited job opportunities, and problems concerning their legal status. Many of them suffer from poverty, food insecurity, poor quality services, and sexual and gender-based violence (SGBV). The living conditions of refugees cause and aggravate mental health and psychosocial problems. Policies and practices regarding refugees statuses, rights, and services have a big impact on living conditions of refugees and thereby influence their mental health and psychosocial wellbeing. MHPSS was developed to promote psychosocial wellbeing of refugees and minimize harm. Egypt currently hosts different groups of refugees with different statuses who suffer from many problems. Approximations of the number of refugees in Egypt range from one to three million, including both documented and undocumented refugees and asylum seekers, victims of trafficking (VoT) and stateless persons.

**Objective and Methodology:** Literature and desk review was conducted to study the refugee situation in general and policies and practices related to the mental health and psychosocial wellbeing of refugees in Egypt in particular.

**Findings:** MHPSS wellbeing of refugees in Egypt is affected by their living conditions. Poverty, marginalization and lack of access to services as health care, education and community support pose additional risk of mental illness on refugees. Access to services is determined by legal status and/or the country of origin of the refugee. Policy gaps, as well as insufficient and inconsistent practices are a challenge to MHPSS wellbeing of refugees in Egypt.

**Conclusion:** Legal status has a relatively high impact on refugees' psychosocial wellbeing as it provides some legal protection and access to some services, such as health care. MHPSS for refugees in Egypt is affected by poor coordination, lack of commitment of some stakeholders, insufficient financial resources and the weak capacity of public health system

**Key words:** Refugee(s), Asylum, Mental, health, Psychosocial, Egypt, documented, undocumented, VoT, policy(s), Practice(s).

**Word count:** 12 395

## Introduction

Recently, the refugee<sup>1</sup> crisis has triggered international attention, especially on with regard to humanitarian and security concerns. The media has covered political and social debates that erupted in response to the wave of refugees that arrived in the summer of 2015, the largest movement of refugees in Europe since the Second World War. The problems in coping with this influx were exacerbated by the threat of terrorism and the rise in anti-migrant sentiment – the latter being, in part, due to the former. Worldwide, there are around 65 million people who are forcibly displaced, of whom around 25 Million are recognized refugees - this figure has almost doubled since 2011 <sup>2</sup>. The remaining 40 million are considered internally displaced<sup>3</sup> (Ferris and Kirişci 2016; UNHCR 2015c).

Currently, around one third of refugees from all over the world originates from the Middle East. Syrian refugees make up for majority of refugees from and in the Middle East. At the same time, the Middle East is an important place of refuge, hosting around 22 % of world refugees. Egypt, Turkey, Lebanon, and Jordan are important host countries in the Middle East Hosting millions of refugees ( IASC 2016; IOM 2016; UNHCR 2015c).

Egypt, with its strategic, central location in the Middle East, has always been a land of immigrants. Foreigners have immigrated to Egypt fleeing war while Egyptians have rarely migrated abroad until the 1950s. Egypt hosted people fleeing Russia after the Bolshevik revolution and the Armenian massacres by Turkey early in the 20th century. It hosted the Albanian and Greek governments in exile, as well as 25 000 Croats during World War II. African politicians such as Kwame Nkrumah and Patrice Lumumba found asylum in Egypt during 1960s (Zohry 2003).

Egypt Currently hosts different groups of refugees, mainly Palestinians, Sudanese, South Sudanese, Somalis, Ethiopians, Eritreans, Iraqis and, most recently, Syrians. Estimates of the number of refugees in Egypt range from half a million to five million, of whom less than 250 000 are registered with the UNHCR. Egypt host documented voluntary migrants, but their numbers can be neglected compared to the number of refugees. Egypt is also a main transit country for human trafficking and smuggling to Europe and Israel and has been a part of the corridor for humanitarian assistance during Libyan crisis in 2011. In addition, Egypt is home to around 10.000 stateless persons (Abed 2004; Amnesty International 2013; HRW 2008; Issa 2013; Grabska 2006a; Kergoat 2013; UNHCR 2016e; Zohry 2003).

Refugees often suffer from trauma due to having lost their home and loved ones, as well as their financial assets and having witnessed war and violence. Having arrived in a new community, they face difficulties integrating into a new society. These difficulties are often made worse by language and cultural barriers, limited job opportunities, and problems concerning their legal status. Thus many

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<sup>1</sup> Refugees in this paper refers to: **any person left out his or her country of residence because of natural disasters, conflict, war or fear persecution based on race, religion, nationality, membership of a particular social group or political opinions regardless their legal status either in origin or host country. Including: documented and undocumented refugees and asylum seekers, victims of involuntary human trafficking, foreign stateless persons.**

<sup>2</sup> Of which around 16 Million Registered with UNHCR, 3 Million asylum seekers waiting RSD and 5.2 Palestinians registered with UNRWA

<sup>3</sup> Including around 3.5 Million stateless people.

refugees are vulnerable to poverty, food insecurity, poor quality services, and sexual and gender-based violence (SGBV). As a result, refugees also run a high risk of facing psychological problems, ranging from transient conditions such as temporary grief to more complicated ones like psychosis. These problems may in turn aggravate existing medical conditions as well as make the person in question more vulnerable in her already shaky circumstances. The negative impact of mental and psychosocial problems does not only affect the individuals but extends to their communities (Hassan et al. 2015; IOM 2016; Meffert and Marmar 2009; Lindert et al. 2016; Robjant et al. 2009; Tempany 2009; UNHCR 2016; Ventevogel et al. 2015).

In addition, Egypt is already facing many problems of its own. Its inhabitants face difficult living conditions, including growing political instability, poverty and economic hardship, high unemployment, and insufficient access to quality services. Hosting refugees places additional pressures on the already limited resources and services and perceptions of competition among Egyptians and any newcomers thus increases the risk of social tensions (IOM 2016; Goździak and Walter 2013; Grabska 2006a; UNHCR 2016).

Mental Health and Psychosocial Support (MHPSS) currently is a basic component of humanitarian support for refugees given by UN agencies, governments and NGOs. In many instances, the target population cannot benefit from these services due to constraints they face in accessing them. Some refugee groups as undocumented refugees, stateless persons and VoT are unreachable by the stakeholders and become missed during services planning and provision (Al Obaidi and Atallah 2009; IASC 2007; Palmer 2007; Watters 2001). This paper intends to address the conditions for different groups of refugees in Egypt based on their legal statuses and backgrounds and to compare the situation of MHPSS for refugees between Egypt, Turkey, Jordan and Lebanon, as they are the biggest hosts for refugees in the Middle East. Also, this paper will analyze the MHPSS situation, policy and practices of different stakeholders in Egypt and address possible policy and practice gaps in MHPSS for refugees in Egypt. Finally, the paper will provide recommendations to strengthen MHPSS policy and practices to improve the MHPSS wellbeing of refugees.

# 1. Background to Egypt:

## 1.1. Demographic background

Egypt is located in the Northeastern part of Africa, except for Sinai Peninsula, is located at Asia. It looks out into the South Eastern coast of the Mediterranean Sea and the North Western coast of the Red Sea with a total area of around one million K.m<sup>2</sup>. Egypt has common borders with Libya to the west, Sudan to the south and Palestine (Gaza Strip) and Israel to the northeast. Suez Canal runs through Egypt. The over whelming majority of Egypt's population live in the Delta and the Nile Valley on 6% of Egypt's area. Deserts constitute the vast majority of Egypt's territory. Administratively, Egypt is divided into 27 governorates (CAPMAS 2015b).

Egypt is the second most populous country in both the Middle East and Africa and 15th populous in the world with prospected population in 2016 of around 93 Million constituting 1.25% of the total world population (UN 2015a). The median age of Egyptian population is 24.8 years, the annual rate of population change is 2.2 % and Total fertility is 3.38 children per woman (WHO 2014b; UN 2015a). Migrants' trend in Egypt is fluctuating over years, the Net migration rate was -0.5/1000 population in 2010-2015 (UN 2015b).

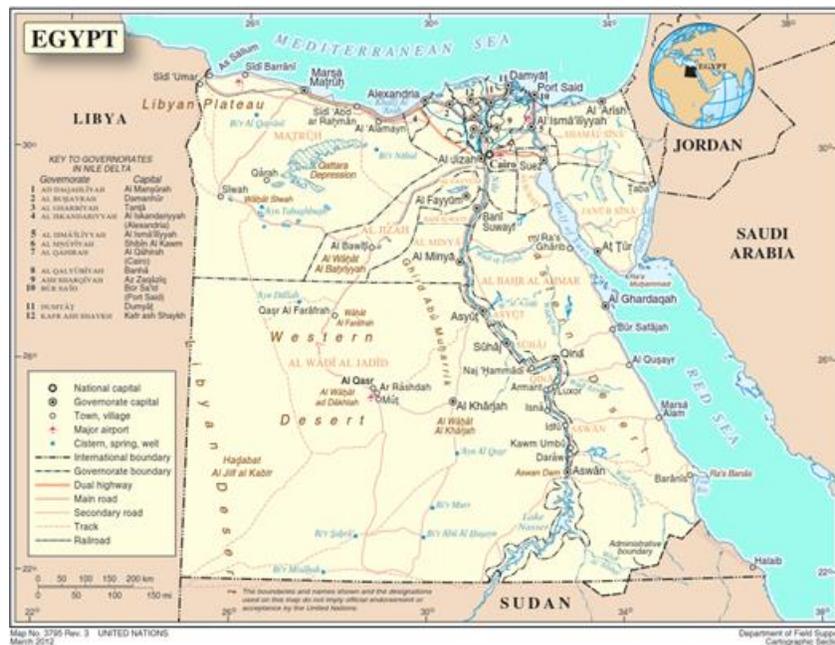


Figure 1 Map of Egypt (UN 2012)

## 1.2. Socio-economic status:

Egypt is a lower middle-income country. Its economy relies mainly on tourism, remittances from Egyptians working abroad, revenues from the Suez Canal and oil. Egypt has witnessed improvement of macroeconomic performance as fiscal policy, monetary and structural reform (WHO 2014b). Despite these supposed improvements, there is disparity in distribution of wealth in Egypt. Egypt has high unemployment, wide spread corruption, privatization and increasing poverty. Following Egyptian

revolution in 2011, economic situation and living standards for most Egyptians went worse, unlike their demands in the revolution.

The current economic crisis in Egypt was manifested in massive increase in prices, reduction of the value of Egyptian Pound against most currencies affected by decrease in Egypt's reserve of foreign currency, increased deficit in public budget, increased inflation and national debits and decrease in subsidy for fuel, electricity, water (Ayesh 2016; Bloomberg 2016; CESR 2013; Joya 2016). Absence of effective Law for minimal and maximal wages enhance the gap between social classes in Egypt.

In 2015, Gross domestic product (GDP) was 330.8 billion USD, growth rate 4.2% and Inflation was 10.4 %. Poverty incidence fell from 19.4% in 1995–1996 to 16.7% 1999–2000. Lower Egypt experienced reductions in poverty from 13% to 5% in urban metropolitan centers and from 22% to 12% in rural areas. Upper Egypt on contrast is experiencing increased poverty from 29% to 34% in rural areas and from 11% to 19% in urban areas (WHO 2014b; UN 2015a; UN 2015b).

86 % of males and 75 % of females Egyptians ever attained school, with 7.4 median of years of schooling for men and 5.8 years for women. Educational attainment is associated with wealth, with the largest differentials between males and females observed in the lowest two wealth quintiles. Educational attainment differs too by place of residence and gender. in rural Upper Egypt 82 % of men have ever attended school, compared with 66 % of women (El-Zanaty and Associates 2014). This reflects gender and social inequality in Egypt, also culture might be playing a role in this disparity.

Egypt guarantees the right to free public education, basic and general education. Early childhood education is underfunded and available to only 20 % of Young Children. Regarding the quality of education, Egypt lies at the bottom of international ranking (WB 2014).

98 % of households obtain drinking water from an improved source and 91% of households solely use an improved toilet (El-zanaty and Associates 2015). Population density in Egypt is 94/Km<sup>2</sup>, about 37 Million in 2016 (about 40% of the population) lives in urban areas, mostly in crowded conditions. In some areas of Cairo and Alexandria, density exceeds 100 000 person/Km<sup>2</sup>. Egypt's 1105 slums represent approximately 30% of residential areas and inhabited by around 16 million people. The availability of utilities, health and social services are severely limited in the slum areas (WHO 2014b; UN 2015a; UN 2015b).

### 1.3. Sociocultural background:

Egyptians are a fusion of different ethnicities including Africans, Arabs, Berbers, Greeks, Persians, Romans, and Turks (Zohry 2003). Arab culture dominates the other cultural components, Arabic is the only official language and Islam is the official religion of the state and the main source legislations according to the Constitution. Christianity and Judaism beside Islam are the only recognized religions by the state. About 90 % of Egyptians are Sunni Muslims and 10 % are Christians, predominantly Coptic orthodox. Religious freedom in Egypt is highly undermined (US Department of State 2016; US department of State 2002).

### 1.4. Health situation:

Since 1990 Egypt has witnessed improvements in the population health status, reflected by improvements in health indicators specifically those related to maternal and child health, which were targeted by vertical programs that achieved relatively big and fast success. Egypt succeeded to lower maternal mortality by 62.5% and under 5 mortality by 75% and increase life expectancy at birth to 70.8 year in 2015. Between

2010-2015, the crude death rate was 6.2/ 1000 live births, under-5 death rate was 23.3/1000 live birth and maternal mortality rate was 44.6/100 000 live births. Egypt has not record new polio cases since 2004. Egypt recently has achieved success with improving access to the new drugs for hepatitis C which is a big public health challenge in Egypt (WHO 2014b; WHO 2016). Despite these achievements in health sector, the public health in Egypt is currently challenged by high and increasing burden of diseases especially non communicable and their risk factors, declining quality of public health services, poor governance and accountability reflected in lack of equity in distribution of health resources geographically and over social strata, brain drain of human resources for health (Loza and Sorour 2016).

Many risk factors for non-communicable diseases are very prevalent in Egypt like obesity, high blood cholesterol, high fasting glucose levels, insufficient physical activity, high levels of tobacco use and substance abuse, non-adherence to safety measures as seat belts. Problems with infection control and unsafe injections contribute to 150 000 new annual cases of viral hepatitis among other blood transmitted diseases (El-zananty and Associates 2015; MoHP Egypt 2014; Rashad and Sharaf 2015c; WHO 2014b; UN 2015b).

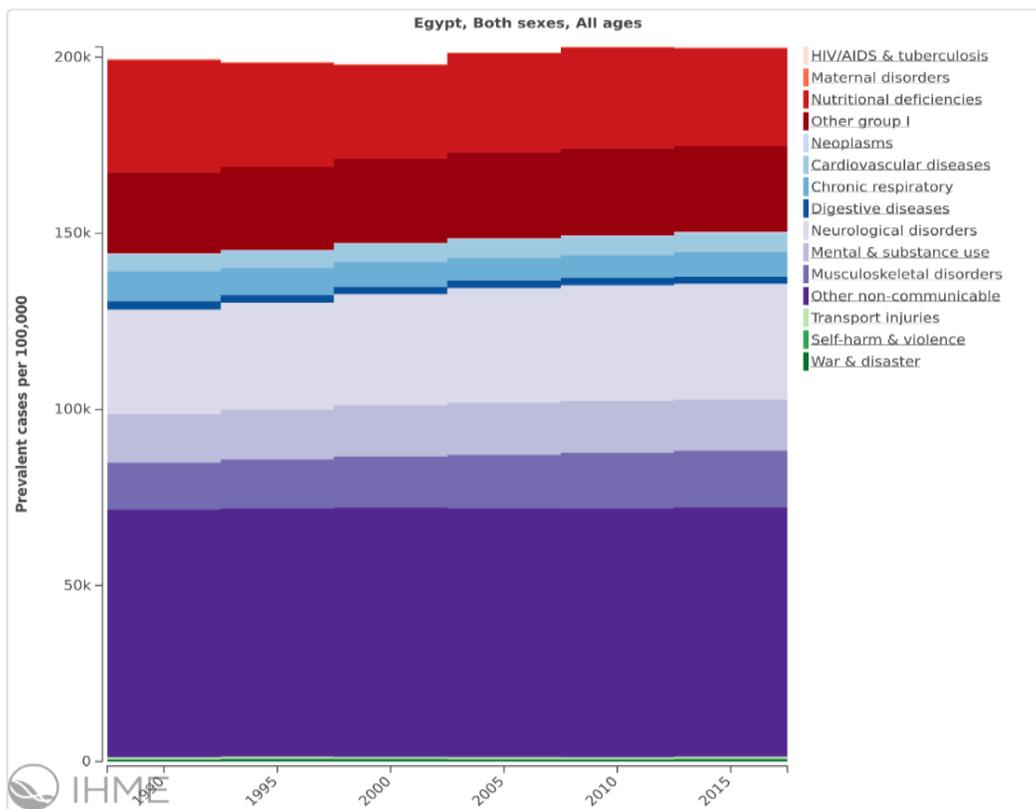


Figure 2 Trends in Prevalence of most common causes of disability in Egypt, 1990-2015 (rate per 100 000 Population)  
(IHME 2016)

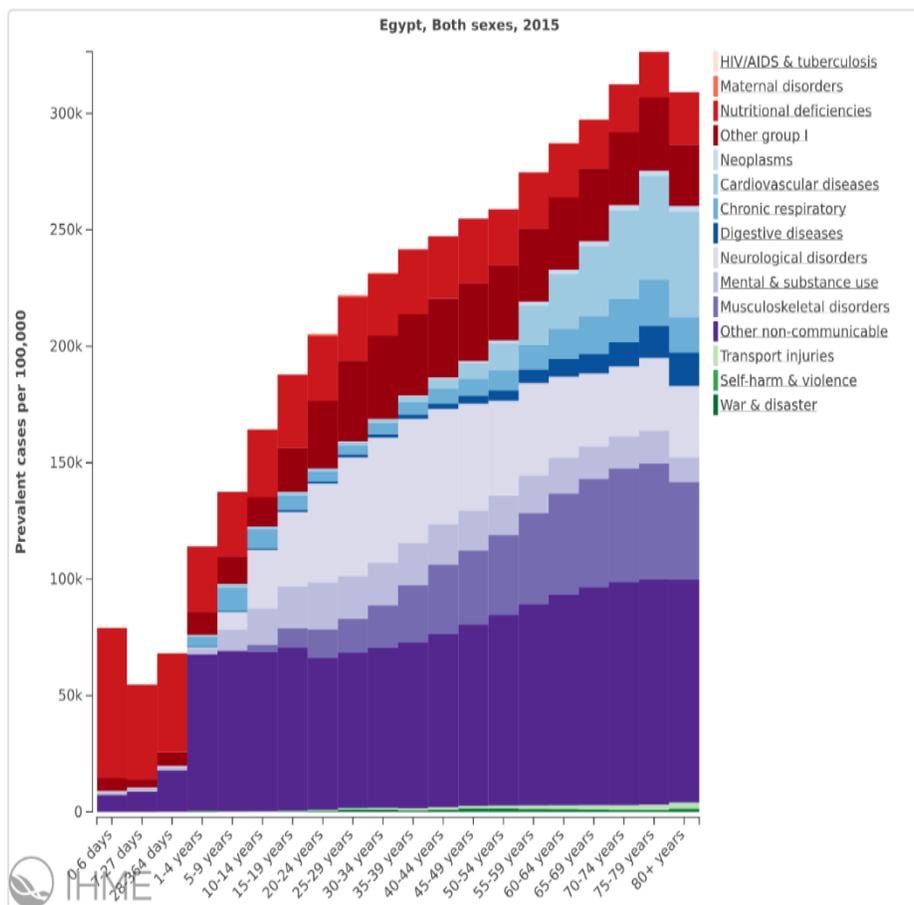


Figure 3 Distribution of prevalence of most common Causes of Disability in Egypt by Age group (Rate per 100 000 Population) (IHME 2016)

#### 1.4.1. Burden of disease

Egypt like other developing countries faces a double burden of disease, communicable and non-communicable diseases including mental health diseases. Neuro-psychiatric and digestive disorders are the leading causes of disability in Egypt accounting for 19.8% and 11.5% respectively of the non-fatal burden. Ischemic heart disease, Congenital anomalies, Cerebrovascular disease, Lower respiratory infect and Cirrhosis hepatitis C are the leading causes of premature death orderly 2015 (IHME 2016; WHO 2014b; WHO 2015a).

##### 1.4.1.1. Communicable diseases

Communicable diseases have largely been controlled in Egypt; yet diarrheal diseases, acute respiratory infections and viral hepatitis still scoring high burden of disease. High coverage rates for routine immunization contributed to the large decline of Vaccine-preventable diseases. Viral hepatitis is one of Egypt’s biggest public health challenges as it affects 10% of the population and millions more at risk for infection. Tuberculosis is the third most important communicable disease problem yet Egypt ranks among countries with mid/low level of tuberculosis incidence (WHO 2014b; WHO 2016).

##### 1.4.1.2. Non communicable diseases

The prevalence of hypertension and diabetes mellitus in the adult population in Egypt is around 26% and 9%, respectively. Prevalence of obesity among adult males is 21.8 % and 39% among females and

rise up to 62.4 % in females in the age group 45-54 years. The incidence of cancer is 110–120 cases /100 000 population. The commonest cancers are breast, liver, bladder and lymph node. The major challenges facing the area of non-communicable diseases include: the national surveillance does not include non-communicable diseases, lack of integrated service delivery and referral system, over medicalization for these diseases (Ellabany and Abel-Nasser 2006; WHO 2014b).

#### 1.4.2. Health system

##### 1.4.2.1. Health financing

In Egypt, Total Health Expenditure in 2014 was 178 US \$ per capita which equals 5.6 % of GDP (CAPMAS 2015a). Out Of Pocket (OOP) expenditure accounts for 59-70 % of THE. This is catastrophic expenditure and has a big toll especially on the most poor who pays a good percentage of their income on health care yet receive lower quality services( El-saharty 2006; Nakhimovsky et al. 2011; Pande et al. 2015; Rashad and Sharaf 2015a). Egypt's public expenditure on health in 2014 was 42 401 million EP (68 US \$ Per Capita) which equals 5.37% of the state public expenditure and 2 % of GDP. Charities and NGOs contribute around 1.4% of THE. Private and unions' insurances cover only 0.5% of THE (CAPMAS 2015a). Health Insurance Organization HIO participate by 6 % of THE, theoretically it covers 60 % of population; employees, students, pensioners, widows and the newborns. actually only less than 25 % of the covered population (some scholars suggest only 10 % or less) use HIO services mainly due to perceived low quality of services, absence of some services at time of demand and limited geographical distribution of the HIO facilities (Nakhimovsky et al. 2011; Pande et al. 2015; Rashad and Sharaf 2015b; Shawky 2010; WB 2010).

##### 1.4.2.2. Service Provision:

Generally, Egypt's public health provision system is fragmented among different organizations, mainly MoHP, MoHE, and HIO. Each organizations has different legislations, policies, financing and administrative mechanisms and technical capacities. The MOHP is the major provider of primary, preventive, and curative health care in Egypt, with around 5 000 health facilities and more than 80 000 beds around the country. The MOHP service delivery is organized along different dimensions, including geographic (rural and urban), structural (health units, health centers, and hospitals), functional (maternal child health centers), or programmatic (immunization, and diarrheal disease control). The MOHP is the largest provider of inpatient health care services with about 1 048 inpatient facilities with about 80 000 beds. The private sector has 2 024 inpatient facilities, with a total capacity of around 22 700 beds which equals about 16% of the total inpatient bed capacity in Egypt (MoHP 2004). The capacity of both public and private sectors is not sufficient, especially regarding inpatient care, compared to the standards of health care provision and the size of population and burden of disease in Egypt.

See Annex 1 Capacity of different levels of public hospitals.

The lack of referral system in Egyptian health system and fragmentation of service provision contribute to patients' overload, chaos and shortage of materials in public hospitals and the low quality of the provided services. Egyptian Health system depends heavily on institutional medicalization, neglecting community based health care, high levels of trained staff and expensive equipment that is hard to maintain (Jenkins et al. 2010a; Pande et al. 2015; WHO 2006). This reveals poor organization and

planning of Egyptian Health system. There is poor governance in this Centralized system (top down), unequitable allocation of resources without community participation, decrease access to services and increased feelings of injustice. Lack of gate keepers in the Egyptian health system lead to over medicalization and treatment of many cases at higher levels of health care and this has higher cost/benefit ratio.

## 1.5. Mental health in Egypt:

### 1.5.1. Burden of mental health and substance abuse problems:

The Prevalence of mental and substance use disorders in Egypt 2015 was 14 553/100 000 population (14.5 % of population)(IHME 2016). The overall prevalence of mental disorders in community based survey in 2003 among 14 640 adults in 5 areas (Alexandria, Giza, Qaliubia, Fayoum and Ismailia) was 16.93%. The 3 most common disorders were mood disorders (6.43%), anxiety disorders (4.75%) and multiple disorders (4.72%) followed by major depressive disorder (2.70%) and premenstrual dysphoric disorder (2.52%). The least common were alcohol dependence/abuse (only 5 cases) and adjustment disorder (only 4 cases) (Table 1).

Women had a significantly higher odds of having a mental disorder (OR = 2.24; P < 0.001). People living in Ismailia, Giza and Fayoum have significantly higher odds of mental disorder compared to those living in Alexandria. Occupation (housewife, unemployed), marital status (widowed, divorced) are significant risk factors for mental disorder. Residence was not associated to odds of mental disorder. Regarding education, those having secondary or higher education have significantly lower odds of mental illness. Having children below 3 years and being a current smoker were found protective factors. Crowding index higher than 3 was the only significant socioeconomic factor associated with mental disorder (OR = 1.26; CI: 1.13–1.41; P < 0.001). Other factors such as having a car or living in a home connected to the water and sewerage systems were not associated with having a mental disorder (Ghanem et al. 2009; Scheffler et al. 2011).

Type of disorder	Rate (%)	95% CI
Mood	6.43	6.04–6.84
Anxiety	4.75	4.40–5.10
Somatoform	0.67	0.54–0.81
Psychotic	0.19	0.13–0.28
Alcohol dependence/abuse	0.03	0.01–0.08
Drug dependence/abuse	0.13	0.08–0.21
Adjustment	0.03	0.01–0.08
Multiple	4.72	4.38–5.08

Table 1: Prevalence of mental disorders in Egypt from preliminary survey 2009  
(Ghanem et al. 2009)

The National Addiction Survey 3rd phase (2005–2007) in 8 governorates (geographically representative) showed that 9.8% of the sample used drugs at least once, 3.1% are occasional users, 4.8% are regular users and 1.6% are drug dependents. The most common substances were cannabis and its derivatives 93.5%, alcohol and its derivatives 22.6%, pharmaceutical drugs 11.7%. The National Addiction Survey 4th phase was performed for one governorate, Cairo, and mainly targeted the lower socioeconomic class. 7% of the sample (15 years and above) were found to be addicts. Ratio of males to females using drugs is 2:1, greater than other governorates where the ratio is 13: 1. This is indicating a growing addiction problem among females in Cairo. The influence of religion only appears in alcohol use (Christians more than Muslims) and that alcohol and substance use is the highest among the age 20- 45. Regarding education, there is an inverse relationship between the level of education and the use and dependence on substance. Addiction was found more prevalent among manual workers. There was no relation between marital status and addiction (GSMHAT 2012).

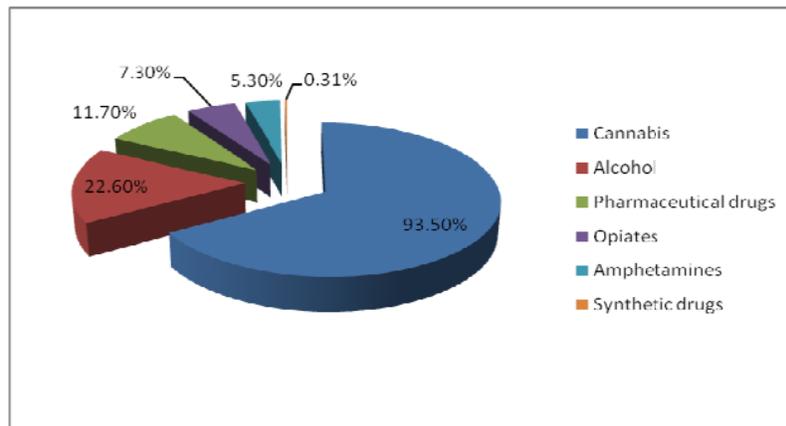


Figure 4 the distribution of addictive substance in Egypt

(GSMHAT 2012)

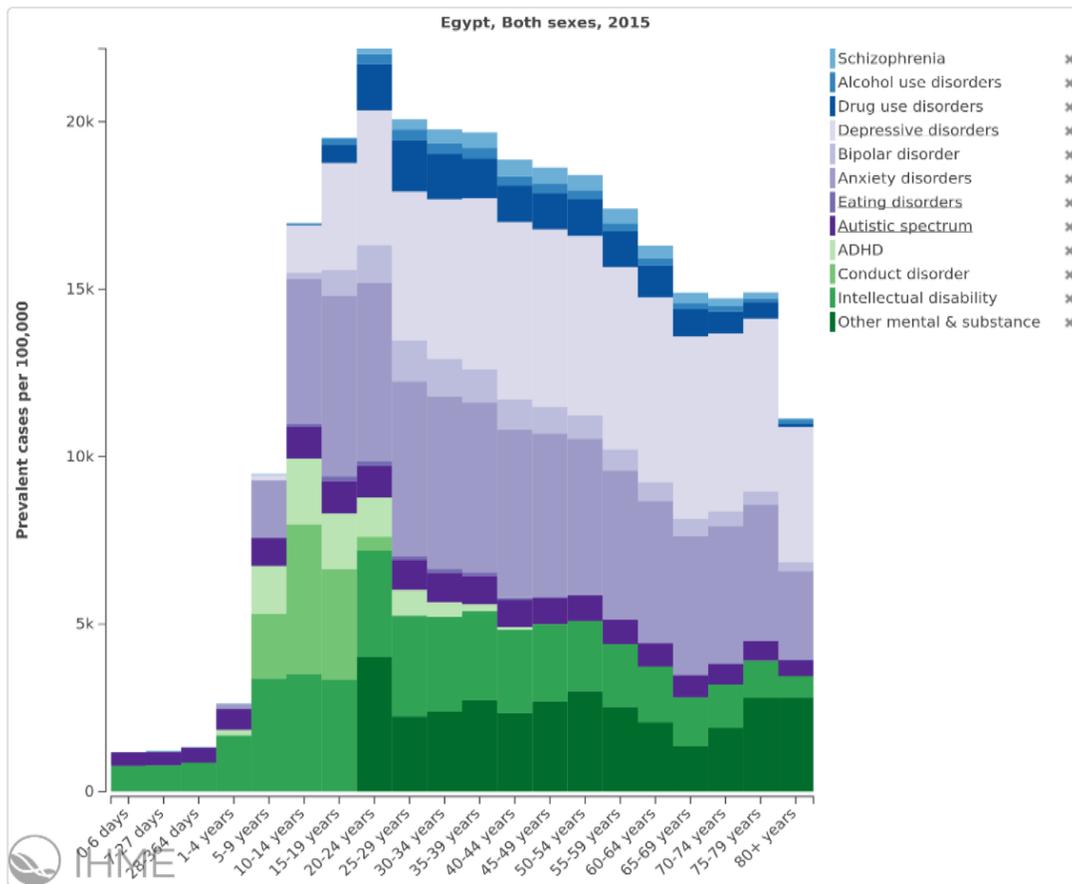


Figure 5 Prevalence of Mental Health and Substance abuse conditions in Egypt, 2015 (rate per 100 000 Population) (IHME 2016)

### 1.5.2. MH system in Egypt

MoHP is the main provider of mental health services in Egypt. Public mental health services in Egypt are managed through two main systems. First, Mental Health Secretariat MHS, headed by the General Secretary of Mental Health GSMH, which reports directly to the Minister of Health. GSMH supervises 18 mental hospitals and centers in 13 governorates and one community mental health center provides service for mental patients, families and community in the district of Kafr El Dawar, Behara through bio-psycho-social model of management in collaboration with the Family and PHC units in the district. The services provided by GSMH facilities include general adult psychiatry, geriatric psychiatry, addiction including gender-oriented care for female addicts and adolescent addiction, child and adolescent psychiatry, forensic psychiatry and rehabilitation and community psychiatry. There are no special services for women who are victims of drug abuse. Human resources for mental health in the GSMHAT's facilities are around 5259 worker in all inpatient facilities and 608 worker in outpatient facilities. The actual cost of treatment in addiction departments is about 2550 - 3000 EP/month and varies according to the type and setting of service (about 300-400 US \$ at 2012-2015). The Ministry of Social Affairs and

National Fund cover cost of treatment of addiction patients admitted through their hotline otherwise patients contribute to the treatment costs (GSMHAT 2012).

The Second system consists of, 13 mental health departments in the General and Central Hospitals of MoHP (reported as 7 in MH atlas 2014). These departments and clinics are managed by curative care departments in the governorates, while MHS responsible for technical supervision and support. There are psychiatric departments in 9 public medical schools. The total licensed facilities for providing mental health services in Egypt were 61 facilities (17 governmental and 44 private) as per 2013. The total bed capacity of mental health sector were 7921 bed (1966 beds in private sector and 5955 beds in public sector) (WHO 2014b; GSMHAT 2013).

The budget of Mental Health Secretariat comes directly from the national revenue as part of the budget allocated to health (around 180 M EP 13/14= 2.09 EP/capita). Budget for the mental health departments and outpatients departments comes directly from the hospital budget, which is a part of the curative care budget. Government expenditure on mental health is about 2% of the government expenditure on health, about 59% of this amount is spent mostly on few large centralized mental health hospitals (WHO 2014b; Jenkins et al. 2010a; GSMHAT 2013). This reflects disparities in coverage and access to MH services resulting from unequitable allocation of the deficient resources in the mental health sector. Beds available for acute psychiatric care in GSMH facilities are inadequate as 60% of the beds are occupied by chronic patients of which many can be discharged according to studies. Access to MH services is affected by disparities in allocation of resources geographically as the density of psychiatric beds in or around Cairo is 3.17 times greater than the density of beds in the entire country (GSMHAT 2012; WHO 2014c; Jenkins et al. 2010b; WHO and MoHP Egypt 2006). These figures indicate low geographical coverage of mental health services compared to number and distribution of population. Data on MH care generally is scarce, including services uptake and utilization. data are very fragmented, reports and studies from the same source and from different sources (mental health atlas, MOHP including GSMH) are reporting different indicators, incomplete and sometimes inconsistent (Jenkins et al. 2010b). It is impossible-methodologically- to compile these figures together and draw trends without systematic reviewing and meta-analysis.

According to the most recent MH atlas 2014, regarding Inpatient care, the ratio of Mental hospital beds / annual admissions is 6.6 / 1.7 per 100 000 population. Outpatient visits ratio is 485 /100 000 population /year. Total number of inpatients is 4 633. 34% of inpatients stay less than one year. Many indicators were not reported in the MH Atlas 2014: number and ratio of treated cases of severe mental disorders, mental health day treatment sessions, General hospital psychiatric unit beds / annual admissions, Residential care beds / annual admissions, Inpatients stay 1-5 years and more (WHO 2014d), which reflects the weakness in the HMIS in public health sector in Egypt.

According to the 2014 MH atlas, Ratio of MH hospital beds is 6.6/100 000 population, the ratio of psychologists is 0.12/100 000 population, ratio of psychiatrists 0.68/100 000, the ratio of Nurses is 3.1/100 000 population, ratio of Social workers is 0.29/100 000 population and the total ratio of MHW is 7.3/100 000 population. This indicate high deficiency in HRMH in Egypt compared to standards. WHO standards for low income countries including Egypt is 22.3 MHWs per 100 000 population, consists of 6% psychiatrists (1.2/100 000 population), 54% nurses (13/100 000 population), and 41% psychosocial

worker (9.1/100 000 population) (Kakuma et al. 2011; Scheffler et al. 2011; WHO 2014a; WHO 2014c; WHO 2011).

GSMH reported treating 17 980 inpatients in its facilities in 2013 (including psychiatry and addiction) and 40 4281 visits to its Outpatients clinics. Total admission of 3 216 patients in 2010, compared to 3 126 in 2011, 95% of them are males. Regarding Outpatient's services, in 2011 Total number of patients was 27 606, of which 4.3% females and 95.7% are males. New patients are 26% of total patients admitted in 2011 (GSMHAT 2013). Neuropsychiatric outpatient visits to Public and Central Hospitals of MoHP were 487 770 in 2013 (10% of all outpatient visits to all medical departments) (CAPMAS 2015b). This shows great disparity in uptake of mental health services by females, and the number of treated cases does not meet the burden of disease on mental illness in Egypt that indicates that many mental patients are left without mental health care services.

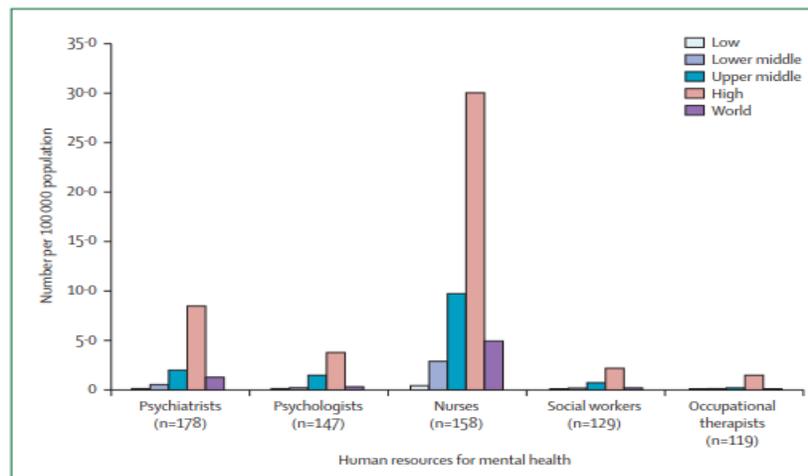


Figure 6: Human resources for mental health per 100 000 population, by country income group defined by the World Bank, 2010. (Kakuma et al. 2011)

### 1.5.3. MH Policy and laws

Egypt's mental health program was formulated in 1986. A new program was adopted in 2002 and aimed to integrate mental health into community care, develop health recording and information gathering system, provide essential drugs and develop human resources. Other areas like quality assurance, development of intermediate and alternative systems of providing mental health care, child and adolescent psychiatry services, the role of NGOs, increasing awareness about mental health problems, promoting mental health and preventing mental disorders are still underdeveloped (Freeman and Pathare 2005). The program has not reach its goals yet as MH care still not integrated in PHC, HMIS in the MH Sector still deficient, and HR for MH still insufficient.

Mental Health Act was issued in 2009 replacing the law 141 / 1944 on mental health and concentrated on human rights issues of patients in the psychiatric facilities and on monitoring all activities in these facilities. It contained 7 chapters governing different aspects of MH services like the role of Councils of Mental Health, The Patient's admission, Treatment and Rights, Mental Health Fund and Penalties staff and institutions (GSMHAT 2013).

The National Mental Health Commission NMHC is the governmental body responsible for supervising the Mental Health Act 71 / 2009. Its main role is to develop all aspects of MH policy like admission and treatment of patients, protection of rights of the patients, licensing facilities working on providing mental health service, regulating the work of forensic psychiatry units. Different departments of GSMH have developed internal regulation, guidelines, policies and procedures for delivering services (GSMHAT 2013; WHO 2014c).

See Annex 2 Examples of GSMH departments' policies.

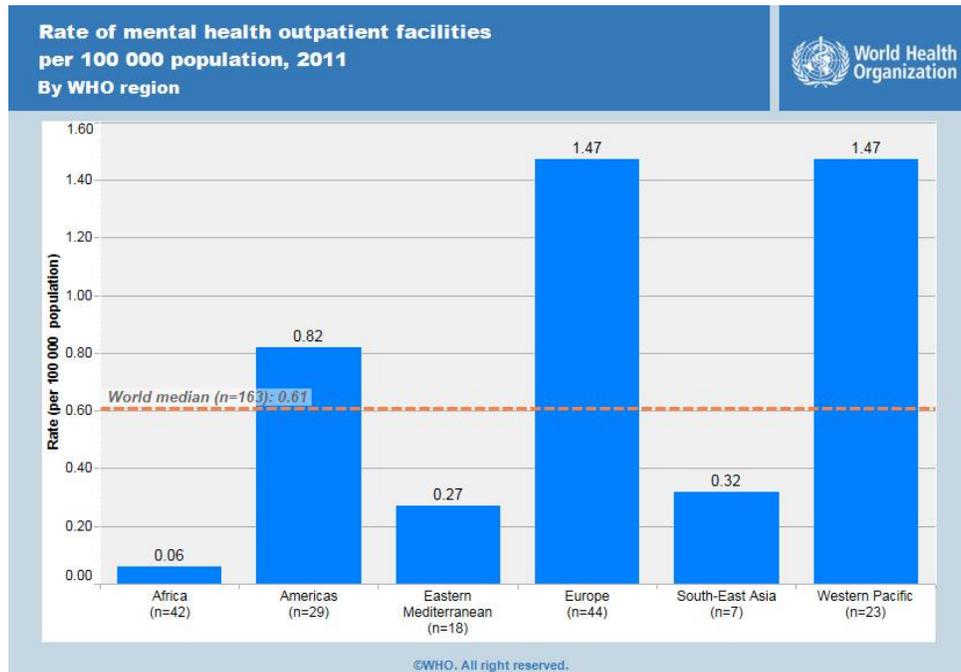


Figure 7: Rate of MH outpatient facilities per 100 000 population, 2011 by WHO region

(WHO 2014)

## 2. Problem statement, Justification and Objectives:

### 2.1. Problem statement:

The refugees suffer twice: once during the conflict that displaced them, with all its dramatic events, and once during their flight - which can be sometimes on foot - and settlement in another country. Refugees face many legal, political, cultural, social and economic constraints. These conditions cause and exacerbate mental illness and adversely affect the wellbeing of the affected persons and their communities especially in the absence of health services and social care (Zohry and Harrell-Bond 2003; UNHCR 2015a; UNHCR 2015b).

Mental health and psychosocial problems in emergencies and conflicts go beyond PTSD and depression. Estimates of mental disorders after conflicts vary due to differences in context, study methods and analysis. Some surveys indicate average rates of 15–20% for depression and PTSD in emergencies and conflicts. Following the crisis, mental health complaints are diverse in nature and severity and sometimes mixed with physical illness. Grief and acute stress are usually transient psychological reactions to the events. Some of these conditions may become chronic problems and interfere with daily life, making recovery harder and placing additional burden on the community (Ventevogel 2015; Robjant et al. 2009; Tempany 2009; Meffert and Marmar 2009; Mowafi 2011a).

MHPS problems in emergencies and conflict mainly have a social or psychological origin. Problems of a social origin include: pre-emergency social problems as extreme poverty, discrimination and marginalization because of race, religious or political affiliations. Emergency-caused social problems include: family separation, disruption of social networks, destruction of community structures, resources and trust, increased GBV. Humanitarian aid may also cause social problems as undermining of community structures or traditional support mechanisms. Problems of a psychological nature include pre-existing problems such as severe mental disorder, personality disorders and substance abuse. Emergency causes a range of mental problems such as grief, non-pathological distress, depression and anxiety disorders (including PTSD). Humanitarian aid can induce psychological problems such as anxiety due to a lack of information about food distribution (Interagency Standing Committee (IASC) 2007; World Health Organisation 1996; Grove and Zwi 2006; Pumariega et al. 2005). Substance abuse problems associated with mental illness and poverty among refugees can lead to increased SGBV and STDs including HIV (Meyer 2013; Kergoat 2013; Pumariega et al. 2005; Lindert et al. 2016).

People with pre-existing chronic psychoses like bipolar disorder, intellectual disability and epilepsy become more vulnerable during crisis. They might experience neglect, abandonment, abuse and interruption of maintenance medication and lack of access to health services. People with a history of severe mental disorder may experience a relapse or exacerbation of existing symptoms. Acute health risks and social problems due to alcohol and drug use can be magnified at times of war and conflict (Ventevogel et al. 2015; Meyer 2013).

In most emergencies, there are gaps between MHPSS and general health care, as is the case with refugees in Egypt and many Middle East countries. The way in which health care is provided during emergency affects the psychosocial well-being of people. MHPSS means to protect the well-being of

survivors, as the wrong way of addressing people's needs in emergencies threatens their dignity, affect their seeking-health-behavior negatively and undermines adherence to treatment regimens (IASC 2007).

Currently, the international and local actors (UN agencies and IGOs, Ministries of Health and NGOs) are struggling to respond to the recent refugee crises and provide the needed health care. In Egypt and Middle East most of efforts now are focused on the Syrian refugee crisis, as it is the biggest crisis in the area now after the flight of around two thirds of Syria's population, mainly to other countries in the Middle East. MHPSS in emergencies and displacement compromises the ability of the health systems to function and provide services to the ordinary population and the new refugee population, as it results in overwhelming patient caseloads, overworked health staff and shortages of medicines and equipment. Political, social, legal and economic constraints deprive refugees in Egypt from adequate health services, especially MHPSS which is essential and of high priority for them at this point in time (WHO 2015b; UNHCR 2016d; El-Khatib et al. 2013; Kaygisiz 2015; Hassan et al. 2015).

## **2.2. Justification of the study: Legal and human rights perspective:**

Human rights of refugees and asylum seekers are guaranteed by the Egyptian constitution, International Humanitarian Law IHL and international conventions and treaties. Egypt is signatory to the 1951 Convention on the Status of Refugees and its 1967 protocol, but made reservations to five provisions, namely article 12(1) (personal status), article 20 (rationing), article 22(1) (access to primary education), article 23 (public relief and assistance), and article 24 (labor legislation and social security). Egypt is also a signatory to the 1969 Organization of African Unity Convention "African Refugee Convention" governing refugee problems in Africa, the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment "CAT", the Covenant on Economic, Social, and Cultural Rights "CESCR" and the Convention on the Rights of the Child "CRC" (Kagan 2011; Library of Congress 2016). These conventions show the commitment of Egypt Toward refugees.

### **2.2.2. Social perspective:**

Psychosocial support offered to the conflict affected population would prevent the development of psychosocial problems and the following unnecessary medicalization of these problems. This benefits the whole community, not just refugees, because it saves society the big cost of the mental health bill and loss of economic revenues generated by refugees. Moreover, this encourages positive interaction between the refugee community and the host community, and facilitates integration. This is also a way to avoid social congestion resulting from competition for resources between refugees and the host community. Support aims to help refugees to develop ways of coping adequately with what they have lived through (MSF 1997; WHO 2003; Cleveland 2012; IASC 2007).

From a perspective of social equity, the refugees are among the most vulnerable groups in most cases, as they have higher risk for health and social problems. Responding to their needs should be prioritized.

### **2.2.3. Public Health perspective:**

Emergencies including conflicts and war create a wide range of problems at the individual, family and community levels. Emergencies erode normally protective supports, increase the risks of diverse problems and amplify pre-existing psychosocial problems and mental health conditions. Conflicts have a disproportionate impact on the poor, who already normally have no sufficient access to health services, specifically those of mental health. This become aggravated in conflicts and emergencies (IASC 2007).

The increased mental health problems put pressure on the different clinical departments, as many mental conditions are associated with physical symptoms. Complicated cases with severely disabling symptoms, violence, addiction, and risky behavior as unprotected sex put the patient and his surroundings in constant danger and have a high health-, social and economic impact. The health impact of mental problems may include HIV and other STDS, unintended pregnancies, harm of self or others by for instance suicide or rape, and blood borne disease from needle exchange among injecting drug users. All of these add additional burdens on the health system and cause high case load among health professionals and deterioration of service (Mowafi 2011b; Johnson 2012; UNHCR 2015e; Hassan et al. 2015).

## 2.3. Objectives:

### 2.3.1. Overall objective:

To analyze policy and practice gaps in MHPSS for refugees and identify their effect on the mental health situation of refugees in Egypt in order to develop recommendations to the concerned stakeholders to improve MHSS services.

### 2.3.2. Specific objectives:

- I. To identify the mental health situation of refugees: needs, service utilization, health seeking behavior, determinants and risk factors.
- II. To map MHPSS's concerned stakeholders in Egypt and their policies and practices towards different refugee groups, and to compare the situation with other similar countries in the Middle East.
- III. To evaluate MHPSS's current policy and practice gaps in Egypt and their impact on mental health and psychosocial wellbeing of refugees.
- IV. To develop recommendation for the concerned stakeholders to bridge gaps in existing policies and/or practices to improve mental health and psychosocial wellbeing of refugees in Egypt.

### 3. Methodology

#### 3.1. Search databases and techniques:

A systematic literature and desk review was conducted using Google, Google scholar, VU e library and Pub med central databases. Manual research was conducted on websites of the following sources: The American University in Cairo (AUC) Digital Archive and Research Repository (DAR Repository), the Centre for Migration and Refugee Studies (CMRS) AUC, library of congress, WHO, Ministries of Health, World Bank, UNHCR, CAPMAS, ICRC and MSF..

Furthermore, data on this topic was requested from a number of fellows during the study.

The snow balling technique was widely used as well, applied to academic and grey literature, as to relevant websites as well. References, links, authors and other resources from the accessed literature were tracked in order to provide a complete background picture of the issues at hand in this thesis. Due to scarcity of academic literature on this topic, intensive desk review was conducted to fill the knowledge gap and to answer all the research questions. Documents include: policy briefs, manuals, guidelines, reports, internal documents, website articles and newspapers articles which was used only to supplement other stronger evidences when possible. Data was filtered for inconsistency or conflicting content. The focus of the analysis was given to the most recent data and data from the most reliable resources, while the analysis is also presenting the other sources and the conflicting data. Meta-analysis of numbers and trends of refugees and health care system performance is unfortunately beyond the scope of this thesis. Reliable resources include: official national and international health authorities, UN agencies and IGOs, active and reputable NGOs, scientific journals, and Egyptian governmental newspapers when they report from the government.

##### 3.1.1. Search Key-words

Combinations of the following words have been used to enhance search results and reach sufficient and informing data: refugee(s), asylum seeker(s), documented, undocumented, displaced, access, health, interventions, policy, practice, services, mental, medical, rejected case(s), closed file(s), urban, socioeconomic, sociocultural, psycho-social, Egypt, Middle East, needs, uptake, utilization, MHPSS, trafficking and protection.

##### 3.1.2. Search language:

English is the sole search language of this thesis because the initial research and the preparatory readings revealed that the majority of the literature on this topic is in English, while Arabic sources are mostly translations of English versions. Arabic sources were accepted though when they were related to the subject and when they provided additional information.

The search for data focused on literature in the past 20 years. Older sources were accepted though, due to the scarcity of literature. Because of this, a part of the literature that is being used includes literature older than 20 years.

##### 3.1.3. Selection criteria:

**Included:** Academic and grey literature on different refugee groups in Egypt including documented and undocumented refugees and asylum seekers, VoT and stateless persons.

**Excluded:** literature and documents focusing only on internally displaced and economic migrants as they were out of focus of the study, despite the similarity on MH aspects among these groups and refugees.

### 3.2. Framework for the analysis:

There was no existing analytical model that fitted the objectives of this thesis entirely. That is why a framework was designed that consists of four variables. These variables are: stakeholders, target populations, policies and practices. Stakeholders and target populations are (of course) the key parties of the issue at hand in this thesis. Policies and practices are the main elements of MPHSS.

The framework is designed to examine the effect of the different stakeholders' policies and practices on the mental health and psychosocial wellbeing of the target populations. The framework also allows for an analysis of gaps between policies and practices.

#### **Variables of the framework:**

- **Target populations:** this variable represents the different refugee groups with different legal situations.
- **Stakeholders:** this variable represents the different actors who provide for policy and/or interventions for the different refugee groups.
- **Policies:** this variable refers to policies adapted by the stakeholders concerning the rights, protection, health care and MPHSS provisions of each group of refugees.
- **Practices:** refers to the attitude and the actual interventions of the stakeholders for each group of refugees regarding their rights, protection, health care and MPHSS provisions.

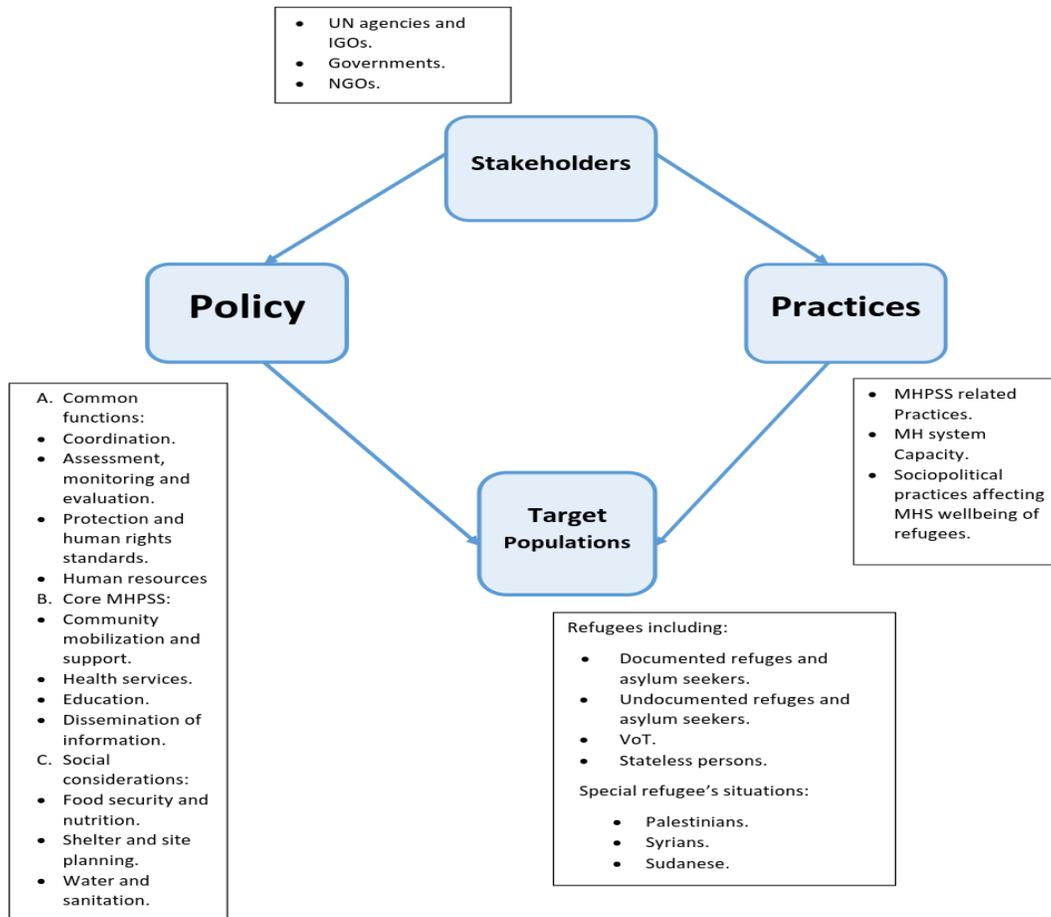


Figure 8: Analytical frame work, MHPSS Target populations, Stakeholders and their policies and practices

### 3.3. Limitations of the study:

The main limitations of this study are changes in the study plan and the inability to perform the original study plan completely. Some elements of the original study plan were expected to provide additional information and bridge some of the gaps in literature on this topic.

The main constraints that faced this study were scarcity of literature on many of the research questions and lack of data and statistics on certain groups like undocumented refugees and trafficking victims. To compensate for bias and lack of adequate data, triangulating data from multiple sources was done if possible to increase credibility of the data and to allow for analysis of differences in reporting. To compensate for bias and lack of adequate data, triangulating data from multiple sources was done as possible to increase credibility of the data and allow for analysis of differences in reporting. Also it was not possible to address the situation and determinants of mental health and psychosocial wellbeing of refugees in Egypt more comprehensively due to the deficiency in data, time and thesis space limits.

#### 4. Development of MHPSS for Refugees:

Until the late 1980's the primary concern of humanitarian response was the provision of services to meet basic needs of displaced people (refugees and IDPs). In this context MHPSS problems were totally neglected. Standard treatment for such problems was developed after humanitarian crises in Cambodia, Bosnia-Herzegovina and Croatia. The term MHPSS was introduced around this time and is now widely used to describe the range of practices that are used to treat mental disorders and to improve the well-being of individuals and communities affected by conflicts or disasters. These treatments are now an integral part of any humanitarian response, and recognized as requirements of humanitarian response in different events, such as the Libyan crisis in 2011, and the ongoing Syrian crisis (Meyer 2013; WHO 2012; Tol et al. 2015).

No single community or agency can be expected to have the capacity to implement all minimally necessary responses during emergencies. Thus it is necessary to engage many different stakeholders and coordinate their actions in order to deal with a sudden crisis. The MHPSS activities include addressing of the psychosocial impacts of conflict and displacement. An essential part of MHPSS are the protection of individuals, prevention of protection risks and the promotion of community support for vulnerable individuals. MHPSS is important both at a time of acute crisis and in the case of long-term displacement (Meyer 2013; WHO 2012; Tol et al. 2015).

The Interagency Standing Committee Guidelines for MHPSS identifies 4 levels of interventions illustrated in the Figure below.

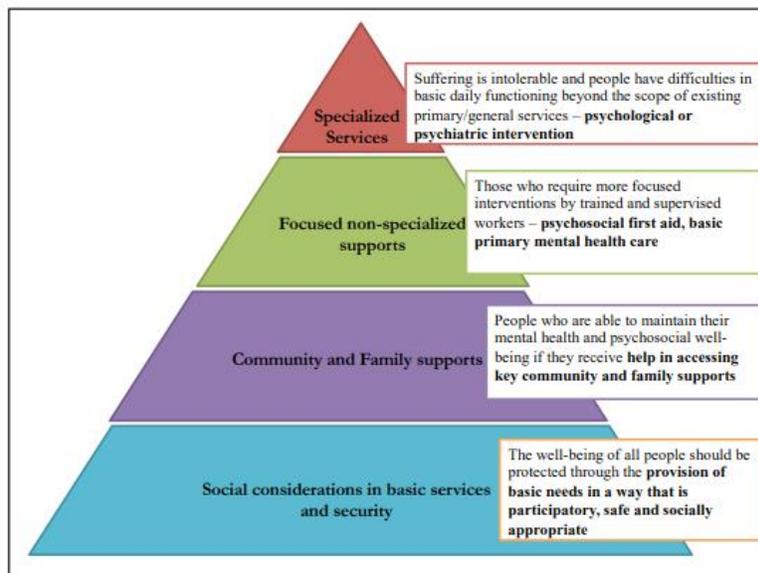


Figure 9: Levels of MHPSS by IASC 2007  
(IASC 2007)

## 5. Displacement in the Middle East:

About 60 % of the 60 million people displaced now have been protracted for 5 to 7 years. This reflects failure of international society including the UN agencies and the major international political players as US and EU to find long term solution for the displacement crises or to stop root causes of displacement. In 2015, the fewest number of refugees returned to their countries since 1983 (IOM 2016; Ferris and Kirişci 2016; Fábos 2015; UNHCR 2015d; IOM 2015).

Right now, there are many concurrent massive displacement crises in the Middle East, in Syria, Iraq, Yemen, and Libya, in addition to the Palestinian long standing problem. Around 5.5 million refugees originated from The Middle East as of mid-2015 and about 16.2 million internally displaced persons (IDPs). Syrian refugees are approaching 5 million (IOM 2016; Ferris and Kirişci 2016; Fábos 2015; UNHCR 2015d; IOM 2015).

Humanitarian activities including MHPSS are affected by the shortage of both financial and human resources in the middle of the ongoing war and absence of any solutions for many of these conflicts in the horizons. Moreover, International attention is fluctuating towards and away from the refugees' crises, affected by the political tug of war, while refugees needs stay unsatisfied (Ferris and Kirişci 2016; European Commission 2016; Nouredine et al. 2015).

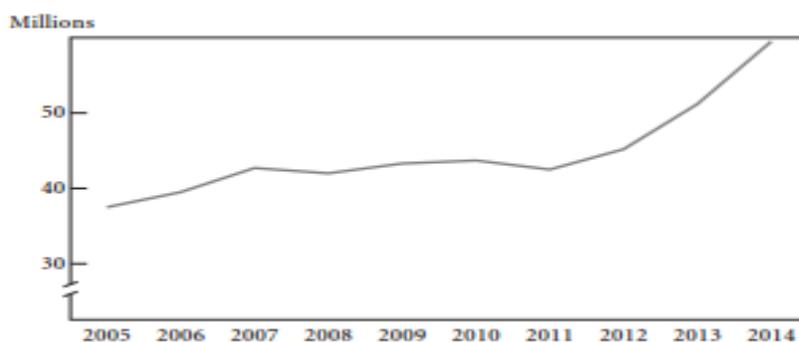


Figure 10: Trend of Number of Displaced People 2005–14  
(Ferris and Kirişci 2015)

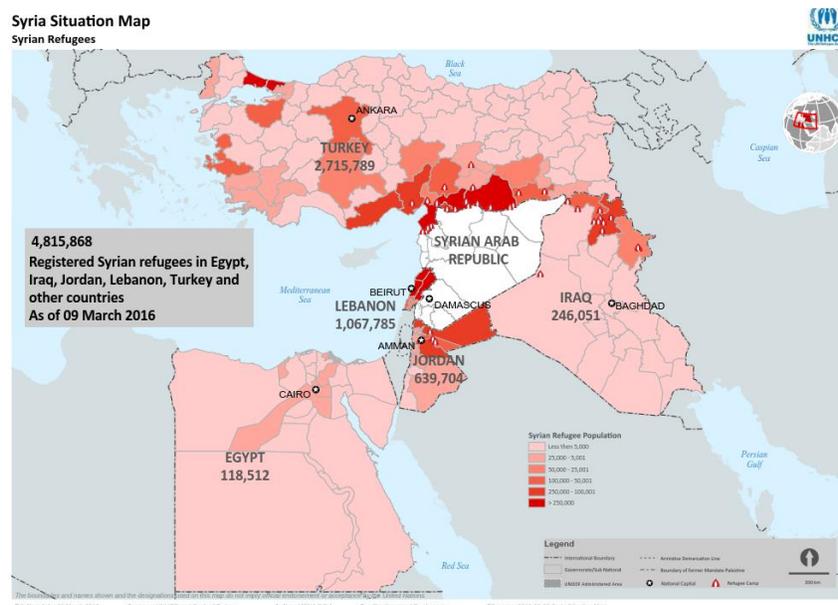


Figure 11 Syrian refugees situation map (UNHCR 2016f)

## 6. Refugees in Egypt:

### 6.1. Refugees Groups in Egypt

Egypt is one of the top largest five countries hosting urban refugees (Pierrot 2013; Roman 2006; Fargues 2009). Government of Egypt claims hosting 5 Million refugees while scholars' estimates are about 1-3 millions. Thousands of refugees denied recognition by UNHCR also continues to live in Egypt (Petrini 2012; Ahram Online 2016; Zohry 2003). The gaps and conflicts in information and inaccuracy of the estimates of refugees in Egypt make it hard to know their real and accurate numbers.

The figure below illustrates the process of displacement and refuge. starting from fleeing during the conflict or war and ending with gaining official refugee status and living in the host country, going back to home country or another country, legally or by smuggling, or living in the host country without documents and legal refugee status.

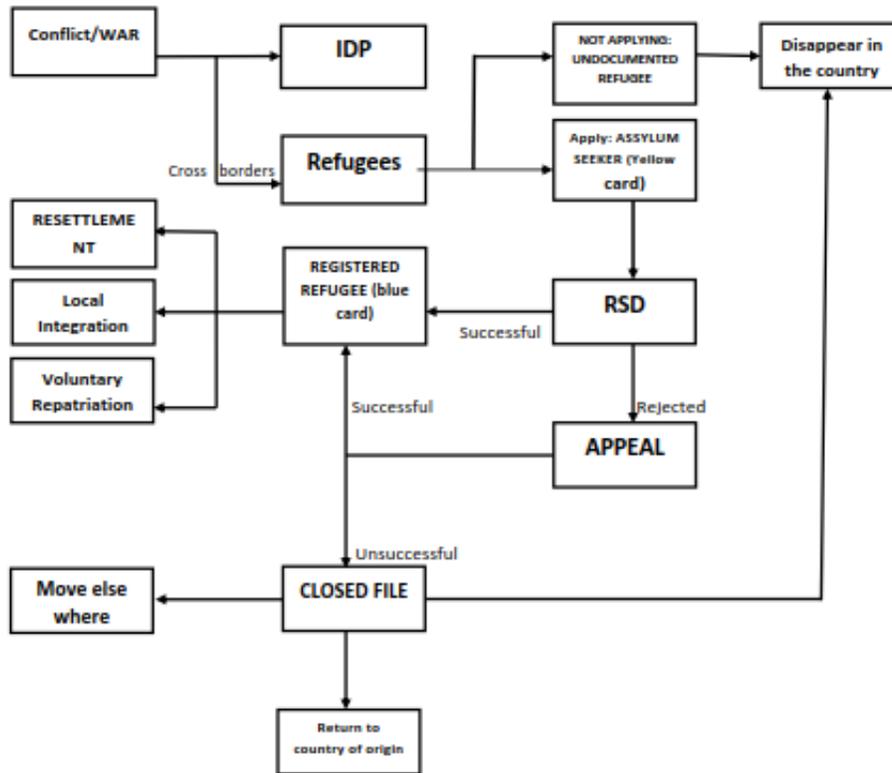


Figure 12: Refugees Process and Status

Adapted from (Azzam 2006)

According to the scope of this study, Target populations are classified in the way presented below, to understand the policy and practice implications for each group.

#### 6.1.1. Documented refugees and asylum seekers:

According to UNHCR Egypt, Those registered in UNHCR in January 2015 were 226 344 Refugees and 30 019 Asylum Seekers (UNHCR 2015a), while in September 2015, UNHCR reported total number of registered asylum-seekers and refugees in Egypt was 184 887 . This number consisted mainly of Syrians (128 019 person including 55 816 children) which equals around 70% of total people registered with UNHCR in Egypt. The remaining 29% of people registered with UNHCR are 26 324 Sudanese, 6 941 Somalis, 6 814 Iraqis, 5 803 Ethiopians, 3 841 South Sudanese and 3 263 Eritreans (UNHCR 2016). Egypt also hosts around 70 000 protracted Palestinians that have special situations (Mowafi 2011; Abed 2004). The reasons behind the difference between total PoC in UNHCR reports in January 2015 and September 2015 is not clear, especially that numbers of resettled refugees and voluntary repatriation in this period can of fill this difference between total numbers of PoC in the two reports.

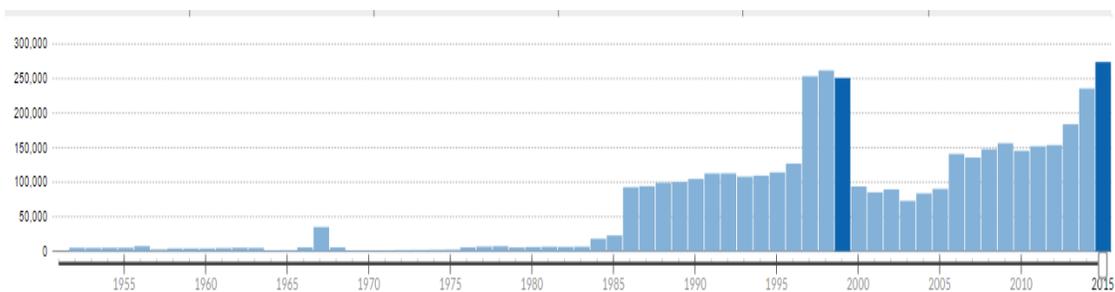


Figure 13: Trends in UNHCR PoC (1950-2015)

(UNHCR 2016)

Refugees and asylum seekers in Egypt, 2001-2011

Refugees	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Palestine	134	70,195	70,215	70,245	70,255	70,198	70,213	70,174	70,024	70,026	70,029
Sudan	4,659	7,629	14,178	14,904	13,446	12,157	10,499	10,146	9,818	10,035	10,324
Somalia	1,177	1,639	3,068	3,809	3,940	4,317	5,139	5,600	6,096	6,172	6,328
Others	5,883	8,624	15,433	16,250	14,716	13,464	11,931	11,996	11,714	12,086	12,693
Asylum seekers	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Sudan	9,529	6,253	5,726	9,720	2,400	2,523	1,343	782	1,310	1,409	2,735
Somalia	2,559	1,977	224	340	538	1,135	770	450	659	516	713
Ethiopia	545	299	325	289	189	193	248	266	217	183	671
Others	543	473	405	353	352	3,159	1,180	773	423	497	1,057
Acceptance and resettlement rate	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Asylum seekers	13,176	8,920	n.a.								
Recognized refugees	3,921	4,944	n.a.								
Resettled refugees	2,057	1,716	n.a.								
Acceptance rate (*)	29.8	55.4	n.a.								
Resettlement rate	52.5	34.7	n.a.								

Notes: (\*) Acceptance rate=(recognized refugees/asylum seekers)\*100; (\*\*) Resettlement rate: (resettled refugees/recognized refugees)\*100

Table 2: Trends in refugees and asylum seekers in Egypt 2001-2011  
(MPC 2013)

Somalis and Ethiopians mainly arrived in the 1990s as a result of civil wars and political instability in the Horn of Africa (MPC 2013). The Iraqis big arrived in exodus from 2006, the number of Iraqi refugees in Egypt in 2008 reached 16 853 (Di Bartolomeo et al. 2010). During The Libyan Crisis 2011, Egypt was part of the corridor for evacuation and humanitarian activities and received large numbers of Egyptians and third country nationals fleeing Libya. Egypt have received by the end of December 2011 around 263 554 people, of which around one third are third country nationals (IOM 2011).

There are about 3 000-8000 Yemenis stranded in Cairo. They could not go back to Yemen because of war and closure of Yemeni airports. They are suffering shortage of resources with little institutional assistance by UNHCR and IOM ( Al Desoukie 2016; Hashem 2016).

### 6.1.2. Undocumented refugees and asylum seekers:

Majority of refugees in Egypt are undocumented. Many of them enter the country and do not register with UNHCR, other continue to live in Egypt after their asylum application has been rejected. The reasons behind this will be discussed in the discussion chapter ( Al-Shermani 2004; Ayoub 2016; Grabska 2006a; Issa 2013; Jacobsen et al. 2014; Roman 2006; Zohry 2012; ; Zohry 2003).

There is no accurate statistics on undocumented refugees' number but they can be Hundreds of thousands. They are mainly from Sub-Saharan Africa in Addition to Syrians and Palestinians from Syria. They have no legal rights or access to services and subjected to detention and deportation by authorities ( Al-Shermani 2004; Ayoub 2016; Grabska 2006a; Issa 2013; Jacobsen et al. 2014; Roman 2006; Zohry 2012; ; Zohry 2003).

### 6.1.3. Stateless Persons:

Statelessness is one of Egypt's unaddressed vital human rights problems it was a common but ignored problem in Egypt during Mubarak's rule, and has persisted following the 2011 revolution (McBride and Kingston 2014). stateless people in Egypt are about 10 000 (McBride and Kingston 2014), yet they do not appear among statelessness statistics by UNHCR annual report on statelessness (UNHCR 2016c).

The children of Eritrean fathers and Ethiopian mothers do not qualify for refugee status in many cases, but are not recognized as citizens of their parents' countries and are therefore rendered stateless. The same goes for other children born of stateless persons living in Egypt, who find themselves without nationality from birth. They receive no monetary assistance, cannot work legally, and are isolated from Egypt's refugee communities (McBride and Kingston 2014).

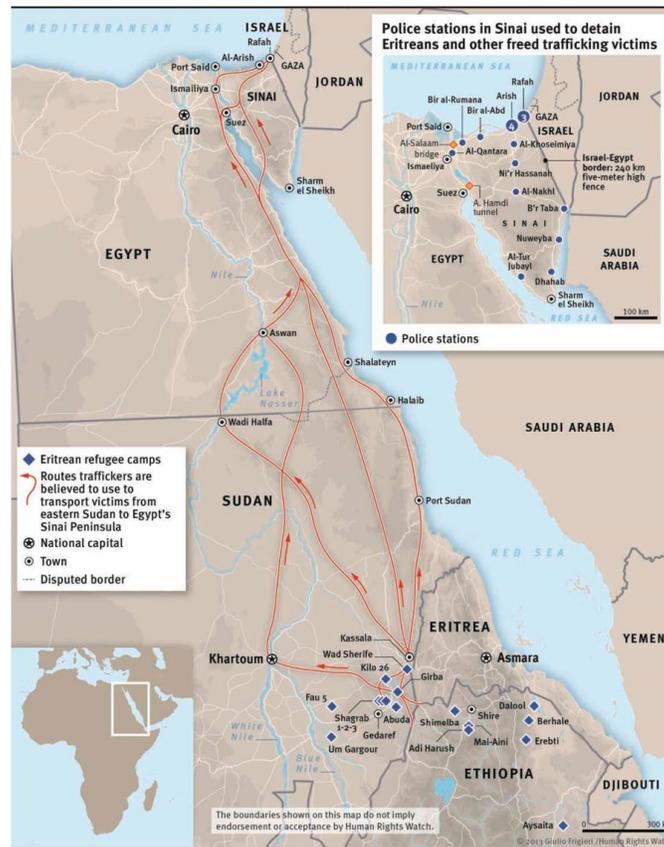
In 2005, Refugees International estimated that between 400 000 and one million stateless children lived in Egypt as a result of discriminatory nationality legislation. Stateless individuals in Egypt currently include Egyptians whose status remains unclear as a result of nationality laws that prohibited children of foreign fathers to attain Egyptian citizenship, individuals of mixed Eritrean and Ethiopian origin, Palestinians, the Banyamulenge ethnic group, children of refugees born in Egypt who cannot establish their nationality, stateless individuals from various Gulf and African states, and Egyptian Baha'is who are denied access to documentation because of their faith (McBride and Kingston 2014).

### 6.1.4. Victims of Trafficking (VoT):

The route of human trafficking through Libya across the Mediterranean Sea to Europe has been compromised by tight policing by Libya in collaboration with Italy. the route of crossing the Sinai into Israel became the alternative (Daoud 2015). Since 2006, over 13 000 refugees, asylum seekers, and other migrants have passed through Egypt to Sinai and into Israel. This number has raised dramatically after the Arab Spring in 2011). Majority are Ethiopians and Sudanese fleeing compulsory military service or religious persecution. Egyptian border police have killed at least 33 persons crossing the borders and wounded dozens more since June 2007 when the first victim Sudanese pregnant woman- was killed. (HRW 2008; van Reisen et al. 2013; Daoud 2015).

Eritrean VoT in Egypt can be abduction from refugee camps in Sudan or from Eritrea. Traffickers ask their families for ransom or sell them in Sinai to other traffickers. trafficking network include high-ranking officials in Eritrea and Sudan and some wealthy Bedouins in Sinai (van Reisen et al. 2013; Daoud

2015) The number of trafficked Eritrean victims who were reported by UNHCR peaked in 2012. Victims reported abuses including torture, extortion of large sums of money to continue the journey, rape, organ theft, and in some cases murder (Daoud 2015).



Map of routes of trafficking of Eritreans through Egypt (HRW 2016)

#### Refugees Groups with special situations:

**Palestinians** are round 50 000-70 000 in Egypt, began arriving from the mid-1930s after the occupation of Palestine with mass arrivals after wars of 1948 and 1967, and 1990-91. The United Nations Relief and Works Agency (UNRWA) responsible for Palestinian refugees in Jordan, Syria, and Lebanon has no command in Egypt. Until the late 1970s they enjoyed the national protection of the Egyptian state. From the early 1980s Palestinians were treated as foreigners (Zohry 2003; Zohry and Harrell-Bond 2003; Abed 2004).

**Palestinians from Syria** fled to Egypt are around 10 000. While Syrians are recognized as asylum seekers on *prima-facie basis*, and thus entitled to access to primary health care and other services, the Palestinian refugees who have fled Syria does not have the same benefits and not treated like the other Palestinians in Egypt (Sammonds 2013).

**Sundanese** mainly arrived in 1990s and 2000s because of the Civil War in Southern Sudan then in Darfur. The exact numbers of Sudanese in Egypt are unknown. (Di Bartolomeo et al. 2010) The

mixed Egyptian Sudanese population of “Arba’a wa Nuss” Slum in Cairo may reach one million. During the Libyan crisis, in May 2012 Egypt has received 1 906 person coming from Libya 86 % of them were Sudanese. They were placed at temporary camps of Salloum on the borders with Libya. The US, Sweden, and Canada opened for resettlement for displaced people in Libyan crisis, but those who arrived after October 2011 were not eligible for this resettlement program (Jacobsen et al. 2014; Ghazaleh 2000; Zohry 2003).

**Syrians:** are granted refugee status on a *prima-facie* basis<sup>4</sup>; therefore not counted as asylum seekers (Ayoub 2016; Amelia 2015; Kergoat 2013). while less than 150 000 Syrian refugee are registered with UNHCR, the real number of Syrians in Egypt exceeds 500 000 according to studies (Issa 2013; Kergoat 2013). Syrians during rule of Morsi did not have to apply for a visa for Egypt in advance as they were granted a 3 month tourist visa on arrival. Since July 2013 Syrian nationals are asked to obtain a visa prior-to-arrival and additional a security clearance from Egyptian authorities (Amelia 2015; Ayoub 2016).

## 6.2. Living Conditions of Refugees in Egypt:

Refugees in Egypt face common hardships and rank among the poorest of the poor (Zohry 2003). They experience socioeconomic challenges including unstable and informal employment, low salaries, violation and denial of rights, low or restricted access to services and assistance. Life of many refugees is unstable, especially those vulnerable population (disabled, children, single-mothers, elderly) (Petrini 2012; Issa 2013; Grabska 2006a; Grabska 2006b). 90 % of Syrian refugees in Egypt are classed as severely vulnerable by UNHCR (Rollins 2016).

These conditions can be aggravated by the other preexisting socioeconomic conditions like chronic illness affecting ability to work and large number of dependents specially children and elderly who have many needs to fulfill, essentially health care , nutrition and education. Other sociocultural, political and legislative issues as race, religion and legal status of refugee and the current political mood in Egypt which is highly swinging since 2011 affect the socioeconomic conditions of refugees increasing their hostility. Egypt -the host community- suffer from political instability, insecurity, degradation of infrastructure and grinding economic crises. These conditions increases hostility of refugees in Egypt and thereby their health problems especially psychosocial ones (Al-Shermani 2004; Rashad and Sharaf 2015b; Kergoat 2013; CAPMAS 2015a; Nassar 2008; Issa 2013).

Each refugee group in Egypt has its different cultural and religious background (Zohry 2003). Many sub-Saharan refugees in Egypt are Christians including mainly South Sudanese, Ethiopians and Eritreans. Syrians and Iraqis in Egypt include Christians, Shia Muslims and Alawi’s among other diverse religious components of Syria and Iraq (Grabska 2006a; Hassan et al. 2015; Zohry 2012). With the increased religious tension and intolerance in Egypt over the past decades, some refugees’ groups can be harassed or exploited because of their religious affiliation.

Xenophobia towards African refugees in Egypt is common, even the being Muslim as Sudanese and

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<sup>4</sup> “Prima facie concept refers to the provisional consideration of a person or persons as a refugee without the requirement to complete refugee status determination formalities to establish definitively the qualification or not of each individual”(Rutinwa 2002)

Somali like majority of Egyptians does not protect against racial discrimination. (Forced migration online 2016; Issa 2013; Kergoat 2013) Reports revealed that a police raid in 2003 on the neighborhood of Maadi in Cairo, which is has high population of African refugees and migrants, arrested every African/dark skinned person they found and has were asking locals for “black” people (Jones 2012; Human Rights Watch 2003).

SGBV in Egypt is very common, for example 98% of women in study in Egypt experienced sexual harassment, and in many cases on daily basis. Sexual harassment occurs in the streets, public transportation, work place and educational institutes (Barnes 2013; HRW 2013). Refugee women in Egypt may suffer sexual SGBV more than Egyptians. Impact of SGBV on refugee women is expected to be greater than in ordinary cases due to their severe vulnerability as they lack most kinds of protection, legal, financial, health and social. Perception of refugees as weak and helpless might be another reason behind their high vulnerability. Many refugee women already have experienced sexual violence during the conflict in their home countries, these additional experiences recall memories and traumas. The perception of African refugee females as prostitutes by Egyptians contribute to the SGBV against them. Many Syrian female refugees in Egypt including young girls are being forced for marriage under the pressure of financial needs. These practices have a very negative impact on the health and psychosocial wellbeing of refugees (Mowafi 2011; European Commission 2016; HRW 2013; Kergoat 2013; Johnson 2012; Meffert and Marmar 2009; Amnesty International 2016; Yount 2005; UNHCR 2015e).

In 2003, the governmental newspaper “Al-Ahram daily” published letters from readers expressing complaints about the problem of an increasing number of African and Asian refugees who were accused of not only taking jobs away from nationals but also bringing social problems such as promiscuity and prostitution (Al-Shermani 2004), these perceptions on refugees might play role in violations against them. Social congestion in Egypt because of economic hardships and absence of law and justice, which was among main reasons of 2011 revolution, can be directed towards refugees as some Egyptians see refugees as a burden on the tight resources of Egypt. The increased violence by the state are among the factors creating accepting environment and silence about violations toward refugees.

### 6.3. Health Situation of Refugees in Egypt:

#### 6.3.1. General Health:

Health problems among refugee community have not been well documented due to the instability in refugees’ lives, poverty and legal status among other factors affect refugee’s health profile, specifically health seeking behavior. Yet there are indications we can use to draw picture of health problems among refugees.

Refugees are more borne to some diseases. Besides mental health issues, refugees suffer from nutritional issues as a result of poverty and instability, this would affect mostly, infants, children and pregnant women, STD due to rape or risky sexual behaviors that are common. Risk of HIV increases due to drug use which accompany mental illness and poverty (Johnson 2012; Mowafi 2011; Meyer 2013; Kergoat 2013; Pumariaga et al. 2005; Lindert et al. 2016; Grove and Zwi 2006; Asgary and Segar 2011; Gammouh et al. 2015). in Egypt, Maternal and child health is of high priority for refugees in Egypt as children and women constitute about 38% and 48% of UNHCR Egypt total caseload (Kergoat 2013).

### 6.3.2. Mental health and psychosocial wellbeing:

Refugees in Egypt often suffer from loss of hope, deteriorating psychological and medical conditions, and limited livelihood opportunities. They are particularly vulnerable to poverty, food insecurity, access to poor quality services, as well as SGBV, including abuse and exploitation. Refugees in Egypt do not live in camps, but are living among Egyptian communities across Egypt, mostly in Alexandria, Cairo, Giza, and Qalyubia (Iskander 2010).

Stigma associated with mental illness in many Middle Eastern countries including Egypt remains a barrier towards seeking mental health services. Patients seek care in other health programs or go to traditional healers instead. This somatization is also evident among Arab refugees both in Middle East and west. This behavior is misleading for health planning and resources allocation and can be tackled by integrating MH services in the primary health care system (Mowafi 2011).

“When I think of my life here and our problems, when I think of resettling and how I can’t get it, my head hurts so much. Now my head hurts all the time. I can’t sleep. My body aches. It feels like there are worms crawling all over my body.” Said Habiba, a mother of eight, Somali refugee in Egypt (Al-Shermani 2004), this gives us a little indication about the pains refugees suffer from.

## 6.4. Stakeholders for MHPSS of Refugees in Egypt:

### 6.4.1. Government of Egypt (GoE):

Egypt has no national comprehensive policy on refugees’ only fragmentary domestic legislations to regulate their legal status and has not taken any fundamental steps towards improving lives of refugees in Egypt (Library of Congress 2016; Kagan 2011). GoE interest in refugees is mostly for control and security reasons rather than humanitarian concerns as reflected by the treatment of refugees by Egyptian authorities.

- **MoHP:** Main provider for preventive care and inpatient health services including mental health. Provide limited health services to registered refugees, with exception to Syrians who has same access to public health care as Egyptians.
- **Ministry of Interior:** must provide security clearances for Syrian refugees as of 2013 to gain entry visa to Egypt and a main player on general state policy towards refugees. A main perpetrator of violations towards refugees including detention, deportation and murder.
- **Ministry of Manpower and Immigration:** responsible for providing work permits for refugees.
- **Ministry of Education:** provide primary education for refugee children.

### 6.4.2. UN Agencies and IGOs:

- **UNHCR:** determines the refugee status in Egypt not GoE and is responsible for their protection and assistance. UNHCR also has the responsibility for stateless people in Egypt. (UNHCR 2015a; Unhcr 2015; Zohry 2003; Kagan 2006).
- **Unicef:** provides primary and preventive health care and education for refugee children through its implementing partners (NGOs and GoE) (UNICEF 2015).

- **IOM:** the main actor in resettlement of refugees to other countries, IOM provides non-food items and basic services, including medicines and health care, and involved in building the capacity of NGOs.

There are institutions that play very important role on refugees' issue in Egypt along with IASC like International Medical Corps (IMC), Doctors without Borders (MSF), Red Crescent community, Save the Children, CARE and Plan International.

#### 6.4.3. NGOs:

- **El-Nadeem Center:** mental health and psychosocial services for refugees who have been victims of torture. Capacity building for workers with refugees. The Center also provides medical statements and testimony for survivors taking cases before various bodies. El Nadeem has a program that specifically addresses violence against women and providing counselling.
- **PISTC:** MH Care services, MH Capacity building.
- **St. Anderw:** Education, Resettlement Legal Aid, Psychosocial counseling and referral services for refugees from 34 countries.
- **Caritas Egypt:** Waiving fees and financial assistance for mh patients
- **Mahmoud Specialised Charity Hospital:**
- **Refugee Egypt:** provide psychosocial support in preparation for repatriation, resettlement or integration in Egyptian.
- **AMERA-Egypt:** provide legal advice regarding resettlement and local integration. Provide psychosocial counseling and crisis intervention for refugees who have experienced trauma and torture. AMERA-Egypt also participates in policy development and public education initiatives on refugee protection concerns.
- **Egyptian Foundation for Refugee Rights (EFRR):** provides legal services to refugee and migrants. Advocate for the rights refugees and migrants in Egypt.
- **Refugee Centre for Human Rights:** offers legal assistance to refugees and asylum seekers, the handicapped and street children. RCHR assists asylum seekers in preparing their applications for asylum, resettlement to another country and provide legal aid for detained refugees and asylum seekers. RCHR also provides non-legal assistance to refugees, like referrals of refugees who need medical assistance and education for refugee children.
- **Egyptian Organization for Human Rights (EOHR):** legal Aid for refugees.
- **Center for Refugees and Migration studies (CRMS):** at American University in Cairo (AUC) pursues research in refugee issues. It runs the Refugee Legal Aid Project in collaboration with AMERA - EGYPT.
- **Tdh:** provides psychological and social support and trains social workers from refugee communities.

See Annex 3 3RP partners in Egypt.

## 6.5. Policies and Practices on Refugees in Egypt:

### 6.5.1. Rights and Protection:

There are different policies governing status and determine the services to be provided for the different groups of refugees, and in many areas there is no policy by many stakeholders specifically GoE.

**Refugees:** Egypt does not determine refugee status and treat refugees as a foreigners even when they have refugee's status from UNHCR. Egypt offer limited access to PHC and education to some refugee groups with support from UNHCR and other UN agencies and IGOs. Registered refugees has the right to work but in practice this this not the case (McBride and Kingston 2014; Library of Congress 2016; Azzam 2006; Hilal and Samy 2009). Presidential Decree 89 /1960 on the Residency and Entry of Foreigners bans foreigners who do not have valid travel documents from entering the country though undocumented refugees are considered illegal, subjected to detention and has no access to public services (Grabska 2006a; (McBride and Kingston 2014; Library of Congress 2016).

**VOT:** The UNHCR guidelines point out that not all victims or potential victims fall within the scope of the refugee definition and being a victim of trafficking in human beings does not represent a valid ground for claiming refugee status (van Reisen et al. 2013). Egyptian Anti-Trafficking Law 64 / 2010 criminalizes human trafficking and provides protective measures for the victims (IOM 2012).

**Stateless:** Nationality is a universal human right but stateless persons do not enjoy this right. The GoE has no policy on protection of stateless individuals. They fall in the command of UNHCR (UNHCR 2016c; Pierrot 2013).

#### **Refugees with special situations in Egypt:**

**Syrians:** During rule of president Morsi, Syrian refugees exclusively gained some privileges, like equal treatment in university fees to Egyptians. In 2013 after removal of Morsi by the army in a soft coup after massive public protests against him, Claims that Syrians participated in "Rabaa" sit-in of Morsi's supporters after his removal were used to justify additional restrictions on Syrian refugees specially security ones by the government as need for visa and security clearance prior to entering the country. This corresponded anti-Syrian messages in the Egyptian pro regime media and among some Egyptian citizens and has led to some threats and assaults to Syrians in Egypt and has exacerbated negative views against the Syrian community generally. Incidents of Syrians being arrested, detained, and deported for not having a valid residency were reported. These restrictions and hostilities have led to an increasing number of Syrians registering with UNHCR. Concurrently, there has been an increase in requests among Syrians registered with UNHCR to close their files as they seek to leave Egypt ( Hassan et al. 2015; Human Rights watch 2016). 23.6 % of participants of a study on Syrian refugees in Egypt reported they did not feel safe. The most pressing concerns were; issues with their residency (14%), physical assault (10.8%), verbal harassment (17.2%) as well as robbery (17.2%) and threats (12.9%). Many Syrians have also taken to attempting irregular departure from Egypt in an effort to reach Europe ( Hassan et al. 2015; Irw 2013; Delol et al. 2013; Amelia 2015; HRW 2016; Sasnal 2015; UNHCR 2013a).

**Sudanese:** Until 1995, Sudanese did not need to apply for refugee status as Wadi El Nil Treaty (1976) allowed them to enter Egypt without a visa and gave them rights of residency and work. Sudanese who came prior to 1995 are relatively well integrated and many of them have dual nationality. In 1994 the Egypt requested UNHCR to process Sudanese asylum seekers. In 1995, an assassination attempt on President Mubarak in Addis Ababa attributed to Sudanese Islamists, revoked Wadi El Nil Treaty, affecting the situation for new Sudanese arrivals and those residing in Egypt. Visa and

residence permit requirements were imposed, and Sudanese asylum seekers had to go through the regular asylum procedures. In 2004, Egypt and Sudan signed the Four Freedoms Agreement. The agreement exempts Sudanese from visa requirements and guarantees reciprocal rights of residence, work and ownership of property. Yet, the Agreement has no impact on the situation of Sudanese asylum seekers, who still go through UNHCR despite being supposedly exempt from visa requirements. It seems that the Egypt differentiates between Sudanese citizens (who benefit from the agreement) and asylum seekers (who do not), this was clear in the treatment of Sudanese fleeing Libya since 2011 (Jacobsen et al. 2014).

Violations of Egypt towards refugees include arbitrary arrest and detention in un-humanitarian conditions, closing borders against refugees, deportation and killing (Harild et al. 2015; Library of Congress 2016; Grabska 2006a; Azzam 2006). Detained refugees by Egyptian authorities include women and children. Majority of detainees are Syrians, Palestinians coming Syria, and some other sub-Saharan refugees. Detention circumstances in Egypt are miserable; with lack of hygiene, health care, crowding and lack of ventilation specially in Egypt's hot weather known to cause many cases of heat fatigue lead to death sometimes (UNHCR 2013; EIPR 2013; EIPR 2014). In 2009, The Egyptian Foundation for Refugee Rights (EFRR) reported death of one year old Ethiopian refugee who was detained with her mother in conditions worse than those they fled from in Ethiopia according to the report (IDC 2016).

On December 2005, 27 Sudanese refugees and asylum seekers were killed and hundreds were injured by the Police in during breaking their sit-in in Cairo that was demanding refugee status interviews, a clearer and transparent process, protection from the Sudanese government, protection of the vulnerable and investigation of detentions and mission persons (Azzam et Al. 2006; Mahmoud 2005; Johnson 2012). As well, the political conflict followed construction of the "Great Renaissance Dam" in Ethiopia has led to societal congestion against Ethiopians, and African refugees generally (Kergoat 2013). These violation to human rights and Egypt's commitments and obligations towards refugees necessarily have very negative effect on physical and mental wellbeing of refugees and their communities.

The restrictions by GoE on NGOs compromise their ability to function and provide services for refugees. These restrictions were unprecedented after 2013, GoE has shutdown many NGOs, frozen assets of others, arrested and prosecuted some human rights activists and civil society workers and prevented many from activist and civil society workers from leaving Egypt (FIDH 2016a; FIDH 2016b; Hafez and Ghaly 2012).

#### 6.5.2. General and Mental Health Care and Psychosocial wellbeing:

Refugees have limited access to healthcare in Egypt. the Gaps in the 1954 MOU between UNHCR and Egypt, as lack of mutual accountability and collaboration on refugees issues, affects negatively refugees' access to health care (Kergoat 2013; Meffert and Marmar 2009; El-Shaarawi 2015).

According to a 2005 decision of MoHP, refugees have a right to public primary health services but they pay fees for services unlike Egyptians who don't. Registered refugees and asylum seekers can access healthcare services through UNHCR implementing partners such as Caritas. In practice, the availability of

Public health services for documented refugees depends on their ability to pay (Hilal and Samy 2009). UNHCR's health program focuses on primary and emergency care services along with prioritized secondary and tertiary healthcare through public and community based service providers.

On January 2016, UNHCR and MoHP signed a MoU to improve access to public health care services for all refugees and asylum-seekers registered with UNHCR to primary health care and public hospitals in areas with high concentration of refugees. It is too early to assess the impact of the step on improving access to HC for refugees. UNHCR is assisting the MoH with the upgrade and refurbishment of Primary Healthcare clinics and provision of specialized medical equipment to hospitals in refugee hosting areas and has contributed USD 1.1 million to 6 hospitals across Egypt and 20 PHC centers for the purchase of medical equipment (UNHCR 2016b; UNHCRa). Persons of Concern registered with UNHCR, have access to public primary and emergency healthcare in Egypt, though access to public primary curative care is provided for a nominal fee (UNHCR 2016a).

All MHPSS interventions taken by the major stakeholders i.e. UN agencies and IGOs, are targeting mainly registered refugees and asylum seekers and continue to ignore the undocumented refugees and other vulnerable refugee groups.

See annex 4 Egypt's compliance with IASC 2007 guidelines on MHPSS for refugees

Summary of MHPSS Stakeholders' policies, Practices for Target populations:

	<b>GoE</b>	<b>UN agencies and IGOs</b>	<b>NGOs</b>
<b>MHPSS Policy</b>	No comprehensive policy, delegate its duties to UNHCR. Fragmented legislations on protection, status, and Health care. Differentiate between refugees on status and country of origin.	<b>UNHCR:</b> main body for refugees' related issues, determine refugee status. Responsible for stateless persons. Provide access to services through its implementation partners (GoE, NGOs and IGOs) <b>IOM:</b> resettlement.	Different NGOs adapt different policies on refugees according to their mandates, including: legal aid, Basic support, Education, Health care, PSS and rehabilitation.
<b>MHPSS Interventions/services</b>	<b>MoHP:</b> Providing PHC for documented refugees and asylum seekers (with support from UNHCR and IOM). <b>MoE:</b> Pre university education for some groups of refugees.	<b>UNHCR:</b> Status and protection. Cash assistance. Health care and psychosocial support for recognized refugees and asylum seekers (through implementing partners) <b>IOM:</b> resettlement. Health care and rehabilitation through implementing partners.	Health care and MHPSS. Legal aid, advocacy and research. Education. Cash assistance.

		<b>Unicef:</b> provide education and health services, mainly primary and preventive care for documented refugee children.	
<b>Target population</b>	<b>GoE:</b> all population in Egypt. <b>MoHP:</b> documented refugees and asylum seekers.	<b>UNHCR:</b> Recognized Refugees and Asylum seekers and Stateless people. <b>IOM:</b> Refugees and asylum seekers, VOT.	Documented refugees and asylum seekers. Undocumented refugees and asylum seekers. VoT.

## 7. Comparison on MHPSS Services between Egypt, Jordan, Lebanon and Turkey:

The Ratio of refugees per 1 000 inhabitants makes Jordan, Lebanon and Turkey among the top five countries with refugee's density. With 209 refugees /1 000 inhabitants, Lebanon ranked number 1, followed by Jordan with 90 refugees / 1 000 inhabitants (UNHCR 2015d).

See Annex 5 for Comparison between Mental health systems and burden of disease in Egypt, Lebanon, Jordan and Turkey.

**Egypt:** Limited response/few actors i.e. approximately 6 international organizations and a small number of national NGOs. No case management and referral systems (Save The Children 2014).

Detailed situation of MHPSS for refugees in Egypt presented in the chapter Refugees in Egypt.

**Jordan:** hosts about 664 100 refugees at mid-year 2015 under UNHCR's mandate in Jordan, most of them from Syria. Jordan has Comprehensive MHPSS response for Syrian refugees in host communities and in 5 refugee camps. Approximately 36 organizations working across all levels, majority working in level 3. National case management and referral system and Standard Operations' Procedures SOPs are in place (Save The Children 2014). The management of mental disorders by non-specialized health workers (e.g. general health/PHC staff) is limited, no interventions for alcohol and substance use problems, and limited psychosocial work in education. Most MHPSS services are provided at centers, with a limited community-based care (MHPSSWG 2016).

**Lebanon:** Lebanon is the third-largest refugee-hosting country, with 1.2 million refugees under UNHCR's responsibility. About 99% of refugees in Lebanon from Syria, in addition to 7 300 Iraqi refugees (UNHCR 2015d). Lebanon has Comprehensive MHPSS program; approximately 40 organizations working across all levels both national and international; majority working in levels 2 and 3 intervention. Case Management SOPs are being finalized and revised together with the national system. Case Management Practical Guidance has been developed to support case management in the emergency response and endorsed by MOSA. Local level referrals are updated regularly through coordination (Save The Children 2014). Most services does not meet the needs, refugees are struggling to meet their basic needs like housing, food, education, medication and health services and security. Refugees are complaining about the way they are being treated when demanding services The Lebanese situation is complex and delicate because of war in Syria and its impact on Lebanon due to the geopolitical relationship between Lebanon and Syria. Information about availability of services is lacking, most activities are targeting children and women (El Chammay et al. 2013).

**Turkey:** the world's fourth- largest host of individual asylum seekers. Hosting around 2.2 million registered Syrian refugees under government temporary protection regime, besides high numbers of individual asylum applications to UNHCR including Iraqis, Afghan and Iranians (UNHCR 2015d).

Turkey has Basic MHPSS program with 15 organizations working across all levels. There is No national case management or referral system (Save The Children 2014).

The sensitive nature of this topic especially politically and socially contribute to the scarcity of literature and data on refugees. Also some groups are hard to trace and study as the undocumented refugees, stateless people and victims of trafficking due to many factors. The nature of trafficking makes trafficking routs hidden over the extended shores and borders of Egypt. Undocumented refugees and stateless persons stay hidden not to be arrested (Chatty et al. 2005; Fabos and May 2016; Grabska 2006b; McBride and Kingston 2014).

### 7.1. Stakeholders:

There is limited number of stakeholders for refugees in Egypt, and less number of stakeholders concerned with the most vulnerable groups of refugees, i.e. Undocumented refugees and asylums seekers, VoT and stateless persons. The lack of commitment and the poor coordination among the stakeholders and the insufficient funding prohibits development of comprehensive policies and services for refugees (Library of Congress 2016; Grabska 2006b; Kagan 2006; Issa 2013; Grabska 2006a).

The effective stakeholders as UN agencies, IGOs and NGOs lack have enough power or resources to play more comprehensive role in regulating all issues of refugees in Egypt, the political and legal structure in Egypt would not allow for such a role.

UNHCR is the main body for refugees in Egypt. It determine refugee status, provide most of the social assistance for recognized refugees and stateless people fall under its mandate. Until June 2016, UNHCR Egypt has received only 39% of the required funding for the year (UNHCR 2016a), which reflects the shortage of resources for refugees in Egypt and poor of commitment of the donors towards refugees. Other international stakeholders as IOM, UNICEF, IMC work with UNHCR through The Interagency Standing Committee IASC on providing services for refugees, each according to its area of work.

Many NGOs work as implementing partners with UNHCR and other international stakeholders in providing assistance for refugees, yet the number of NGOs engaged in MHPSS is very limited. Some NGOs work independently and provide services for wider groups of refugees including undocumented.

The government of Egypt (GoE), the supposed most important stakeholder, delegating all its responsibilities toward refugees to UNHCR, and neglect its commitments toward them which affect negatively the daily lives and psychosocial wellbeing of refugees in Egypt (Cleary 2008; Leaning et al. 2011; Bélanger-Dumontier and Vachon 2015). GoE does not provide services for refugees except for limited access to education in public schools and health care in public hospitals. Egypt's reservation to article 22, section 1 of the Refugee Convention denying refugees the right to public education. Ministry of Education 24/1992 decree is allowing the children of recognized refugees to attend public schools. UNICEF has reported that only 53% percent of Syrian children that are eligible to enroll in schools attend, due to the insufficient kindergartens and the inability of schools to accommodate more students (Library of Congress 2016).

As the Egyptian health system is poorly functioning in many dimensions including mental health care coverage and quality, its ability to help refugees questionable even in presence of suitable policy environment.

## 7.2. Target populations:

As the different groups of refugees have different legal situations, there are different policies governing their issues and determine the services to be provided.

the current evidence suggest that majority of refugees are undocumented, including VoT and stateless persons and legally invisible, and sometimes considered "illegal", thereby have neither legal rights nor access to public services including health care. Undocumented refugees and asylum seekers face difficulties to access health care in public facilities, even if they can pay the non-subsided fees because they lack legal documents.

Among reasons that majority of refugees in Egypt are undocumented the complexity of RSD process, which have low acceptance rates that pushes refugees not to register to avoid rejection (Grabska 2006a; Zohry 2003). Also many refugees see Egypt as transient country that they try to leave as soon as possible even through smuggling so they have no interest in the documentation issue (Roman 2006; Zohry 2012). Some rely on little savings they could have get before fleeing or family member living abroad support to get other status than refugees despite they fall in the definition of refugees (Al-Shermani 2004; Issa 2013; Jacobsen et al. 2014). In many cases, refugees are mistaken as economic migrants and vice versa,

with no clear distinction between the two groups and absence or conflict between policies and measures for those groups (Anderson et al. 2011). This adds to the difficulties in gaining reasonable concrete numbers of each group especially in absence of practical international consensus on idioms of asylum and migration and rights entailed thereby.

This situation of marginalization, discrimination, poverty, the weakened social structure and lack of community support and services for refugees increase their risk of mental health and psychosocial problems and worsen the existing problems (Quosh et al. 2013; Harrell-Bond et al. 2013; McBride and Kingston 2014; Ayoub 2016).

The very limited number of NGOs offering services for refugees generally and undocumented especially are very limited and do not have the capacity to target all the affected populations in absence of other sources of aid and support. Restrictions on NGOs in Egypt including those working with refugees have further undermined their capacity to help refugees.

### 7.3. Policies:

There is neither international consensus nor comprehensive national policy on refugees' issues. The gaps and fragmentation in policies on refugees generally creating weak legal framework governing their rights in Egypt. GoE unwritten policies of not integrating refugees and the discriminating against some groups of refugees based on origin, in addition to Egypt's reservation on some articles in the Convention on the Status of Refugees that deny refugees the right to education and work, obstruct development of comprehensive and transparent policy on refugees and thereby negatively affect organization of the services needed by refugees and impose risk on mental and psychosocial wellbeing.

Lack of adequate commitment and coordination among international powerful actors hinder development of adequate consensus on comprehensive international policies on refugees and constitute challenge to the current stakeholders to raise sufficient resources to satisfy basic needs of small group of refugees.

### 7.4. Practices:

MHPSS for refugees in Egypt in general is affected by the lack of resources, policy gaps and inconsistency, and the discrimination among refugees based on their legal status and nationality. The recognition of refugees and asylum seekers gives them partial advantage regarding legal protection and access to services.

MHPSS services are very limited, mainly offered for documented refugees and asylum seekers by the different stakeholders. Services include monetary assistance, legal assistance, Health Care, Primary education by UNHCR and some IGOs as IOM, CARE, through their implementing partners as GoE (MHoP and MoE) and NGOs.

The offered services still do not comply with IASC guidelines for MHPSS for refugees which is a main reference for services for refugees. Absence of comprehensive mental health care services offered for refugees in Egypt which necessarily increase risk of further deterioration of mental health and psychosocial health of refugees. Services offered for undocumented refugees are very limited and offered by limited number of NGOs. The offered financial support by UNHCR for refugees is very limited compared to their numbers and their socioeconomic and health problems (Library of Congress 2016).

Despite that MHPSS interventions are designed to prevent violations to human rights, Practices like detention, torture, deportation and murder continue occur for some refugees putting their health and lives in danger.

### 7.5. MHPS wellbeing of refugees:

MHPSS wellbeing of refugees is highly affected by the sum of policies and practices on refugees, socioeconomic and sociocultural conditions. As MHPSS interventions are designed to promote psychosocial wellbeing of refugees and reduce harm, deficiency in there interventions undermines mental health and psychosocial wellbeing.

MHPSS for refugees in Egypt generally is deficient, on both policy and practice levels.

MHPSS is affected by the shortage of financial resources for both refugees theme and mental health care and deficiency in Human resources for mental health (Save The Children 2014; UNHCR 2013a).

Turkey, Lebanon and Jordan offer relatively better MHPSS support for refugees than Egypt

Despite they have higher load of refugees and the health systems and situation in the four countries is relatively similar. They also have better coordination and availability of information compared to Egypt.

The living conditions of refugees in Egypt highly contribute to the mental and psychosocial problems among refugees. The uncertainty about future and possibility of going to homelands, limited resources

and access to services with lack of integration in Egyptian community are main challenges for the refugees in Egypt. Practices like detention by Egyptian authorities and continuous exploitation of

refugees in workplaces and in the community as well threaten the lives of refugees not only their mental wellbeing.

## 8. Conclusion and Recommendations

### 8.1. Conclusion:

As presented before, refugees in Egypt suffer from many issues that undermine their mental health and psychosocial wellbeing, in absence of appropriate MHPSS interventions to minimize the harm.

The MHPSS for refugees in Egypt in affected by the poor coordination, lack of commitment of some stakeholders, insufficient financial resources and the weak capacity of public health system.

The policies and practices on refugees specially regarding status, rights and access to services including health care, education and work has great impact of refugee's psychosocial wellbeing.

The main policy gaps identified are absence of comprehensive national policy on refugees and absence of international consensus on target population are related terms and definitions, policy and SOPs on refugees' issues. Policies and services for refugees neglect the undocumented refugees.

Legal status has a relatively high impact on refugee's psychosocial wellbeing as it provide some legal protection and access to some services as health care, despite being limited. Undocumented refugees and asylum seekers, VoT and stateless persons lack legal, financial and psychosocial protection which increase their risk of mental and psychosocial problems.

Socioeconomic problems like poverty, unemployment and exploitation of the illegally working refugees and lack of adequate access to health care and psychosocial support, affect the ability of refugees to sustain themselves and their dependents and hereby increase their vulnerability to mental health and psychosocial problems and aggravate the preexisting conditions.

Sociocultural problems as discrimination based on race or faith and SGBV have very negative impact on the refugees and their communities as this leads to variety of health and social problems and lead to further marginalization of refugees.

The offensive violating measures as detention, deportation and excessive use of force with refugees not only endanger their mental health and psychosocial wellbeing, but also threaten their lives directly.

## 8.2. Recommendations:

### For Egyptian Public Mental Health System:

- Integration of Mental health care into primary health care system with improving governance in primary health care system and quality of its services.
- Increasing public expenditure on mental health.
- Promote human resources for mental health to reach the optimum capacity to achieve effective coverage for quality mental health care services for both citizens and refugees, with improving retention of MHW.
- Task shifting and creating transient cadres to fill the need for human resources for mental health.
- Distribution of human and financial resources for Mental health equitably and avoid centralization of services.
- Decentralizations of decision making on mental health policies and practices to local health administrations in different governorates.
- Decreasing hospitalization, shifting towards community model of health care.
- Outreaching population at risk of mental illness and provide preventive psychosocial support.

### For Refugees' Status and Protection issues in Egypt:

- Immediate cessation and accountability for violation toward refugees' rights as detention and deportation by GoE, and removal of restrictions on refugees' basic rights as asylum, work, education and health care.
- Formulation of comprehensive national policy on refugees, improving legal framework governing refugees in Egypt and providing them the due recognition and protection by GoE.
- Prevent detention of VoT, provides them with asylum rights and status.
- Provide legal status and protection for stateless persons.

### For MHPSS for refugees in Egypt:

- Strengthen coordination among IASC, GoE, IGOs and NGOs on MHPSS.
- Conduct comprehensive and participatory situation analysis for MHPSS for all groups of refugees in Egypt.
- Engage more international and stakeholders for MHPSS for refugees.

- Increase financial and human resources available for MHPSS for refugees in Egypt.
- Provide equal and adequate MHPSS for marginalized groups of refugees as undocumented refugees and VoT.
- Including affected communities in policy making and monitoring its implementation to promote community ownership.

#### For research:

- Conducting systematic review on determinants of mental health and psychosocial wellbeing of refugees in Egypt and comprehensive assessment of impact of current policies and practices on psychosocial wellbeing of refugees.
- Developing a method for more accurate estimation of all refugees count in urban setting like Egypt.

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## Annexes:

### *Annex 1 Capacity of different levels of public hospitals*

**Integrated hospitals** contain 20-60 bed, Provide primary health care and specialized medical services in the rural areas. Equipped with surgical theatres, X-ray equipment, and laboratories. Responsible for serving 10 000 to 25 000 people.

**District hospitals** contain 100- 200 bed, provide specialized medical services and are available in every district. Responsible for 50 000 to 100 000 people in the urban districts.

**General hospitals** contain more than 200 beds and involve all medical specialties.

**Specialty hospitals** are available in urban areas in all governorates. Include specialties such as psychiatry, chest, fever, heart, ophthalmology, tumors, and gynecology and obstetrics.

(WHO 2014c)

### *Annex 2 Examples of GSMH departments' policies*

**The Addiction Department Policy:** encompass the therapeutic programs, team structure, admission and discharge policy. It is based on voluntary admission for patients. Specific operational policies were developed for subspecialties such as Gender Oriented Care model and specific program for adolescent addiction.

**The Child and Adolescent department policy:** regulate the service providing and the general therapeutic guidelines including Place structure, Team formation, Tool used (psychological assessment and therapeutic tools), care pathway, unified patient registration form.

**General and local policies and procedures:** Different hospitals have internal regulations for the admission, care pathway, outpatient management that follows the Mental Health Act and its working memorandum. No national suicide prevention strategy and service users and families does not participate in any stage of policy or laws making.

(GSMHAT 2013)

*Annex 3 3RP partners in Egypt*

- Arab Council for Supporting Fair Trials and Human Rights (ACSFT) Egypt.
- CARITAS Egypt.
- Catholic Relief Services (CRS) Egypt.
- Islamic Relief Worldwide (IRW) Egypt.
- Psycho Social Training Institute in Cairo (PSTIC).
- Refuge Egypt.
- Terre des Hommes (TDH) Egypt.
- Tadamon.
- United Nations High Commissioner for Refugees (UNHCR) Egypt.
- United Nations Children's Fund (Unicef) Egypt.
- World Food Programme (WFP) Egypt.

*Annex 4 Egypt's Compliance with IASC guidelines on MHPSS:*

The guideline are adapted only by UNHCR agencies and partially by some IGOs and IGOs. The IASC guidelines are not adapted officially by GoE or MoHP.

Area	Sub Area
Coordination	1.1 intersectorial coordination of MHPSS: Limited coordination, Limited response from GoE, limited involvement of NGOs.
Assessment, monitoring and evaluation	2.1 Assessments of MHPSS issues: Incomplete assessments by different stakeholders, does not address the majority the undocumented refugees.
	2.2 participatory systems for monitoring and evaluation: No.
Protection and human rights standards	3.1 Application of human rights framework: Weak MHPSS response, no enforcement of Human rights.
	3.2 response to protection threats and failures through social protection: Limited Programs by Un agencies and NGOs, Mostly for documented refugees and asylum seekers
	3.3 response to protection threats and abuses through legal protection: Limited protection Programs by Un agencies and NGOs, Mostly for documented refugees and asylum seekers.

Human resources	4.1 recruitment of staff and volunteers who understand local culture: Local (Egyptian and refugees) staff and volunteers in Un agencies and NGOs.
	4.2 Enforcement of codes of conduct and ethical guidelines: No data was found.
	4.3 training of aid workers in MHPSS: yes (tdh and PSTIC).
	4.4. Prevention and management of problems in MHPS well-being among staff and volunteers.
Community mobilization and support	5.1 conditions for community mobilization, ownership and control of emergency response: very limited.
	5.2 community self-help and social support: very limited.
	5.3 conditions for appropriate communal cultural, spiritual and religious healing practices: limited for some groups of refugees, by NGOs and faith based organizations.
	5.4. Support for young children and their care-givers: limited support by UN agencies, IGOs and NGOs for documented refugees and asylum seekers.
Health services	6.1 PS considerations in provision of general health care: for some groups of refugees and in certain settings.
	6.2. Access to care for people with severe mental disorders: Limited access to mental health care, poor mental health resources, undocumented refugees are not eligible for public or UNHCR services.
	6.3 Protection and care for people with severe mental disabilities or disorders living in institutions: No information was found.
	6.4 collaboration with local, indigenous and traditional health systems
	6.5 alcohol and other substance use harm reduction: limited psychosocial rehabilitation programs, mainly by NGOs.
Education	7.1 access to safe and supportive education: Limited access to Education for Documented refugees.
Dissemination of information	8.1 information to the affected population on the emergency, relief efforts and their legal rights: Access to information by Un agencies and NGOs, Mostly for documented refugees and asylum seekers
	8.2 information about coping methods: Access to information by Un agencies and NGOs, Mostly for documented refugees and asylum seekers
Food security and nutrition	9.1 PS considerations : Food Programs by Un agencies and NGOs, Mostly for documented refugees and asylum seekers.
Shelter and site planning	10.1 social considerations: N/A Urban refugees.
Water and sanitation	11.1 social considerations: N/A Urban refugees.

Annex 5 Comparison between Mental health systems and burden of disease in Egypt, Lebanon, Jordan and Turkey

Country	Ratio
Lebanon	16095.76308
Turkey	14439.35443
Jordan	14306.05122
Egypt	14553.03716

Prevalence of Mental and substance use disorders cases per 100 000 Population, both sexes, all ages, 2015

Indicator	Government expenditures on mental health as a percentage of total government expenditures on health (%)	Stand-alone mental health legislation	Mental health plan	Mental health policy
Country	2011	2011	2011	2011
Egypt	2.29	Yes	Yes	Yes
Jordan		No	No	No
Lebanon	4.8	Yes	No	No
Turkey		No	Yes	Yes

Country	Year	Skilled health professionals density (per 10 000 population)
Egypt	2009	63.5
Jordan	2010	66.1
Lebanon	2011	59.2
Turkey	2011	41.1

Indicators	Beds for mental health in general hospitals (per 100,000)	community residential facilities (per 100,000)2	Beds in mental hospitals (per 100,000)	Beds in mental hospitals (per 100,000)2
Country		2011	2014	2011
Egypt	0.47(2011)		6.56	9.4
Jordan	0.6(2014)	2.32	6.93	5.1
Lebanon	1.1(2011)		0.85	39.44
Turkey	3.84(2014) 5.56(2011)	0.01	5.42	4.54

Indicator	Mental hospitals (per 100,000)	Mental health units in general hospitals (per 100,000)	health outpatient facilities (per 100,000)	day treatment facilities (per 100,000)	Community residential facilities (per 100,000)
Country	2011	2008-2010	2011	2011	2011
Egypt	0.04	457(2010)	0.11	0	
Jordan	0.03	70(2009)	0.99	0.02	0.02
Lebanon	0.07	60(2008)	0.24	0	0.16
Turkey	0.01	1616(2010)		0.01	0

Indicator	Psychiatrists working in mental health sector (per 100,000)	Psychiatrists working in mental health sector (per 100,000)2	Nurses working in mental health sector (per 100,000)	Nurses working in mental health sector (per 100,000)2	Social workers working in mental health sector (per 100,000)	Social workers working in mental health sector (per 100,000)2	Psychologists working in mental health sector (per 100,000)	Psychologists working in mental health sector (per 100,000)2
Country	2014	2011	2014	2011	2014	2011	2014	2011
Egypt	0.69	0.54	3.1	2.08	0.29	0.23	0.12	0.13
Jordan	0.37	0.27	1.46	0.89	0.22	0.1	0.09	0.15
Lebanon	0.87	1.41	0.77	1.72	2.32	0.47	1.65	2.12
Turkey	1.51	2.13		2.22	0.77	0.76	1.43	1.62

(WHO 2016a)