

**The Egyptian Health System's Response
to Refugees and Migrants in Post-
Revolutionary Egypt**

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Master in International Health
10th September 2012 – 16th September 2013

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Amsterdam, The Netherlands

16th September 2013

Number of words: 12,941

The Egyptian Health System's Response to Refugees and Migrants in Post-Revolutionary Egypt

A thesis submitted in partial fulfilment of the requirement for the degree of

Master in International Health

by

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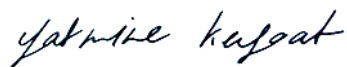
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Master in International Health (MIH)

10th September 2012 – 16th September 2013

KIT (Royal Tropical Institute)/ Vrije Universiteit Amsterdam

Amsterdam, The Netherlands

September 2013

Organised by:

KIT (Royal Tropical Institute), Development Policy & Practice

Amsterdam, The Netherlands

In co-operation with:

Netherlands Vrije Universiteit Amsterdam/ Free University of Amsterdam

(VU) Amsterdam, The Netherlands

Dedication:

I dedicate this thesis to my refugee clients who by opening up to me, have opened up a new realm for me, showing me a different reality than the one I "imagined".

I pray to God that He will alleviate the pain and suffering of the millions of refugees and displaced persons world-wide and that they will, one day, reach a safe haven.

May God grant them safety, security, dignity and health.

Acknowledgements:

I would like to thank the Erasmus Mundus scholarship that allowed me to take part in the TropEd Masters of Science Programme in International Health for the academic year 2012-2013. I am eternally grateful for having been awarded this scholarship which allowed me to follow my academic ambitions and make this dream come true.

I am thankful to my professors at both TropEd institutions I attended; the Institute of International Health and Development (IIHD) at Queen Margaret University in Edinburgh and the Royal Tropical Institute (KIT) at the Vrije Universiteit in Amsterdam for their continuous support and encouragement throughout the year.

Many thanks to my thesis adviser and back-stopper for believing in my topic, for their support and encouragement throughout my fieldwork and writing, and for being so flexible with their respective time-tables.

I would also like to thank my informants for welcoming me (for some, welcoming me back) into their institutions and being so generous with their time, valuable information and feedback. This thesis wouldn't have been possible without their contribution and I dedicate it to them.

A special thank you to my mentors; Dr. Hanan Sabea for her support throughout my undergraduate years and for bringing out the best in me and showing me my true 'Anthropological essence' and Dr. Ashraf Azer for his support throughout my professional career and for being such a role model.

I am grateful to my family for their continuous support throughout this experience. Thank you for always having my back and believing in me, for allowing me the space to become the person I am meant to become, and for loving me for who I am. Special thanks to my Mama, Wafaa Soltan, who has always been an inspiration for me and for so many other people. I wouldn't be the person that I am today if it wasn't for you.

Last but not least, I would like to thank all my friends and amazing people I encountered throughout this experience. You have made it all worthwhile and I am grateful for the happy moments (and stressful ones) we shared and those still to come. Your friendship and support really made a difference and I can honestly say that you were my family away from home.

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Abbreviations

AMERA	Africa and Middle East Refugee Assistance
ARV	Anti-retroviral Treatment
AUC	American University in Cairo
CBOs	Community Based Organizations
CHVs	Community Health Volunteers
CMRS	Centre for Migration and Refugee Studies
ECC	Exceptional Care Committee
EGP	Egyptian Pound
EIPR	Egyptian Initiative for Personal Rights
EMRO	Eastern Mediterranean Regional Office (WHO)
EPI	Expanded Programme on Immunization
FHM	Family Healthcare Model
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IAWGs	Inter-agency Working Groups
IOM	International Organization for Migration
MENA	Middle East and North Africa
MOHP	Ministry of Health and Population
MOU	Memorandum of Understanding
NAP	National AIDS Programme
NGOs	Non-Governmental Organizations
NTP	National Tuberculosis Programme
OAU	Organization of African Unity
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PLHIV	People Living with HIV
PMTCT	Prevention Mother-to-Child Transmission
POCs	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
TB	Tuberculosis
UNFPA	United Nations Family Planning Association
UNHCR	United Nations High Commissioner for Refugees
UNJPS	UN Joint Programme of Support
USD	US Dollar
VCT	Voluntary Counselling and Testing
VOTs	Victims of Trafficking

WFP
WHO

World Food Programme
World Health Organization

Glossary

Asylum Seekers: “Individuals who have sought international protection and whose claims for refugee status have not yet been determined (by the United Nations High Commissioner for Refugees (UNHCR)) irrespective of when they may have been lodged”.(1)

Closed Files: “Rejected” asylum seekers who have previously applied for Refugee Status Determination (RSD) and had their files rejected by the UNHCR; they no longer hold legal representation in the country and are comparable to irregular migrants.

Financing: “Health financing refers to the function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively”.(2) Efficient health system financing raises adequate funds for health in order to facilitate universal coverage, to ensure protection from financial catastrophe and catastrophic expenditure, and to provide adequate financial incentives to providers.(2–4)

Health: “A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.(5)

Health System: “A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health” (6) this includes “all the activities whose primary purpose is to promote, restore and/or maintain health; the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people’s legitimate expectations and protecting them against the cost of ill-health”.(5)

Health Workforce: Health workforce or human resources for health is defined as “all people engaged in actions whose primary intent is to enhance health”. These include clinical as well as management and support staff who ensure management, timely delivery of services and overall performance of the health system.(2) “A well performing workforce is one that is responsive to the needs and expectations of people, is fair and efficient to achieve the best outcomes possible given available resources and circumstances.” Common concerns revolve around improving education, distribution, productivity and retention.(4)

Health Information System: “A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status”.(3) This information is used by policy-

makers, health care providers, development partners and the general public in decision-making, identification of problems and needs, evidence-based decision making to support health policies and the optimal allocation scarce resources.(2,7)

Irregular Migrants: “Individuals who enter a country, often in search of employment, without the required documents or permits, or who overstay the authorized length of stay in the country”.(8)

Leadership and Governance: “Leadership and governance in building a health system involve ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability”.(2) Accountability is a key aspect of good governance. It concerns the collaboration between the various stakeholders of a health system be it governments, nongovernmental organizations, public and private sectors who bear the responsibility of financing, monitoring, and delivering health services and promoting national leadership; through management of resources to formulate and achieve policy goals and strengthen national health systems.(2,9) Stakeholders must work jointly with communities to promote and maintain population health in a participatory and inclusive manner.(9)

Local Integration: A process whereby refugees progressively attain more rights and entitlements from which “freedom of movement, access to education and the labour market, access to public relief and assistance including health facilities” over time leading to permanent residency. It is a process which enables refugees to become less reliant on humanitarian aid and gradually becoming more self-reliant and able to contribute economically to the host country; and a process of assimilation, whereby refugees are able to live alongside host populations without discrimination or exploitation.(10)

Medical Products, Vaccines and Technology: “A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective (and rational) use”.(2,11) Medical products are essential in the prevention, diagnosis and treatment of disease and alleviation of quality of life and disability.(11)

Parallel System versus National Health System: In this study, a difference is made between a “refugee parallel health system” made out of UNHCR implementing and operating partners and the “National Health System” which comprises the public, private and charity Egyptian health sectors.

Persons of Concern (POCs): In this research “POCs” refers to recognized refugees and asylum seekers falling under the UNHCR mandate.

Prima-Facie: “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”.(12)

Primary Health Care: “Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system (...). It is the first level of contact of individuals, the family and community with the national health system (...) and constitutes the first element of a continuing health care process. (It) addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly”.(13)

Refugees: According to the 1951 Refugee Convention, refugees are individuals outside of their country of nationality or habitual residence and have a “well-founded fear of persecution” due to “race, religion, nationality, membership of a particular social group or political opinion” and due to such fear are unable to return.(10)

Secondary Health Care: “An intermediate level of health care that includes diagnosis and treatment performed in a hospital or health centre having specialized personnel, equipment, laboratory facilities and bed facilities”.(14)

Service Delivery: Service delivery/provision includes the “management and delivery of quality and safe health services”. It covers a continuum of services delivered depending on peoples’ needs throughout their lifetime, including health promotion and education, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care.(15) Notions of access, availability, utilization, coverage and people-centeredness are often used to reveal whether services provision is efficient and whether it responds to people’s needs.(2) Health equity and universal health coverage are often presented as ultimate goals.(15,16)

Tertiary Health Care: “Tertiary health care is (the highest) specialized medical care that cannot be performed at primary and secondary levels. It includes sub-specialty expertise in surgery and internal medicine, diagnostic and therapeutic modalities for treating advanced and/or potentially fatal diseases”.(14)

Transient Populations: A term which signifies both refugee and migrant populations in the context of this study.

Abstract

Background: Egypt is a hub for one of the five biggest refugee and migrant populations in the developing world. Egypt's reservations on the 1951 Refugee Convention combined with creation of a "parallel system" under the UNHCR mandate are obscuring the government's legal requirement for provision of healthcare to a growing refugee and migrant population.

Objective and Methodology: Literature review supplemented with key-informants' interviews was done to determine strengths and weaknesses of the health system dealing with refugee and migrant populations in post-revolutionary Egypt.

Findings: Refugee status and access to healthcare are closely interlinked. Security concerns and targeted attacks on specific refugee communities are affecting refugees' health and access to healthcare. Main challenges in the National Health system are exclusion of refugees and migrants from the MOHP strategy, discriminatory practises, out-of-pocket health expenditure, lack of awareness and skills in addressing migrants' health. Constraints in parallel health system are limited coverage for chronic diseases, shortfall and inequitable funding distribution, lack of accurate data and structural gaps in health work force, concentration of healthcare services in Cairo, lack of a participatory and people centeredness component.

Conclusion and Recommendations: Improving refugees' and migrants' access to healthcare requires a "paradigm shift" in their inclusion in future healthcare strategies; a "long-term" strategy in which the public sector becomes a principal partner and a "diversification of responses" in all areas of key-stakeholders' work. Refugee health needs to be viewed within the particular challenges a post-revolutionary Egyptian context represent.

Key-Words: refugees, migrants, health systems, Egypt, Arab Spring.

Word-Count: 12,941.

Introduction

My interest in public health came about when I was working as a psycho-social caseworker for refugee women victims/survivors of sexual and gender based violence (SGBV) at Africa and Middle East Refugee Assistance (AMERA) in Cairo from 2011 to 2012. While working in this context I came to appreciate the extent to which survivors of SGBV needed comprehensive health and psycho-social support in order to overcome traumas faced, and the extent to which their access to healthcare relied on advocacy and timely referrals to partner organizations.

By working in this context, providing individual case management, advocating on behalf of clients and mediating with medical service providers, as well as being an active member of an inter-agency SGBV medical subgroup, I came to realize the magnitude of healthcare challenges faced by the refugees and staff alike, be it access to information and quality healthcare, timely referral, access to treatment, or language barriers affecting doctor to patient communication.

By working alongside representatives from the United Nations High Commissioner for Refugees (UNHCR) and a wide array of service providers, I was able to explore the 'mosaic' of the healthcare system in place responding to refugees' and asylum seekers' needs in Egypt; some of the challenges faced and persistent gaps in accessing quality and timely healthcare.

I was present in Egypt during the first wave of revolution on the 25th of January 2012 as well as during the second wave after the 30th of June 2013, which put my work in an even stronger light. This thesis attempts not only to describe the health system responding to refugees and migrants alike, but also to capture how rapid changes on a political level influence the policy environment and access to services including healthcare. I hope to propose recommendations that address the latter.

Chapter 1: Background

1.1. Target population

For the purpose of this thesis, a distinction is made between recognized refugees and asylum seekers on one hand (persons of concern (POCs) to the UNHCR), and closed files and irregular migrants on the other hand.

Individuals in the process of applying for refugee status determination (RSD) at the UNHCR are termed "asylum seekers" and are granted a yellow card providing them with limited services as well as protection from refoulement (forcefully returning a refugee to his country of origin). As for recognized refugees, their claims have been found to fall under the 1951 Refugee Convention and the 1969 Organization of African Unity Convention (OAU) granting them a blue card which entitles them to an "indefinite right to stay", full access to services at UNHCR partner organization and a higher chance of being resettled to a third country.(17,18)

"Closed files" represent asylum seekers who do not meet the refugee definition and hence have had their claim rejected. If the UNHCR decision is appealed and denied a second time, the file is closed and the person no longer enjoys protection or access to UNHCR services in Egypt; automatically turning their status into one of irregular migrants. "Irregular migration refers to the movement of people without valid documentation, which, in turn, translates into illegal presence in the country".(19)

The difference between these two categories is that whereas one individual is granted status, a relative degree of protection by international law and entitled to receive aid by international organizations, the other is left to fend for him or herself.

1.2. Demographic and Geographic Characteristics

The Middle East hosts 42% of the total world's transient population with numbers reaching 20 Million refugees, asylum seekers and irregular migrants.(20)

Egypt, with a population of 85 million (21), is known for being a point of departure, transit and arrival of migrants.(22) Its strategic location, being at a proximity to countries that are common points of departure of refugees and asylum seekers, makes it a hub housing one of the five biggest refugee populations residing in urban areas in the developing world.(23)

In order to fully capture the scale of migration in Egypt today, it is essential to highlight its key transit geographic position spanning from Sudan to the Sinai Peninsula to Israel and Libya. Migration patterns have changed substantially over the last decade bringing about challenges of irregular migration, smuggling and human trafficking¹.(18,22)

There are no official statistics for irregular migrants in Egypt; however the Ministry of Foreign Affairs in 2008 estimated the number to range from 2.2 to 4 million of which a very small number held refugee status.(24)

Refugees come from more than 25 countries (the majority coming from Sudan, Somalia, Iraq, Ethiopia, Eritrea, Palestine and Syria)².

Following the Arab Spring in 2011, a large number of refugees seeking asylum from neighbouring Arab countries - Libya, Iraq and Syria - arrived in Egypt which undoubtedly changed the refugee population demography.

In May 2013, UNHCR Cairo listed 18,765 registered asylum seekers and 84,797 recognized refugees. Syrian refugees represented 54% of UNHCR's caseload whereas in previous years Sudanese and Somalis represented the biggest refugee communities.(Table 1.)

Between July 9th and 14th 2013, Syrian refugees' numbers reached 88,929 (including those awaiting registrations) which represents a 63% increase in 3 months³.(25) Due to political unrest since August 14th 2013, an additional 107,000 Syrians approached UNHCR for registration which surpassed UNHCR expectations for 2013.(26)

Refugees have been known to reside in the capital, Cairo, where the majority of service providers including the UNHCR, Non-governmental Organizations (NGOs) as well as Community Based Organizations (CBOs) are located.(23) However, recent trends show that refugees are no longer concentrated in the largest cities of Cairo and Alexandria, but that due to the rise in rents and difficult socio-economic conditions, they are dispersed in poorer governorates across the country. Available information on Syrian refugees shows that their biggest concentration is in 6th of October City (on the outskirts of Cairo), Cairo and Alexandria as well as 25 other governorates.(27) (Table 2.)

¹ According to the UNHCR in 2012, 70 victims of trafficking (VOTs) from Israel reached Cairo seeking asylum, and in 2013, 1,700 POCs remained at a camp in Saloum at the Egypt-Libya border awaiting durable solutions.(64)

² There is also a large population of female domestic workers from the Philippines and other South-East Asian countries but due to their "invisibility" working within homes, this population is outside the scope of this study.(20)

³ According to informants, the real number of Syrians present in Cairo exceeds 500, 000 individuals.

Table 1. Number of Refugees and Asylum Seeker, UNHCR Cairo, May 2013

Nationality	Asylum Seekers					Refugees					Grand total	%
	Children		Adults		Total	Children		Adults		Total		
	Female	Male	Female	Male		Female	Male	Female	Male			
Syria	0	0	0	0	0	12140	13133	15580	15188	56041	56041	54%
Sudan ¹	2167	2245	2747	4091	11250	2063	2310	3064	5805	13242	24492	24%
South Sudan	219	237	307	158	921	47	38	76	50	211	1132	1%
Somalia	246	291	587	349	1473	717	703	2556	2460	6436	7909	8%
Iraq	199	217	394	412	1222	841	941	2034	1885	5701	6923	6%
Ethiopia	124	58	1176	285	1643	78	74	499	327	978	2621	2.5%
Eritrea	138	134	620	315	1207	126	144	591	502	1363	2570	2.5%
Others	92	106	343	508	1049	99	87	234	405	825	1874	2%
Total	3185	3288	6174	6118	18765	16111	17430	24634	26622	84797	103562²	100%

¹ Number of asylum seekers who would be eligible for South Sudanese nationality based on ethnicity is 4,000 individuals.

² The active population figures include 1369 individuals registered by Salloum office.

*Note: Syrians are granted refugee status on a *prima-facie* basis; therefore not counted as asylum seekers.

Source: UNHCR Egypt Fact Sheet, May 2013.(25)

Figure 1. Map of Egypt and its Governorates



Source: ElSharkawy, 2009.(28)

Table 2. Syrian Refugees Location Breakdown in Egypt, July 2013

Governorate	6th of October	22914
	Alexandria	14543
	Cairo	8068
	Damietta	7862
	Kalyobiya	6255
	Giza	4553
	Sharkia	2681
	Helwan	2434
	Others	3531
Total	72841	

Source: UNHCR Egypt, Weekly Statistical Update, 9-14 July 2013.(27)

1.3. Political Context

Most refugees arriving directly in Egypt are fleeing political persecution, or religiously and ethnically driven civil wars hope to be later resettled in a Western country. However, resettlement opportunities have become more and more scarce leaving them in a state of “indefinite waiting” in Egypt.(29)

Internally, the two waves of revolution which took place in Egypt, the first on the 25th of Jan 2011 and the most recent one on the 30th of June 2013 with the ousting of former President Morsi, represent specific challenges to refugees and migrants residing in Egypt.

The fall of Morsi’s regime was accompanied by a policy shift concerning Syrian refugees stemming from rumours about Syrians being involved in pro-Morsi demonstrations. Whereas previously they were welcomed by the state and society allowing them access to jobs, public schools and healthcare, Syrians are now facing growing discrimination, are required an entry visa and security clearance prior to flight, and risk deportation with 476 Syrians being denied entrance to Egypt since July 8th 2013.(30,31)

A political dispute between Egypt and Ethiopia set off on the 28th of May 2013, after Ethiopia announced the building of the “Great Renaissance Dam” over the Nile river leading to a societal backlash against the 2,500 Ethiopian refugees and asylum seekers, and by consequence other African refugee communities.(32,33)

1.4. Health Risks and Profile of Refugees⁴

A common finding of research conducted on refugee health in urban Cairo found that refugees display illness on three dimensions: individual, social and political. Physical illness is inseparable from psycho-social traumas associated with the refugee experience; where “traumatic past, chaotic present and uncertain future” are intermingled in refugees’ narratives of ill-health.(34)

The health profile of refugees in Egypt is influenced by their “urban experience” with the majority of them living in Cairo and being exposed to poor living conditions, over-crowded neighbourhoods, environmental pollution, inadequate diet compounded by food shortages, unemployment, wide-spread xenophobia, and lack of access to healthcare.(24,35–38)

Children and women represent 38,6% and 48,4% respectively of UNHCR total caseload; with Ethiopian and Eritrean women representing 71.6% and 57,4% out of the total number for these communities.(Table 1.) These demographic characteristics of the refugee population reflect specific health needs related to child health and sexual and reproductive health (SRH) that need to be addressed.

Urban Cairo exposes refugee women to a heightened risk of SGBV. The most frequent sites of violence according to refugee women are domestic work, streets and public transportation making fear of violence a “full time world experience” for these women.(39)

Particular health problems refugees and migrants tend to display are chest, back and stomach pain, psychological disorders (including post traumatic stress disorder (PTSD)), heart disease, hypertension, tuberculosis (TB), diabetes and nutritional problems.(37)

The most updated information concerning refugees’ specific health needs in Egypt looks at Syrians with more than 60% of the UNHCR caseload displaying serious medical conditions, chronic or non-communicable diseases (diabetes, cancer, cardiovascular and respiratory disease) requiring secondary and tertiary care.(27,40)

Specific needs differ according to gender: whereas men more frequently display critical medical conditions, chronic and mental illnesses, physical disability and the results of torture (only male victims of torture are recorded), women are more affected by difficult pregnancies and SGBV (only female victims recorded).

⁴ No information could be found about migrants’ health profile. Therefore, this section only draws on refugees’.

Specific needs are also related to particular vulnerable categories which are also intertwined with gender; whereas males represent 80% of those who have legal and protection needs and 81,2% of unaccompanied and separated children are male; women represent 98,4% of child spouses, 94,8% of single parents and represent a particular category of "women at risk" (unaccompanied, single women who could be subjected to SGBV).(27) (Appendix 1.)

Chapter 2: Problem Statement, Justification and Objectives

2.1. Problem Statement

Although Egypt is a signatory to the 1951 Refugee Convention, its 1967 Protocol, as well as the Organization of African Unity (OAU) Convention, it has not developed domestic asylum procedures and institutions.(19,41)

In 1954 a Memorandum of Understanding (MOU) was signed between the Egyptian government and the UNHCR (Appendix 2) placing all matters relating to refugees under the UNHCR mandate and operating since then as a parallel foundation for refugee policy.(18) UNHCR carries out registration, RSD and provides healthcare and other essential services to its POCs.(10,34)

The government's reservations on the 1951 Convention⁵ combined with the creation of a parallel system for refugee affairs, is obscuring the government's legal requirement for the provision of healthcare to refugees.(42)

The very 'temporality' of refugees' presence in Egypt and the general 'policy denial' of the government, who previously relied on resettlement and voluntary repatriation as durable solutions for refugees, is no longer feasible.(18,19,43,44) The changing migration trends come with an increasing need for local integration, which should incite the newly appointed government to take into account the growing refugee and migrant populations' healthcare needs in its strategic planning for health in the long run.

A report commissioned by Medecins du Monde and Americans Aiding Refugees in 2006 concluded that patterns of care and patterns of inaccessibility characterized the health system serving primarily recognized refugees displaying life-threatening or low-cost health concerns. Asylum seekers and closed files were consistently "falling through the cracks" of the health system due to limited access, lack of proper identification documents and UNHCR prioritization of recognized POCs.(17,44)

The main purpose of this study is to determine how the Egyptian health system is currently responding to the healthcare needs of a growing refugee and migrant population, and to assess whether or not the current health system in place for refugees and migrants is able to provide quality and

⁵ The five reservations relate to personal status, rationing, access to primary education, access to public relief and assistance, and labour legislation and social security.(43)

timely healthcare. The observable gaps at each level of the health system will contribute to recommendations on how to tackle these in the long run.

2.2. Justification

This topic addresses current dilemmas in dealing with the growing refugee populations residing in urban centres stemming from revolutions taking place in the Middle East and placing a burden on the health system of neighbouring hosts countries such as Jordan, Lebanon and Egypt.

The current gap in the literature concerning refugee and migrant populations' access to healthcare in Egypt needs to be addressed by producing new knowledge around this important topic. Limitations in the existing health system need to be documented in order to direct future efforts towards strengthening the existing health system and providing more cost-effective services.(17)

“States have the legal, social and political responsibility to fulfil human rights of migrants regardless of legal status”.(45) Migrants represent a “permanent feature of a globalized society and countries” and responding to their needs is essential.(45)

If refugee health is not addressed adequately and further transmission of infectious diseases occurs, this could potentially present a risk to the general Egyptian population. The resulting burden of disease needs to be addressed through an already extended Egyptian healthcare system ready to respond to such risks.

The topic goes hand-in-hand with the spirit of the Egyptian revolution, in aspiring to a democratic system which would cater to the needs of the most vulnerable and setting up an equitable healthcare system with healthcare for all.

2.3. Objectives

The **Main Objective** of this thesis is to **identify the challenges and persistent gaps in the Egyptian Health System affecting refugees' and migrants' access to healthcare in post-revolutionary Egypt, in order to inform key-stakeholders and policy-makers on possible interventions to overcome these challenges**

Specific Objectives:

- To describe the strengths and weaknesses of the Egyptian health system in responding to refugees' and migrants' healthcare needs using a Health Systems framework.
- To determine whether or not the overall goals of a "well-functioning" health system have been achieved for refugees and migrants.
- To formulate recommendations to the key-stakeholders on how to support the existing health system to provide care and integrate refugee and migrant population in future healthcare strategies and policy-making.

Chapter 3: Methodology and Conceptual Framework

3.1. Methodology

This study relies primarily on literature review and is complemented by key-informants interviews. The literature review captured what is known about the Egyptian Health System's response to refugee and migrant populations. Key-informant interviews sought to fill the gap in knowledge not covered in published literature.

3.1.1. Literature Review

3.1.1.1. Search Strategy

A literature review was conducted using databases such as SCOPUS, PubMed, Google Scholar and Google. The American University in Cairo (AUC) online archives "DAR" (46) and the Centre for Migration and Refugee Studies (CMRS) online website (47) were consulted for thesis proposals written around the topic. Hand searching of research was conducted at the periodicals section of the CMRS at AUC. Furthermore, internal documents and reports, and other relevant grey literature including news articles were requested from key-informants following each interview conducted.

The search language used was English while no strict delimitation on publishing date was imposed (due to limited data).

3.1.1.2. Key-words

A combination of the following key-words was used while undergoing research: refugee(s), migrant(s), access, health, systems, analysis, healthcare, service delivery, governance, information systems, medical products, workforce, financing, urban, psycho-social, post-revolutionary, Egypt, Cairo, Arab Spring.

3.1.1.3. Inclusion and Exclusion Criteria

Inclusion criteria: research conducted on refugee communities, their health and access to healthcare in Egypt.

Exclusion criteria: data on refugees in camp settings and on internally displaced or stateless persons; sources discussing impact of Arab Spring on other Arab countries' Health Systems.

3.1.2. Key-Informants' Interviews

Face to face semi-structured interviews were carried out with key-informants. Some relevant data was also gathered while attending a full-day training for Community Health Volunteers (CHVs).(Appendix 3.)

An overall topic guide was drawn up after the initial literature review was completed. It addressed the remaining gaps in knowledge related to the conceptual framework, and was used in a flexible manner to adjust to interview's content and gaps in knowledge needing further information.

Different questions were asked depending on informants' area of expertise and whether the latter was affiliated to a governmental, inter-governmental or UN organization, a medical or mental health service provider, or a local charity hospital.(Appendix 5)

Key-informants included UN, governmental, inter-governmental organizations; UNHCR implementing and operating partners and local service providers.(Appendix 4.) One key-informant wished to remain anonymous⁶, therefore it was decided that for all informants, only organizations' names and informants' area of work would be mentioned.

Ethical clearance was not required, as questions were related to health systems and service provision, and did not involve data on individual patients. The academic purpose of the research was highlighted. Oral consent was requested at the start of the interview. After consent, the majority of interviews were recorded in order to ensure that informants were quoted accurately.

3.2. Conceptual Framework

The WHO Health Systems framework (2007) was used to analyse the observable strengths and weaknesses at each building block of the health system (Figure 2) arising from both literature review and fieldwork.

The approach is worthwhile for the present research as it allows a categorization of the data into a logical framework, reflecting a comprehensive view of the health system in place to respond to refugees' and migrants' health needs in Egypt.

⁶ This particular organization will be referred to as "International Medical NGO".

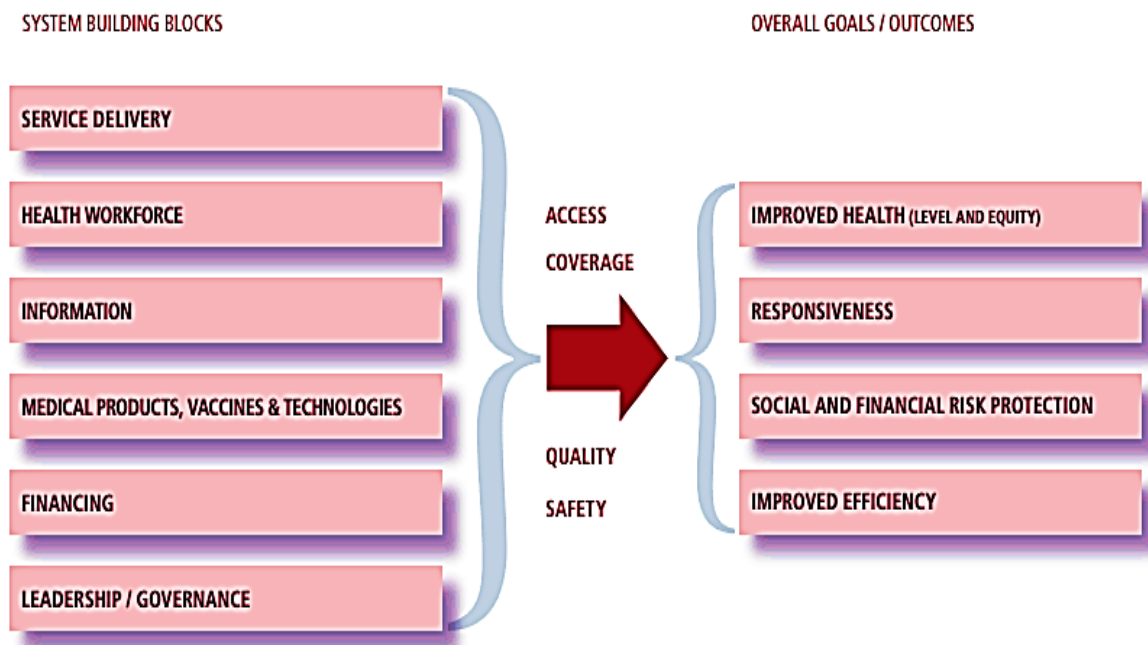
A special emphasis was placed on explaining the available services for refugees and migrants in the national health system and parallel system led by UNHCR.

Chapter 4 draws on the six building blocks, namely service delivery (1), leadership and governance (2), health information systems (3), financing (4), health workforce (5) and medical products, vaccines, and technologies (6).

Chapter 5 draws on notions of coverage, access, safety and quality and how they reflect on efficiency and responsiveness of the health system in place, financial risk protection and overall health and wellbeing of refugees and migrants.

A health systems analysis has the potential to foster health system strengthening, positive synergies between stakeholders, and to foster the creation of policies and strategies that respond to existing gaps while ensuring optimum utilization of services and allocation of funds.(40,42)

Figure 2. WHO Health Systems Framework



Source: WHO’s Framework for Action, 2007.(6)

3.3. Limitations of Methodology

One of the biggest limitations of this study was in the lack of published data available on the Egyptian health system's response to refugees and migrants, particularly post-Arab Spring. The majority of the research on the topic looked at recognized refugees and asylum seekers but not irregular migrants.

A possible explanation for this deficiency is in the lack of appropriate statistics regarding this population, which makes them "invisible" and hard to reach by researchers (since they are not registered at the UNHCR). As a result of the limited published literature available, this thesis relies more heavily on the results obtained from key-informants' interviews than originally intended.

Due to the lack of accurate statistics, changing geographical trends are not recorded in the literature on refugees in Egypt. In order to reflect the most accurate picture of refugees and migrants' access to healthcare, the study had to take into account the totality of Egypt and not solely focus on urban Cairo, as originally planned.

The thesis topic is of sensitive nature, given the current political instability, policy environment and growing suspicion around international NGOs receiving foreign funding. This could have led to bias in key-informants' interviews. This was addressed by seeking introductions by trusted colleagues, and focusing interviews on concrete knowledge on the different building blocks (away from their political significance) and its academic purpose.

Chapter 4: Findings

This chapter will draw on the six building blocks of the health systems framework to describe the strengths and weaknesses of the health system currently in place. The sub-chapters highlight primary concerns raised by key-informants.

When appropriate, this chapter will systematically present information from both the “National Health System” (encompassing public, private and charity sectors) or the “Public sector” and the UNHCR “Parallel System” serving primarily refugees and asylum seekers.

For some of the building blocks, no published literature was available for the Egyptian context; therefore the findings presented rely entirely on the information provided by key-informants drawing on the UNHCR “parallel system”.

Findings from the literature are referenced. The remaining findings presented here come from of key-informants’ interviews.

4.1. Service Delivery

4.1.1. Organization of Service Provision

Health services for refugees and migrants in Egypt consist of a “mosaic” of service providers belonging to a “parallel system” under UNHCR and limited healthcare services under the MOHP.

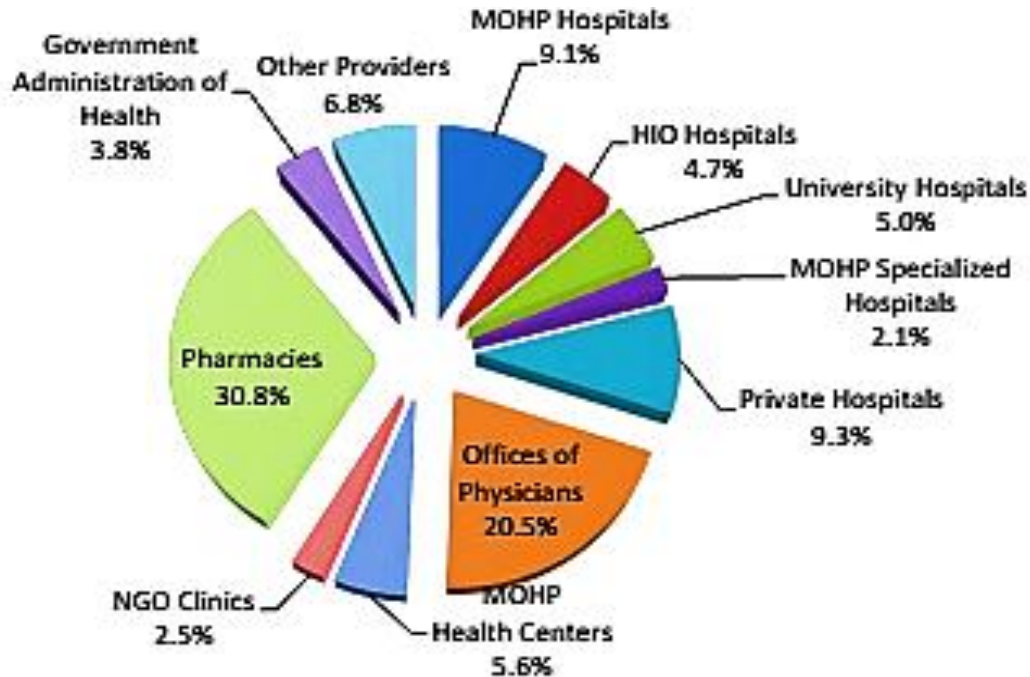
4.1.1.1. National Health Services

The Egyptian health sector encompasses several actors: public sector (Ministries of Health and Population (MOHP) (main regulator), Higher Education, Defence and Interior), private sector (for profit hospitals, specialists’ clinics and pharmacies) and civil sector (NGO’s and faith based medical service providers).(50)

Although the MOHP is the major provider of primary, preventative and curative care with 5,000 health facilities and more than 80,000 beds; occupancy rates of 50% are recorded due to poor quality of services compared to private hospitals.(51)

As figure 3 shows, in 2008 pharmacies accounted for 30,8% and specialists clinics (“offices of physicians”) accounted for 20,5% of total health expenditure.(52)

Figure 3: Health Providers Percentage of Total Health Expenditure



Source: Egypt National Health Account 2008/09.(52)

4.1.1.2. Parallel System

The parallel health system responding to refugees’ and migrants’ healthcare needs in Egypt supported by the World Health Organization (WHO); the International Organisation for Migration (IOM); several UN organizations⁷ with UNHCR at the forefront. Services are implemented by UNHCR medical NGOs implementing partners (Refugee Egypt, Caritas, Psycho-Social Training Institute in Cairo (PSTIC) and Mahmoud Specialised Charity hospital), a network of operating partners, local and international NGOs (AMERA, El Nadim, Saint Andrew’s, “International Medical NGO”), an informal doctors network (Appendix 6) and a network of contracted private and public hospitals available for referrals (Appendix 8).(7,8,32,46)

⁷ Including the United Nations Family Planning Association (UNFPA), the UN Joint Programme of Support on HIV/AIDS (UNJPS) and the United Nations Children Funds (UNICEF)

4.1.2. Services Available

4.1.2.1. National Health System

According to the Egyptian government's healthcare policy, refugees have access to free primary and emergency healthcare services, vaccination and treatment of TB and HIV delivered nation-wide with no restriction on nationality or status. However, secondary and tertiary care in the private sector are delivered at higher costs to refugees as they are considered as foreigners.(24)

The Egyptian National Tuberculosis and AIDS Programmes (NTP and NAP) and the Fever Hospital in Cairo are working jointly with Refugee Egypt providing diagnostic facilities, free treatment and in-patient care.(14) Moreover, refugees are mentioned in the MOHP priority outcome for HIV, supported by the Global Fund and a steady collaborating with Refugee Egypt.

Refugees and migrants have access to the Expanded Program of Immunization (EPI) led by the MOHP either through nation-wide campaigns targeting specific catchment areas, at healthcare clinics, or at refugee clinics.(14) The EPI coordinates with Caritas and Refugee Egypt, offering on site vaccinations and mobile clinics upon demand to reach refugee dense areas.

According to a governmental source, in order to receive TB treatment and under 5 vaccinations, an ID is required which could be problematic for irregular migrants.

For migrants specifically, the WHO and UNHCR have short term projects with the MOHP specialized health centres, representing 42 hospitals covering all areas of specialization with a large capacity. These projects address Iraqi and Libyan migrants specifically, providing free-of-charge primary, secondary and tertiary healthcare and treatment of repercussions of war. (Appendix 7)

The Egyptian public health system response to refugees and migrants is mainly working on a preventive and prophylactic level; infection control representing a main area of concern.

One respondent emphasized the fact that, apart from the specific joint programmes directed to Libyans and Iraqis; the MOHP ensures support of migrants for communicable diseases but that the "burden of non-communicable diseases" falls upon UNHCR for providing secondary and tertiary care to refugees.

On the other hand, a shift in prioritization of the MOHP during times of unrest was reported going to emergency and safety having a direct repercussion on prevention of diseases for the entire population including refugees and migrants.

4.1.2.2. Parallel System

UNHCR's main implementing partners, Caritas, Refugee Egypt and Mahmoud Hospital, respond to the biggest number of POCs. Services cover all levels of healthcare ranging from primary healthcare (PHC); general clinical and chronic consultations; referrals to specialists, comprehensive sexual SRH services, child health and nutritional support (available at Refugee Egypt).(14,54,55) (Appendix. 6)

UNHCR implementing partners do not provide secondary level care directly, but rather through referrals to contracted hospitals which have established agreements and pre-determined fixed costs with the UNHCR.(14) (Appendix 8.)

Refuge Egypt is the only service provider for TB and HIV related services for POCs and the main interlocutor with the NAP and NTP.(14) It delivers prevention and health education, anonymous voluntary testing and counselling, access to condoms, prevention of mother-to-child transmission (PMTCT), free treatment, nutrition support and referrals for in-patient care at the Fever hospital in Cairo.(14)

Psychiatric assessment, counselling and psycho-social support are delivered by PSTIC (UNHCR's main implementing partner for mental health services), El Nadim (a local human rights organization), AMERA and "International Medical NGO" covering all areas of mental health.(56)

Support and care for victims/survivors of SGBV and torture are delivered irrespective of refugee status and free-of-charge by several organizations.(Appendix 6.)

Responses to SGBV include medical examination, emergency contraception, post-exposure prophylaxis (PEP) for HIV, presumptive treatment of STIs, psychological support and legal counselling.(14,57) Services offered to victims of torture include comprehensive mental health services treatment and referrals for in-patient care.(Appendix 6.)

Health Education and awareness workshops are delivered by Refugee Egypt, El Nadim and AMERA. The ultimate goal of these projects is to inform the communities about available healthcare services, increase refugees' confidence in seeking healthcare and advocacy for themselves, improve

doctor to patient communication, spread health messages to the communities, and create a platform for sharing and discussing health concerns⁸.(23)

4.1.3. Access to Services

A study on the perceived needs of 486 African refugees in Cairo recognized that medical care was recorded as their first priority followed by food assistance, schooling and legal aid.(36)

In 2006, a three month sit-in demonstration took place in front of the UNHCR office, among the refugees' demands was better access to healthcare.(17)

The literature points out to the considerable barriers refugees face when trying to access the Egyptian public health sector such as corruption, misdiagnosis, discrimination, language and communication problems, and suspicion and mistrust from the part of refugees of Egyptians medical practitioners.(34,42,58)

In the parallel system, although refugees have access to a number of medical service providers, their access and prioritization of care depends on their refugee status and the availability of funds.

Some service providers are open to migrants within certain limits, but the general consensus is that they would access the Egyptian public and private sector at higher costs and additional challenges if their presence is illegal.(44)

Long term response to migrants' and closed files is not guaranteed within the parallel system and more often than not, falls upon IOM which offers limited services, delivered within a short time-frame.(59) (Appendix 6.)

IOM offers comprehensive care to irregular migrants and closed files on a case by case basis and requiring a vulnerability criteria assessment. Individuals are assisted for a maximum of six months and are notified prior to treatment taking place.(Appendix 9. IOM 2013 Coverage)

The most vulnerable cases were reported for closed files, migrants who don't have a refugee claim and those awaiting UNHCR registration appointments, to whom only the public sector was affordable. Arabic-speaking migrants were said to access services with more easily than others.

⁸ Such as anaemia, female circumcision, SGBV, breast feeding, nutrition, and stigma around TB and HIV

4.1.4. Exceptional Care Committee

UNHCR policy states that in order to receive secondary and tertiary healthcare all POCs need to go through an Exceptional Care Committee (ECC).(14)

Due to funding constraints, limited tertiary health care services are available to recognized refugees. As for asylum seekers, their RSD process needs to be firstly determined by UNHCR before submitting their case to the ECC.(14)

The ECC consists of an external medical doctor, a selected referral hospital, and a UNHCR staff member.(14) Its objective is to ensure that medical referrals are prioritized based on medical needs and prognosis and to guarantee equity, cost-effectiveness and efficient use of resources.(14)

By placing an increased attention on cost effectiveness and a “value for money” approach in targeting gaps which affect morbidity and mortality, UNHCR runs the risk of not addressing priorities expressed by the refugees themselves.

Interventions for cancer, renal failure, heart surgery and congenital conditions must always be approved by the ECC prior to treatment.(14)

The remaining interventions needing approval by ECC are (14):

- Referrals to secondary, specialist consultations and diagnostics exceeding 500 EGP
- Referrals to tertiary care
- Cancer treatment
- Thalassemia treatment
- Multiple sclerosis treatment
- Renal dialysis
- Open heart surgery
- Orthopedic surgery
- (Refer to Appendix 10. for UNHCR Non-referral conditions)

4.1.5. Challenges related to Security Concern

The security concern following the revolution had several consequences on refugees as well as service providers.

According to informants, the revolution was accompanied by general anxiety and heightened fear in the refugee population having a direct impact on their wellbeing. Their mobility was reportedly affected due to a lack of

familiarity with their UNHCR documentation by the military and local checkpoints, expired residencies and lack of proper documentation, which in turn lead to delayed access to healthcare.(19)

The latter combined with recent policy shifts, are placing Syrian and Ethiopian refugees in precarious situations. Targeted attacks, eviction, licensing and difficulties in obtaining healthcare at Egyptian hospitals were widely reported both in the literature and by key-informants.(32,33)

According to IOM’s staff, in the last 3 years after the revolution, the lack of security at check points represented a big gap promoting abuse, smuggling and human trafficking having direct repercussions on needed services for such individuals.

4.1.6. Observable Gaps in Service Delivery

Refugees displaying health risks linked to incidents of SGBV, psychological complaints, expensive non-life-saving treatments, and clients with medical conditions awaiting refugee status seem to be systematically unable to access proper and timely healthcare.(17)

According to service providers, tertiary care represents the biggest gap in UNHCR parallel system in place for refugees and asylum seekers.

Specific gaps and efforts made to respond to these gaps are summarized in the following table:

Table 3. Gaps in Service Delivery Identified by Key-Informants

Gap	Reported Reason	Efforts Made
Cancer treatment to asylum seekers	Shortage of funding at Caritas starting November 2011 onwards	1. Advocacy with the National Cancer Institute to offer local and discounted prices 2. Fast-track RSD process
Renal dialysis to asylum seekers	Shortage of funding at Caritas starting November 2011 onwards	1. Fast-track RSD process 2. Referral to IOM (service not guaranteed, on a case by case basis)
Haemophilia treatment to asylum seekers	Shortage of funding at Caritas starting November 2011 onwards	1. Fast-track RSD process 2. Referral to IOM (service not guaranteed, on a case by case basis)
Maternal health for non-registered and closed file pregnant women	Reported sum demanded from public hospitals 1,000 EGP compared to 400 EGP	-

	for an Egyptian	
High cost interventions and interventions which aren't widely available in Egypt – rehabilitation, physiotherapy	Only available to POCs at army hospital in Egypt	Fast-track RSD process
In-patient care for mental health cases	Public sector presents many limitations from which discrimination and language barrier	Referral to private hospitals
Rehabilitation of VOTs, HIV and suicidal patients, patients with handicap, autism and paralysis	1.Rehabilitation programmes available on individual basis but not directed towards refugee community as a whole 2. Importance of having supportive environment and role of the family in patient adherence to medicine	1. For VOTs, referral to IOM shelter with additional supervision and protection 2. Expressed need for health education of patients and families on proper adherence to medication and the role of family members in treatment
Further investigations (X-rays and MRIs)	Reportedly not covered, or only partially covered by Caritas	Advocacy efforts with private doctors who offer services on charity basis
Referral to 2ry and 3ry care to people living with HIV (PLHIV)	1. Difficulty for dentistry 2. In-patient care at Fever Hospital met by resistance from hospital staff	1. Advocacy and daily follow-up on in-patient clients from service providers at Refugee Egypt 2. Refugee Egypt try to provide all needed support including blood transfusion
PMTCT	1. Contracted obstetrician demanding 3 times the price of C-section delivery 2. Referral Hospital stopped giving service due to fear of stigma	Confidential

4.1.7. Patient-Centeredness

There is no complaints system in place in the parallel system to record clients' satisfaction.

One informant highlighted the fact that no clear system, code of ethics or rights of patients is established in either the UNHCR parallel system or in the public health sector.

Two informants emphasized the need to work on “enacting a system of accountability” with regular questionnaire on patients satisfaction, waiting time and attitude of service providers.

A shift in UNHCR healthcare responses, making sure that they do in fact reflect refugees' priorities, focusing on key-responses lacking in both public and parallel system was felt. The latter goes hand-in-hand with a need to strengthen monitoring and evaluation systems, ensuring that programmes are evolving according to needs and responding to observed gaps.

4.1.8. Decentralization

Parallel services were said to expand according to needs, met by the launching of new branches (decentralization) and hiring additional staff.

Decentralization (of UNHCR's medical implementing partners' services) was reported to reduce over-crowdedness at main branches; attain a wider coverage of refugees in different catchment areas around Cairo offering close-to-client PHC consequently, reducing transportation costs and harassment.

However different views on whether refugees would actually go to nearest clinics or continue to commute to main branches were expressed. This was due to a lack of accurate information, perceived difference in quality of services, and resettlement motivation (thinking that main branches have an authority in resettlement processes).

Duplication of services was resolved by writing patients' place of residence on medical booklets and assigning them to nearest clinic.

4.2. Leadership and Governance

4.2.1. The National Health System; a "Deficient" Health System?

One of the key questions raised during the research was "If the Egyptian healthcare system does not cover Egyptians how will it cover refugees?" In order to address this question, one needs to firstly highlight the main challenges of the healthcare system in place as identified by key-stakeholders.

On the technical level:

The Egyptian health system is perceived to be operating beyond its capacity and its shortcomings in responding to the healthcare needs of refugees and migrants emanate primarily from shortcomings in the other health systems building blocks, including scarcity in resources, weak infrastructure, misdistribution of doctors, unequal spread of public and private hospitals in Cairo and problems of health workers retention and absenteeism.

One informant illustrated this by pointing out the general dissatisfaction faced by the Egyptian health workforce due to basic salaries, lack of security and protection after the revolution, unsuitable and unsafe environment, lack of maintenance and lack of continuous education. "All this affects the motivation and receptiveness of an added caseload of non-nationals".

This was illustrated by the repercussions of the 25th of January 2011 revolution on the public, private and charity sector. The biggest burden resulting from incidents and injuries fell upon public hospitals. Access to PHC centres was affected especially in rural areas and areas around Cairo which may affect refugees and migrants living in those areas. The private sector was affected by increasing prices and a brain drain of qualified practitioners which may affect quality of private services open to migrants and closed files. In charity hospitals, the main concern was limitation of resources mainly allocated to Egyptians as a priority before migrants.

On the policy implementation level:

The revolution is felt to have had clear repercussions on the policy, bureaucracy and implementation level; diminishing the MOHP leadership in carrying out prior agreements and formulating a concrete health strategy.

For example, one of the joint goals of the WHO working as an advisory to the MOHP was to formulate a national health strategy, which failed for the last three consecutive years. In addition, the high turnover of staff at management level delayed the implementation of activities, especially those directed towards refugees and migrants (since they do not represent a key priority for the government).

In 2012, several shifts in the MOHP have engendered a "wait and see" attitude which is seen to be affecting the overall health system.

This combined with the growing scepticism over international NGOs and a newly drafted NGO legislation appears to have culminated in many limitations on legal registration procedures, clearance for funds as well as new collaborations between the parallel system and Egyptian civil society.

4.2.2. Accountability for Refugee/Migrant Healthcare

In determining the degree of leadership and governance of the Egyptian government, one informant stated "We don't have a national ownership of refugee or migrant healthcare; it is left to be taken care of by UNHCR and IOM".

The lack of accountability was highlighted in the persistent lack of statistics on refugee and migrant populations in Egypt. It was felt that as data on

transient populations were not available hence, they do not figure in the MOHP strategic plan. "It is something temporary so it cannot be strategic".

As there are no solid numbers to use as evidence, this was seen to directly affect advocacy efforts with donors for funding and with the Egyptian government for policy change and inciting them to engage refugees in their healthcare strategy, the latter of which is currently absent.

Another problem which was highlighted several times is that "rules do not apply" and that even though there are laws governing refugees' and migrants' access to healthcare services in Egypt, the latter is not implemented at the health facilities' level due to a reported miscommunication between the MOHP and its hospitals.

Due to the fact that a number of services in the public sector are open to refugees on an informal basis and thanks to advocacy efforts; the latter was perceived as unstable with collaboration depending on "good will and personal relationships" but no formal system for accountability.

A difference in accountability was drawn between refugees having access to public hospital under the UNHCR umbrella, upholding norms of "care with a standard" and migrants who are left "at pray" of the public sector facing many risks⁹ not being under an institutional mandate.

4.2.3. Parallel System: UNHCR and IOM Strategies for Health

Since UNHCR guarantees access to healthcare to refugees and migrants under its mandate and within IOM's intervention for migrants, health is presented as one of the major response components, their healthcare policies need to be highlighted.

4.2.3.1. UNHCR

UNHCR emphasizes the spirit of self determination, community participation in cost of healthcare and the importance of primary health care (PHC) highlighted in the Alma Ata declaration.(14,60) The need to focus on PHC was said to reduce "pre-matured referral" with cost implications with a potential to manage 80% of patients' total.

UNHCR policies for healthcare place special attention to women, children, elderly, persons with disabilities and minorities who have been traditionally

⁹ Some of the risks: discrimination and abuse, denied healthcare at hospitals, and confiscation of passport until the bill is paid.

excluded and disenfranchised.(10) Three areas of focus namely; HIV and AIDS; Nutrition and Food Security as well as Reproductive Health are represent key areas of response in UNHCR strategic plans for 2008-2012.(10)

Refugee Egypt, the main UNHCR implementing partner focusing on these three areas of response in Egypt, stated that their services were targeted toward gaps that affect morbidity and mortality of the refugee population and weaknesses observed at the MOHP level¹⁰, which they try to address accordingly, while being open to changing their programmes according to refugees' needs.

According to the UNHCR policy on refugee protection and solutions in urban areas, UNHCR's long term healthcare strategy is to "augment the capacity of existing public and private services (...) (by) avoid(ing) the establishment of separate and parallel services for its beneficiaries, (...) instead seek(ing) to reinforce existing fully authorized delivery systems".(61) UNHCR Egypt Health standard operating procedures (SOPs) reiterate this point stating that "The strategic goal of UNHCR is to integrate refugees and other POCs into the Egyptian public health system".(14)

UNHCR's ultimate goal was said to be mainstreaming; to find opportunities to draw out from a parallel system into a more integrated public health system in which services for nationals, migrants and refugees would be leveraged by UN agencies for quality and sustainability of care¹¹.

Awareness of UNHCR's previous efforts made towards mainstreaming was low. It was felt to be a viable option but not in the immediate future. Some perceived it as the only option for improving the overall health system; with a portion of humanitarian aid being injected into the existing health infrastructure improving quality and sustainability in the long run. The success or failure of such an initiative was said to rely on political will and financial and capacity building resources.

The literature points out to the dangers associated with having "refugee-centric" programmes which bear the risk of increasing xenophobia.(62) Instead, both UNHCR implementing and operating partners need to become aware that unless both host and refugee communities are targeted in long

¹⁰ According to an informant maternal mortality rates in Egypt were much higher than refugee clinics and UNHCR contracted hospitals.

¹¹ Efforts towards this goal were carried out by UNHCR, WHO, UNFPA and Egyptian Initiative for Personal Rights (EIPR) at the end of 2010.(100) They wanted to revisit Egypt's Family Healthcare Model (FHM) by running a pilot project at selected healthcare centres with high density of refugees. However after the events of the revolution, efforts were put on hold due to change in ministries affecting on-going policy dialogue.

term development; discrimination will remain a fact of life for the majority of migrant populations.

4.2.3.2. IOM

The IOM being an inter-governmental organization, their role was argued to give them a “different leverage” than UNHCR and other NGOs vis-a-vis the Egyptian government.

Their activities in Egypt are manifold; although they provide direct healthcare assistance to vulnerable migrants; their main role is to alleviate refugees’ and migrants’ access to the Egyptian healthcare system in place and contribute to the existing health infrastructure and human resource. They focus their efforts on migrant dense areas and border crossings in Aswan, Saloum, North and South Sinai.(63) (Appendix 11.)

Their ultimate goal is to build the MOHP capacity “because they are the ones on the ground all over Egypt who can really provide the support”. They achieve this by awareness raising campaigns, capacity building on basic skills and migrant health concepts delivered at PHC centres; community cohesion activities, as well as ensuring MOHP leadership through creating a migration health committee at the MOHP in North Sinai.(59,63)

“We are trying to shift the responsibility to give it back to the government but to have an established network, we need to have a proper system in place there that would not be dependent on IOM per se or any other donor/NGO; anyone who wants to support the government the committee is there to help them do that. (However), this whole sustainability is a question mark”. (IOM staff member)

4.2.4. Leadership

4.2.4.1. Advocacy Efforts

A considerable amount of advocacy was reported to go into the work of service providers in ensuring timely referral and access to healthcare and creating new pathways to healthcare services for refugees and migrants.

Internal advocacy was said to emanate from an inconsistency in the system and had the potential to raise expectations of clients and promote refugee dependency on case workers in the long run.

Advocacy and accompaniments needed to be made “within a framework” and the role of advocates was to be conscious of the limitations of the Egyptian healthcare system in which they operate.

External advocacy efforts, on the other hand, were considered successful at:

- **policy level:** to raise the profile of refugees and migrants through a bottom-up approach at healthcare centres and lobbying at governmental level
- **facility level:** by approaching MOHP and charity hospitals and having informal agreements for referrals¹² at subsidized prices as well as free surgeries
- **practitioners’ level:** activating a network of doctors willing to receive refugees on pro-bono basis
- **service providers’ level:** collecting charity funds for the most vulnerable

External advocacy was said to have “limitless potential” which is characterized by a “ripple effect”; by winning over an institution it is actually opening up the service for more than one client and creating “new advocates” for refugees. However advocacy efforts were believed to require “dedication, complete focus and resources” which often times was not feasible given limited capacity.

Another limitation to advocacy efforts was in relationship to the un-registered status of certain NGOs which restrict their awareness raising and policy efforts combined with government’s shift in priorities which do not leave room for policy dialogue nor change.

4.2.4.2. Emergency Preparedness

For service providers, the aftermath of the revolution came with a need to modify the nature of their work, Cairo becoming an “emergency setting” demanding a different set of “knowledge and expertise in healthcare response”.

Some of the measures that were taken prior to the 30th of June 2013 (in preparation to second wave Egyptian revolution) were spreading messages to the refugee communities on available hotlines; informing them of security measures to take, increasing coordination between organizations, ensuring procurement of Anti-retroviral (ARV), TB and psychiatric drugs at different locations, mapping refugees’ locations around Cairo in case of emergencies, etc.

¹² Refugees and migrants get discounted prices at the National Cancer Institute.

The majority of key informants stated that they were much more prepared during the 30th of June; the events and lessons learnt from the first revolution still “fresh” in their memories but that there was still a gap.

4.2.5. Coordination: Inter-agency Working Groups (IAWGs)

In discussing how coordination was ensured among different organizations working with refugees, no clear coordinating body was discerned by informants; with some stating it should be the MOHP, the WHO or the UNHCR.

The IAWGs (Appendix 12) were mentioned as a means to ensure programmatic coordination, in addition to medical standard operating procedures (SOPs) as a common shared guideline for referrals.

Although these meetings are regarded primarily as platforms for sharing information and resources, both material and human (62) many problems were highlighted by several informants at different organization.

The literature points out to the “non-binding” nature of IAWGs meetings decisions resulting in a lack of follow-up on proposed actions.(62)

Among the problems reported were communication problems resulting in duplication of initiatives, a lack of direct communication with UNHCR for guidance¹³; meetings not addressing the “root causes” of problems; discontinuity of attendees, and no clear leadership.

Several informants stated that there was a need to map out the demographics of refugees and migrants in Cairo and Egypt to determine specific needs and coverage and that the IAWGs offered the right platform for such. Two caseworkers stated that an emergency preparedness group needed to be enacted.

4.3. Health Information System

The HIS was seen as one of the building blocks which need most strengthening; whether it is at the MOHP, the UNHCR or service providers’ level.

The HIS of Egypt does not capture information about refugees or migrants; hence the UNHCR developed its own HIS for refugees in 2011. The data is

¹³ UNHCR lack of guidance in write-up supporting medical documents and reports patients request.

recorded by the three implementing partners; each doctor records daily referrals and service provided on “tally sheets” which are compiled and sent to the UNHCR monthly by medical directors¹⁴. The remaining organizations record their data either manually or in internal data systems which are not shared with other stakeholders in order to ensure anonymity and confidentiality.

The different HIS used do not pool completely compatible information. The only data available widely is the UNHCR yearly country profile report, on which stakeholders rely to assess disease profiles, morbidity and referral trends (including the MOHP) but which does not reflect a global or accurate picture. According to two service providers, doctors do not have the skills to deal with Excel sheets resulting in duplication of information, which can be misleading.

Duplication of services due to lack of a common database has been mentioned in the literature.(62) The tendency of refugees to “shop for services” has been reflecting by several informants¹⁵. Ways to mediate this was by tracing clients’ Caritas or Mahmoud hospital’s medical file number recorded on UN cards; recording received services on Caritas medical booklets; asking questions to clients about services previously received; and increasing communication between different sites.

The majority of respondents recognized the advantage of sharing health information in guiding and informing policy through assessing trends, total coverage, human resource capacity, monitoring and evaluation, and directing services according to needs, labelling the HIS as a “very powerful tool” which could have a direct repercussion on mobilization of resources.

However, they were unsure as to how this could take place and whether or not it was feasible or fair to refugees given aspects of anonymity. Respondents emphasized this concern even though the UNHCR HIS itself is anonymous. As one service provider commented:

“We are not a UNHCR implementing partner; clients can tell us things that they cannot tell the UN and they should have the right to do that because the UN is a legal body and anything said can have implications. I think that a (common) system would be unfair to clients”.

¹⁴ HIS information: consultations, morbidity, referrals, reproductive health, child health, nutrition, HIV, TB.(14)

¹⁵ In addition to resettlement being their primary motivation in seeking services at different service providers.

Available unpublished material drawing on refugees' health determinants, inequities and the contextual environment of Cairo didn't seem to be consulted by key-stakeholders, although representing valuable information and recommendations. This could be due to the fact that this material is not widely accessible.

4.4. Financing

4.4.1. Funding of the National Health System

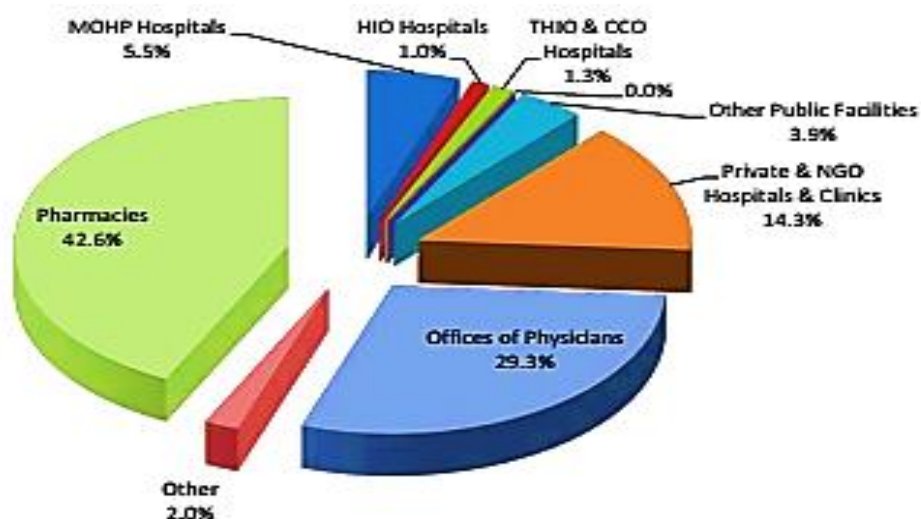
Although Egypt's population is one of the largest in the Middle East and North Africa (MENA) region, its public spending on healthcare is one of the lowest having consequences on the out of pocket payments (OOP) as well as quality and sustainability of healthcare services.(50) (Appendix 13.)

Health financing in Egypt is principally relying on OOP accounting for 60% of health spending, public finance 33,5%, while the rest is funded by donors, public firms and employers' funds.(50) Taking into account that only 51% of the population in 2008 was covered by health insurance, this exposes a large proportion of poor Egyptian households¹⁶ to the risk of catastrophic health expenditure.

"Households rather than risk-pooling entities are the primary managers of health funds in Egypt, and allocate resources to providers directly".(52) Figure 4 provides a breakdown of OOP by provider in 2008 with larger spending directed towards pharmacies (43%) followed by specialists' clinics (29%).(52)

¹⁶ Uninsured informal workers and unemployed housewives

Figure 4. OOP Household Expenditure by Provider



Source: Egypt National Health Account 2008/09.(52)

4.4.2. Funding of the Parallel System

4.4.2.1. Current Funding

The UNHCR budget for Egypt decreased from 24,7 million USD in 2012 to USD 23,4 million USD in 2013.(64)

According to IOM staff, the IOM 2013 budget for Egypt ranges between 2,0 to 2,3 million USD.

(Appendix 9. Funding source for each organization)

4.4.2.2. Recent Shifts

Recent shifts in funding were accompanied by a shift in programmes' focus. Instead of funding key response areas such as reproductive health or the development of PHC centres, donors are now targeting direct interventions for case assistance. Funding earmarked to Syrian refugees, a recent shift in donors' interest towards highly vulnerable groups such as VOTs and specific geographical areas like Sinai and newly developed areas¹⁷ was reported.

¹⁷ Aswan, Luxor, Halayeb Chalat in the South and oasis areas in the West

- IOM health expenditure in the MENA region during the Syria crisis increased by 5.5 million USD (according to respondent)
- The UNHCR Egypt 2013 budget allocation to Syrians was comparable to that of all refugees and asylum seekers (9,700, 000 USD compared to 10,209, 666 USD).(25) (Appendix 14.)

Shifts in donors' interest have been linked to political motivation; Sinai being close to Israel and representing a marginalized area, and where increased attention can have an impact on awareness raising, decreasing trafficking, and bringing about community stabilization.

4.4.2.3. Funding Inequity

The inequity of aid distribution disproportionately allocated to newly arrived Syrians was reflected in key-informants' interviews, leading to tensions between refugee communities as attested by recent reported demonstrations at the Caritas Garden City main branch.

Some of the Syrian-only targeted interventions revolve around immediate RSD, access to mobile registration, exclusive access to Mahmoud hospital, larger amount of Caritas financial assistance, and aid by other organizations such as Islamic Relief and World Food Programme (WFP).(31)

4.4.2.4. Sustainability

The sustainability of funding was questioned by several key-informants being at the "whims of donors", with funding by and large depending on donor organizations and Member States. NGOs were said to be funded on a year to year basis with some having longer time-frames depending on projects running.(Appendix 9.)

Un-sustainability of funding was said to correlate with certain NGOs not meeting eligibility criteria set by bilateral donors; and shifts in initial budgets allocated for medical partners¹⁸. A technical expert mentioned that funding allocated to specific projects does not match real numbers for the transient populations, resulting in a backlog once the funding eventually runs out.

¹⁸ UNHCR funded a joint programme with MOH specialized healthcare centres for Libyans. The initial budget was 8 million EGP; but after the political situation in Libya stabilized, it was reduced to 4,5 million EGP resulting in a backlog of 1,127 million EGP which the MOH had to cover.

Other informants stated that sustainability of funding rested on long standing relationships with donors who directed their funding to programmes displaying similar “values” and agendas.

Organizations have been recently placing increased attention on initiatives promoting community cohesion¹⁹ and sustainability, such as training CHVs and having school projects involving Sudanese and Egyptian youth²⁰, whereby sustainability of interventions is ensured and antagonisms reduced.

The international aid architecture can have a role to play by promoting more sustainable and inclusive funds directed to both Egyptians and migrants in the long term.(45)

4.4.3. Refugees’ Ability to Pay for Healthcare and OOP

The social and financial aspect affecting refugees’ ability to pay for their healthcare and other needs, leading to stress, was brought up in the literature as well as in the key-informants’ interviews.

One informant stated that with funding shortfalls it is now obligatory that patients share a percentage of treatment.(Appendix 15. Consequences of UNHCR funding shortfall)

As a result of Egypt’s 1951 reservation on refugees’ right to work²¹; most refugees rely on domestic work and Caritas financial assistance to subsidize to their needs including healthcare.(18) However, with Caritas assistance decreasing it is unclear how refugees will continue paying for their healthcare.

The majority of healthcare services available require a user-contribution fee (except for mental health cases, victims of torture and SGBV).(Appendix 16. Cost-sharing details).

¹⁹ Community cohesion on three levels between migrants and nationals, between different migrant communities and between community health volunteers (CHVs) and Egyptian health workers

²⁰ IOM recently launched project in Hagana involving three Sudanese schools and one Egyptian school having joint activities with a participatory approach.

²¹ requiring refugees to obtain a work permit

Waiving fees and financial assistance available at Caritas were reported for:

- Unaccompanied minors
- Old age disability and multiple disability
- Victims/survivors of SGBV and torture
- Single mothers
- Large families (5+ children)
- Mental health and suicidal patients

The following table outlines level of OOP and ceiling of healthcare assistance by UNHCR.

Table 4. Level of OOP and Ceiling of Healthcare Assistance

Type of Illness and Healthcare Procedure	OOP Level	Ceiling of Healthcare Assistance
Frequently encountered illnesses	25% of cost of treatment	ceiling of 60 EGP per month
Chronic illnesses	15% of treatment	ceiling of 300 EGP per month
Further investigations (lab, x-rays)	25% to 30% of investigation	ceiling of 200 EGP per investigation
Operations	Depending on ability to pay and money fundraised within community	ceiling: 5,000 EGP; higher fees for both recognized refugees and asylum seekers require ECC with a ceiling of 8,000 EGP

Source: Health SOP's and Informants' Interviews

4.5. Health Workforce

4.5.1. Health Workforce Challenges

4.5.1.1. Public Sector

Lack of trust in Egyptian doctors and unprofessional treatment by healthcare providers in the public sector vis-à-vis refugees (especially Africans)²² have been previously highlighted in both the literature and interviews.(34,36,37,42,65)

Cultural ethnocentrism, a lack of familiarity of service providers with migrants' background and reasons for being in Egypt, and a reported

²² Most challenging circumstance reported for refugees was dealing with healthcare workers and high nurses at the in-patient care level, where difficulties of daily contact is exacerbated by the language barrier.

unfamiliarity with UNHCR identity cards contribute to the exacerbation of refugees trying to seek healthcare in the public sector.

Reported challenges faced by local service providers are particularly related to dealing with rape victims, people living with HIV (PLHIV) and victims of torture which are all related to the “refugee experience”.

4.5.1.2. Parallel System

The human resources challenges faced by the parallel system in place are manifest.

Internally, challenges reported range from heavy reliance on interns, high turn-over of staff (including refugees who get resettled), lack of interpreters (especially for the Oromo, Somali and Eritrean communities), and a problem of doctor to patient communication.

One of the most reported gaps in successful delivery of healthcare to the refugee population is the miscommunication between doctors and patients due to a language barrier and lack of a counselling component. Refugees are a particular group requiring longer consultations with pre-treatment counselling and follow up with a question and answer session.(42)

According to key-informants, reported complaints from refugees state that doctors “rush” examinations without allowing enough time for explanation. In turn, refugees misunderstand their health condition prognosis, medication allocated and reasons for referrals to specialists²³, all having a long term impact on adherence to medication and successful treatment.

The latter was described as shifting responsibility from doctors to caseworkers who play a disproportionate role in giving medical advice and doing medical inquiries on behalf of clients.

(Appendix 9. Health workforce details for each organization)

4.5.2. “Refugee to Refugee” Care

Several medical service providers hire refugee paramedics, psycho-social (PS) workers, and administrators working as mediators between refugee clients and Egyptian medical practitioners. The latter were said to create an “enabling environment” in which refugees feel welcomed, communication

²³ The miscommunication was said to affect the most vulnerable clients who are not able to advocate for themselves.

with doctors is facilitated and tensions mediated, ultimately improving service delivery.

“Refugee to refugee” care, training refugees to serve other refugees, was encouraged by all promoting community sustainability and ensuring “knowledge retention” within refugee communities.

Both PSTIC PS workers and IOM CHVs build on this concept. Their work is multi-dimensional; being trained in counselling advocacy and mediation, in turn understanding the “system’s limitations” and able to “guide” clients through the system’s referral pathways ensuring “smooth” service delivery.

More established PSTIC PS workers²⁴ operate on all levels of the health system be it accompaniments, counselling, responding to emergencies²⁵ and working closely with community leaders receiving referrals for closed files, migrants and victims of torture before beginning their RSD process.(56) In 2012, PSTIC provided support to 1,475 cases from which two thirds were referred by the community or clients themselves.(66)

The success of such initiatives was said to rely on political will and financial resources for both new CHVs and future recruitment of refugees in the health workforce.

4.5.3. Education and Capacity Building

4.5.3.1. National Health System

Since there is no official recognition of migrants by Egyptian authorities; a migrant health component is absent from Egyptian medical curricula.

However, a recent training collaboration has been established by IOM and the Public Health department at Ain Shams University which is paving the way towards bringing more awareness and skills on how to address migrants’ health.

A need to build the knowledge and capacity of the wider national health system in order to diffuse specialized services offered to PLHIV and SGBV victims in refugee clinics was expressed, along with a need to provide trainings on site to selected facilities to sensitize a bigger number of healthcare providers.

²⁴ project began in 2009

²⁵ PS workers work as “emergency responders” being present in different catchment areas around Cairo.

4.5.3.2. Parallel system

The emphasis on capacity building differed depending on the organization. Some highlighted that in order to ensure optimum quality of services, service providers needed to receive continuous education with monthly trainings to raise awareness of the staff²⁶.

Others estimated that knowledge gained by practical experience for medical service providers as opposed to “health educators”, was more valuable, placing less importance on training, only “a fraction of which ends up being implemented”.

4.6. Medical Products, Vaccines and Technology

Due to limited availability of information, this following section will focus on UNHCR’s procurement system.

4.6.1. UNHCR Treatment and Procurement System

Doctors at UNHCR implementing partners, namely Caritas and Refugee Egypt, support the use of generic medication in accordance with the National Essential Drug List (67) as a means to achieve cost effectiveness, in line with the national health insurance scheme (14); while other health practitioners rely on brand-name drugs.

Procurement in urban Cairo for refugees and asylum seekers is arranged through contracted pharmacies which offer subsidized prices. In Saloum refugee camp, international procurement following the UNHCR essential drug list (68) is solicited and presented as having negative implications on opportunities for economies of scale found in the national health system, but believed to decrease abuse of the system which may happen otherwise.

No shortage of procurement *per se* was reported for refugees or migrants in the National health system. However, discriminatory practices of pharmacists were mentioned during key informants’ interviews.

General practitioners monitor and review prescriptions and dosage making sure they do not exceed UNHCR budgeted allocation to treatment.

²⁶ reported trainings: early detection and referral of mental health patients, dealing with survivors of rape, doctor to patient communication and research ethics

No standard treatment guideline to support the rational use of drugs is established. A desire to standardize a protocol for diagnostics and therapeutics between UNHCR's medical implementing partners was expressed in order to achieve cost effectiveness.

4.6.2. Sustainability of Treatment

UNHCR employ a "value for money" approach in treatment delivery in order to "meet end of the year target" and provide healthcare to the biggest number, having positive results on morbidity and mortality of their POCs. Therefore, short-term curable interventions and emergency cases are prioritized over costly treatments for chronic patients.(14)

Achieved sustainability of treatment was expressed for ARVs and TB drugs; psychiatric and mental health, antenatal and malnutrition and a limited window for waiving fees to the most vulnerable.

Treatment was reported as most difficult to access for oncology, renal dialysis, and heart conditions, and for dealing with clients needing adherence to life-long treatment such as diabetic, suicidal, and HIV patients.

Stressors related to refugees' lives in urban Cairo contributing to their ill-health were brought up in both literature (34–38,69) and key informant interviews. It was argued that treating patients did not only revolve around medication but "long term solutions to refugee problems".

4.6.3. Challenges

4.6.3.1. Specialists/Referral Level

Externally, one of the major challenges met by service providers is at the referral level with specialists not abiding to the UNHCR ceiling for medication and a need to improve rationalized prescription.

4.6.3.2. Generic Substitution and Palliative Response

According to service providers and CHVs, generic substitutes are negatively perceived by refugees. Complaints are reconciled by awareness raising about the ultimate goal of the UNHCR "to attend to the need of every person".

According to a caseworker, the system in place is working on a palliative level "trying to lessen the pain but not addressing the real problem". Similarly, the literature points out to chronic cases that need expensive non-life saving operations being denied; leading them to rely on pain medication and the associated dangers.(17)

4.6.3.3. Abuse of System

Several informants mentioned the fact that some refugees seemed to bargain medication in exchange of money resulting in an abuse of the system.

This was presented as having several implications according to respondents; a need to strengthen PHC and proper screening, maintaining prescribing generics, and contribution fees to “responsabilise” patients.

Chapter 5: Discussion

This chapter draws on the findings brought about in chapter 4 to determine how the health system in place in Egypt ensures coverage, access, safety and quality of healthcare for transient populations present on Egypt's soil.

In line with the conceptual framework, the overall goals of a "well-functioning" health system, namely social and financial risk protection, efficiency, responsiveness, and improved health will also be addressed.

5.1. Coverage

The study has shown that the health system responding to refugees and migrants in Egypt is made out of a "mosaic" of service providers belonging to a "parallel system" under UNHCR and limited healthcare services under the MOHP. More often than not, UNHCR bears the responsibility to provide healthcare to its POCs while irregular migrants and closed files seem to be constantly "falling through the cracks" of the health system in place.

In theory, the MOHP ensures support of migrants for communicable diseases only. The "burden of non-communicable diseases" among refugees falls upon UNHCR for providing secondary and tertiary care.

With the revolution having direct repercussions affecting all levels of healthcare especially the public sector and decision making capacity of MOHP, the responsibility for healthcare provision for migrants in the immediate future is most likely to continue depending on UNHCR and other organizations' already established "parallel system".

One of the major gaps in healthcare delivery is in providing secondary and tertiary care and an absence of coverage for chronic diseases, for asylum seekers.

Services offered to migrants are on a case by case basis (IOM), subjected to extra fees (MOHP health centres) and offered within a certain time-frame (MOHP specialized centres) directed towards particular groups (Libyans and Iraqis). Even when organizations state that their services are in fact "open" to migrants, it is uncertain whether or not these populations have access to information on "available" services.

Access to a comprehensive free-of-charge healthcare package at the MOHP specialized centres is guaranteed within a particular time-frame for specific nationalities, such as Libyans and Iraqis. Such projects were seen to serve as a "promotion" for the Egyptian health system aiming to attract a growing

number of patients from neighbouring Arab countries. This may also be seen in light of the short stay of such nationalities.

Free healthcare was also shown to be guaranteed for victims of torture and SGBV (irrespective of refugee status) and mental health patients to whom availability of funding was ensured, guaranteeing sustainability of treatment.

Being in an urban environment, as opposed to a camp setting, creates economies of scale opportunities which can increase coverage. This is demonstrated by UNHCR's use of national procurement system (similar to health insurance scheme providing affordable medication) and contracted private and public hospitals for referrals.

5.2. Access

Refugee status and access to healthcare are closely interlinked leaving closed files, migrants who do not have a refugee claim, and those awaiting registration in vulnerable positions facing discrimination, being denied access and subjected to higher costs in the National health system.

A consistent lack of accurate statistics on demographics, dispersal of migrants around Egypt, as well as limited data on their health profile, has been shown to affect policy and advocacy efforts and interventions, in turn affecting long term access to healthcare and programmes in place for transient populations.

Access to care for chronic cases was demonstrated to be severely affected by funding constraints and a "value for money" approach in UNHCR's service provision.

Although HIV and TB demonstrate an area of strength in service delivery, the latter are only delivered at one site, Refugee Egypt, which may hinder access of other transient populations who are not located in Cairo and those who don't have the knowledge that such services exist.

Although it has been reported that no formal system of accountability is in place when dealing with the public sector, one cannot overlook the fact that it needs to become a principal partner in providing healthcare to refugees and migrants in the long run. MOHP hospitals display a much bigger capacity covering all areas of specializations, not present elsewhere in Egypt and have the ability to respond to the diverse healthcare needs of transient populations.

External advocacy was perceived as having "unlimited potential" in "unlocking" new pathways to healthcare improving access. However, several challenges to advocacy were discerned in key-informants' interviews, such

as lack of human resource capacity, resources and policy limitations. The latter raises a question as to whether advocacy efforts and informal networks for care are sustainable and guaranteed to POCs in the long run.

Currently, El Nadim is the only Egyptian human rights NGO in the body of stakeholders engaging in different activities such as lobbying with the government through the use of testimonies, an extensive network of civil society organizations and the use of social media. Although its efforts are unique in nature, apparent lack of attention of other stake-holders seems to keep such efforts at a minimum. Engaging with more Egyptian NGOs in joint programmes has the potential to foster similar efforts, creating “new advocates” for refugees, new platforms of awareness raising and possibly “alleviating the burden” by offering services which include refugees. However whether policies in place would allow this to take place is unknown.

Apart from efforts undergone by PS workers and CHVs in reaching out to the refugee communities, it is unclear how UNHCR ensures wide diffusion of healthcare information to vulnerable refugees who may not be part of established communities. This could represent an additional risk for minority refugees and VOTs who may fall out of the health system in place in the event that right information does not reach them.

Decentralization throughout Cairo districts was argued to improve access to service delivery, offering close-to client PHC; however it is unclear whether clients still go to the main branches. Healthcare services offered by UNHCR are quasi-inexistent elsewhere in Egypt (except for one Caritas branch and one referral hospital in Alexandria) which could represent an additional gap in healthcare response to VOTs reportedly smuggled from Aswan to Sinai.

5.3. Safety

Evidence of discriminatory practices on the part of local service providers towards refugees combined with recent policy shifts towards Syrians and Ethiopians may affect safety and social protection of refugees.

The majority of service providers interviewed demonstrated a high degree of ingenuity and flexibility when dealing with political upheavals and preparing contingency plans.

Being “multi-taskers”, adapting to changing environments and changing traditional ways of working, as demonstrated by the high degree of flexibility and leadership taken by most organizations during the 30th of June 2013 revolution and earlier, points out the key strengths of this body of stakeholders; being able to diversify their responses according to need.

Mainstreaming, was presented as bearing hope for more equitable services for all present on Egyptian soil. However, such approach requires political will and a heightened transparency about end goals for general health service provision, both of which are currently lacking, as demonstrated by the repeated failure to formulate a national health strategy.

Evidence indicates that integration between local and migrant population in healthcare interventions is low. This could improve health equity, but also to create awareness platforms and community cohesion. However, whether an inclusion principle would guarantee accountability of local partners and quality of healthcare services cannot be presently determined.

5.4. Quality

The UNHCR's implementing partners' health workforce are trained in refugee health, have long established relationship with the community, upholding norms of "refugee to refugee" care, which in turn makes their services better "tailored" to refugee communities' healthcare needs.

Moreover, the majority of UNHCR's contracted hospitals are private hospitals; upholding norms of "care with a standard", delivering better quality care to POCs compared to the general population for which only the public sector delivers affordable services but with a reported low quality.

No clear mechanisms to record patients' complaints are established at UNHCR implementing partners, lacking a "people centeredness" component. There is little evidence that monitoring of the quality of services offered at main branches and new clinics is done on a regular basis in order to ensure access, quality and "consumer's voice".

Low quality of healthcare service in the public sector for transient populations are associated with low awareness about refugees' identities and health risks, combined with deteriorating standards and low incentives for the health workforce. Education and capacity building interventions are in place but insufficient, along with efforts to level up quality of healthcare facilities and provide incentives.

5.5. Financial Risk Protection

The financing system in place doesn't protect refugees, migrants or nationals from financial hardships. Moreover with the funding shortfall and disproportional allocation towards newly arrived Syrian communities, the pool of resources is not equitably allocated towards other nationalities,

asylum seekers and closed files who seem to be systematically falling out of the health system in place.

As demonstrated previously, the national health system relies on OOP with biggest expenditures going towards pharmacies and specialists' clinics. How can the latter affect healthcare seeking behaviour of migrants to whom only the National health system is available? Given the structure of the health system, migrants may be running the risk of self-medicating and "skipping" PHC level with implications on financial security, and overall health.

Vulnerability criteria for waiving healthcare fees coincide with refugees' demographics and health profile, placing attention on unaccompanied minors, single mothers, victims of torture and SGBV and catering to multiple disability and mental health needs. The latter is lessening the burden of having to pay out of pocket for healthcare but a question remains whether Caritas financial assistance is enough to secure quality of life for these individuals?

UNHCR and its partner organization do not appear to pay sufficient attention to the social and financial aspect around refugees' ability to pay for healthcare, affecting adherence to treatment and consequently future cost benefit of interventions in place.

5.6. Efficiency and Responsiveness

In the parallel system, structural gaps exist in service provision in relation to availability of interpreters for various nationalities, consistency of referrals, and making the system more "accessible" for refugees especially the most vulnerable; this can hinder overall efficiency.

The HIS in place does not reflect a global nor accurate picture of POCs' health profile and needs affecting parallel system's responsiveness and efficiency in directing interventions.

Coordination and dialogue between stakeholders regarding the IAWGs' roles and priorities and how such shared platforms should be best used to improve overall efficiency and responsiveness seem to be lacking.

PS workers were shown to be instrumental in flagging vulnerable refugees to PSTIC and the UNHCR, doing two things simultaneously; fostering registration and ensuring right information and timely access to services. Although the latter improves efficiency of the parallel system, it is unclear whether enough funds are directed towards sustaining current interventions and future recruitment from refugee communities.

A participatory component in the planning and implementation of health interventions seems to be missing. Apart from IOM's projects involving refugee and local communities in the planning and implementation, no other programme was mentioned. Addressing priorities expressed by the refugees themselves is key in achieving sound interventions with the ultimate goal to improve refugee health.

5.7. Improved Health

Due to refugees' particular life trajectories involving health risks and additional stressors associated with an urban experience, refugee health and healthcare need to be viewed within a particular framework.

The post-revolutionary situation in Egypt, characterized by frequent political and social disruptions, may disproportionately affect refugees since they are considered as foreigners, subjected to a heightened risk of harassment, xenophobia, and SGBV as previously highlighted, having long term repercussions on their health and wellbeing. These challenges need to be taken into account for health, in its broader understanding, to be achieved.

Gaps in responding to secondary and tertiary care combined with reports of the parallel system mainly operating on a palliative level - prescribing pain medication to patients displaying non-life-threatening expensive interventions - may affect refugees' long term health and quality of life.

The need to undergo ECC in order to receive expensive healthcare interventions combined with the fact that asylum seekers need their RSD to be firstly determined could result in a delay in access to healthcare which may affect overall health and wellbeing. This demonstrates to which extent access is essential for achieving improved health.

5.8. Conceptual Framework Limitations

Limitations of the conceptual framework lied in the fact that it did not directly address the current political environment. Similar studies must adapt the Health Systems framework in the future, in order to bring forth the particular challenges a post-revolutionary Egyptian context.

Some findings overlapped between several levels of the health system; a way to avoid repetition of information was by determining the "best-fitting" building block.

5.9. Limitations of the Study

An inability to network with the Ministry of Foreign Affairs due to the political instability and changing governments after the events of the 30th of June 2013 represents a gap in the informants. However, interviews with the MOHP as well as inter-governmental organizations tried to address this gap.

A patient perspective may have also been useful to increase the depth of this study which represents another area for future research needed to be conducted.

Chapter 6: Conclusion and Recommendations

6.1. Conclusion

Refugees' and migrants' limited access to healthcare in the National health system is intricately related to their "temporary" status, but even more so to the lack of accountability displayed by the Egyptian government in addressing these vulnerable populations' rights and needs.

Shortfalls in the current UNHCR-Egypt MOU, which lacks a mutual accountability and collaboration component in refugee policy, is one of the root causes of a persistent policy denial of refugees' and migrants' healthcare needs.

A growing need to strengthen leadership and governance in order to improve access to healthcare is evident. Unless the MOHP future healthcare strategy addresses refugees and migrants' rights to healthcare their limited access and unjust treatment will remain a "fact of life" in the Egyptian health system.

The starting point is to legitimize the position of refugees in Egypt in the coming years and for authorities to realize that one "cannot divide between human rights for Egyptians and non-Egyptians".(19)

Social and financial risk protection was found to be affected by: absence of healthcare coverage for chronic cases, heavy reliance on OOP, funding shortfall and inequitable distribution, a multitude of challenges including discrimination when accessing the National health system, and policy shifts affecting the safety of particular refugee communities.

Responsiveness was found to be affected by: access to care linked to refugee status and availability of resources, lack of accurate statistics and HIS, limited diffusion on available health services, concentration of healthcare services in Cairo, and UNHCR programmes lacking a participatory and patient-centeredness component.

Improved health was found to be affected by: refugee experience, role of supportive community in adherence to treatment, dangers associated with palliative response, and delayed access to healthcare for asylum seekers.

Current shortfalls in **Health System improved efficiency** could be addressed by: making use of economies of scale opportunities, networking, advocacy and referrals opportunities, integrating local and refugee communities in healthcare interventions, exploring mainstreaming opportunities, engaging with local partners, improving coordination between

stakeholders, increasing dialogue with MOHP, addressing structural gaps and diversification of responses.

Ways to respond to persistent gaps in the health system that would prevent access to healthcare in the long run is by inciting a **“paradigm shift” from exclusion to inclusion** of refugees in the MOHP health strategy,,; for stakeholders to have a **long term strategy** in their healthcare interventions, and to **diversify** their **responses** according to needs and challenges.

If the numerous stressors and challenges faced by refugees a post-revolutionary Egypt and are not addressed by key-stakeholders, “health” in its broader understanding will not be achieved and further attempts to “abuse the system” may increase.

It is unclear at this point what the future holds for refugees and migrants in Egypt under current political and societal turmoil the country is currently going through; however one thing that is clear is that more transparency and a constructive dialogue with authorities, from the part of stakeholders, is needed. It is now or never that change for this population can be set forth and awareness brought to the refugee cause and human rights in Egypt.

This thesis could only cover gaps in the health system itself, but there are numerous questions that can be raised for further research, such as: How does refugees’ inability to pay for their healthcare affect their adherence to treatment? How do service providers monitor and evaluate their programs and services? Is there a difference in quality of services and treatment of refugees depending on the public and private sector?

6.2. Recommendations

Policy Recommendations:

➤ Immediate:

1. For UNHCR to review its policy strategy, increasing partnerships with MOHP hospitals and specialized centres covering a wide range of specializations, and explore with other stakeholders the feasibility and cost-benefits of integration

➤ Immediate to Long Term:

2. For UNHCR, IOM and WHO to engage in a constructive dialogue with the Ministry of Interior, the Ministry of Foreign Affairs and the Ministry of International Cooperation raising the crucial importance of having feasible data about refugee and migrant populations

- Long term:
- 3. For UNHCR to start a negotiation process after the political situation stabilizes and new elections take place to advocate for a new refugee legislation (this could be done together with the National Council for Human Rights, IOM and WHO), and to re-negotiate a new UNHCR-Egypt MOU in which the role and responsibilities of each party are clearly stated

Monitoring and Evaluation Recommendations:

- Immediate:
 1. A thorough assessment of refugees' healthcare needs, utilization of services and health profile of each community to be carried out through individual surveys and qualitative research (UNHCR in collaboration with CBOs, CHVs, and PS workers and the CMRS at AUC) involving patients and their community on key areas of response should be
 2. Increase auditing of services offered at UNHCR implementing partners' main branches and new clinics by distributing anonymous surveys to clients about patient's satisfaction, waiting time and healthcare providers' attitude to ensure access, quality and "consumer's voice"

Interventions Recommendations:

- Immediate:
 1. To each leading inter-agency group organization, to review its goals and open up dialogue with partners on how to improve efficiency of this shared platform enacting an Emergency Preparedness/Security Concern working group
- Long Term:
 2. To IOM, to continue carrying out their efforts with Ain Shams University Public Health department and further collaborate with the CMRS and the Social Research Centre (SRC) Health Equity Programme at AUC (70) to develop a joint training programme addressing migration, migrant health and human rights aspects to be incorporated into the national medical curriculum
 3. To UNHCR and IOM, to further document refugees and migrants living outside of Cairo, and offer those services and livelihood programs so that they are able to subsist to their needs. Due to high risk of smuggling spanning from Aswan to Sinai, increased efforts should be targeted towards those areas combined with partnerships with security and law enforcement

4. To UNHCR and IOM; to set up comprehensive rehabilitation programmes for VOTs, patients with handicap, autism and paralysis directed toward refugee community, in order to capture the most vulnerable who may not be aware of such services

References

1. UNHCR Population Statistics [Internet]. Available from: <http://popstats.unhcr.org/>
2. World Health Organisation (WHO). Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies. 2010.
3. WPRO | The WHO Health Systems Framework [Internet]. WPRO | WHO Western Pacific Region; [cited 2013 Sep 10]. Available from: http://www.wpro.who.int/health_services/health_systems_framework/en/index.html
4. (WHO) WHO. WHO | Key components of a well functioning health system [Internet]. World Health Organization; Available from: http://www.who.int/healthsystems/publications/hss_key/en/
5. World Health Organisation (WHO). World Health Organization Health Systems Strengthening Glossary [Internet]. 2011. Available from: http://www.who.int/healthsystems/Glossary_January2011.pdf
6. World Health Organisation (WHO). Everybody's Business Strengthening Health Systems to Improve Health Outcomes WHO's Framework for Action. 2007 p. 1–56.
7. WPRO | Health information [Internet]. WPRO | WHO Western Pacific Region; [cited 2013 Sep 10]. Available from: http://www.wpro.who.int/topics/health_information/en/index.html
8. Zimmerman C, Kiss L, Hossain M. Migration and Health: a Framework for 21st century Policy-Making. PLoS medicine. 2011 May;8(5).
9. WHO | Governance [Internet]. World Health Organization; [cited 2013 Sep 10]. Available from: <http://www.who.int/healthsystems/topics/stewardship/en/>
10. (UNHCR) UNHC for R. Public Health and HIV's Sections Guiding Principles and Strategic Plans for HIV and AIDS Malaria Control Nutrition and Food Security Reproductive Health Water and Sanitation 2008 - 2012. Geneva, Switzerland; 2012.

11. WHO | Medicines and health products [Internet]. World Health Organization; [cited 2013 Sep 10]. Available from: <http://www.who.int/healthsystems/topics/medicines/en/>
12. Rutinwa B. Prima facie status and refugee protection. 2002;(69).
13. Declaration of Alma-Ata. USSR; 1978. p. 6–8.
14. United Nations High Commissioner for Refugees (UNHCR). Standard Operating Procedures for the Provision of Health Services to Refugees in Cairo. Cairo, Egypt; 2011.
15. WHO | Health systems service delivery [Internet]. World Health Organization; [cited 2013 Sep 8]. Available from: <http://www.who.int/healthsystems/topics/delivery/en/>
16. WPRO | Health services [Internet]. WPRO | WHO Western Pacific Region; [cited 2013 Sep 8]. Available from: http://www.wpro.who.int/topics/health_services/en/index.html
17. Morris B. Limitations to Access to Healthcare by Refugees in Cairo: A Case Study Analysis. Center for Migration and Refugee Studies (CMRS) Periodicals, The American University in Cairo; 2006.
18. Kagan M. Shared responsibility in a new Egypt A strategy for refugee protection. [Cairo, Egypt]: School of Global Affairs and Public Policy, Center for Migration and Refugee Studies, The American University in Cairo; 2011.
19. Hafez, Hend and Ghaly A. The Arab Spring and Migration in Egypt: one year on: Impacts, Perceptions and Attitudes. San Domenico di Fiesole; 2012.
20. Jureidini R. Irregular Workers in Egypt: Migrant and Refugee Domestic Workers. International Journal on Multicultural Societies. 2009;11(1):75–88.
21. Central Agency for Public Mobilization And Statistics [Internet]. [cited 2013 Sep 14]. Available from: <http://www.capmas.gov.eg/>
22. International Organisation for Migration (IOM). Egypt - International Organization for Migration [Internet]. 2012. Available from: <http://www.iom.int/cms/en/sites/iom/home/where-we-work/africa-and-the-middle-east/middle-east-and-north-africa/egypt.html>

23. Coker, Elizabeth; Bichard, Alison; Nannipieri, Andrea and Wan J. Health education for urban refugees in Cairo A pilot project with young men from Sierra Leone and Liberia. Forced Migration and Refugees Study (FMRS) Program The American University in Cairo; 2003.
24. Ahmed, Yasmine and Dibb R. Pandemic Preparedness among Sudanese Migrants in Greater Cairo. The Centre for Migration and Refugee Studies (Formerly FMRS). The American University in Cairo; 2008.
25. UNHCR Cairo. UNHCR Egypt Fact Sheet May 2013. Cairo, Egypt; 2013 p. 0-2.
26. UNHCR. Regional Analysis Syria - 28 August 2013 [Internet]. 2013. Available from: <http://data.unhcr.org/syrianrefugees/documents.php?page=1&view=grid&Org%5B%5D=338>
27. UNHCR Cairo. Weekly Report 9 July - 14 July. Cairo, Egypt; 2013.
28. Elsharkawy H, Rashed H, Rached I. Climate Change: The Impacts of Sea Level Rise on Egypt. 2009;1-11.
29. Mahmoud H. Disrupted Lives and Shattered Dreams: Culture, Identity, and Coping Pathways among Sudanese Refugees in Cairo. Department of Social and Developmental Psychology. Faculty of Politics, Psychology, Sociology, and International Studies (PPSIS). University of Cambridge.; 2009.
30. Baldwin S. UNHCR concerned at arbitrary detention of Syrian refugees in Egypt [Internet]. 2013. Available from: <http://www.unhcr.org/51f27733540.html>
31. World Food Programme (WFP). WFP SYRIA CRISIS RESPONSE Situation Update 9 – 23 August 2013. 2013.
32. Haddon H. Amid dam row, Ethiopian refugees in Egypt protest rising xenophobia [Internet]. 2013. Available from: <http://english.ahram.org.eg/NewsContent/1/64/73582/Egypt/Politics-/Amid-dam-row,-Ethiopian-refugees-in-Egypt-protest-.aspx>
33. Verhoeven H. Why a “water war” over the Nile River won’t happen [Internet]. 2013. Available from: <http://www.aljazeera.com/indepth/opinion/2013/06/2013612105849332912.html>

34. Coker EM. Dislocated Identity and the Fragmented Body: Discourses of Resistance among Southern Sudanese Refugees in Cairo. *Journal of Refugee Studies*. 2004 Dec 1;17(4):401–19.
35. Jefferson SM. Sudanese Refugees in Cairo: A Study of their Health-Care Problems. Center for Migration and Refugee Studies (CMRS) Periodicals, The American University in Cairo; 1999.
36. Briant N, Kennedy A. An Investigation of the Perceived Needs and Priorities in a First Country of Asylum. *Journal of Refugee Studies*, Oxford University Press. 2004;17(4).
37. El-shaarawi NR. Living an Uncertain Future: An Ethnography of Displacement, Health, Psychosocial Well-Being and the Search for Durable Solutions among Iraqi Refugees in Egypt. Case Western Reserve University; 2012.
38. Henry HM. African Refugees in Egypt: Trauma, Loss, and Cultural Adjustment. *Death Studies*. Routledge; 2012 Aug;36(7):583–604.
39. Iskander M. The State of Statelessness: Justice, Violence, Subjectivity, and Urban Asylum Seeking and Refugee Women in Cairo. Cynthia Nelson Institute of Gender and Women's Studies. The American University in Cairo.; 2010.
40. Crisp J, Garras G, Mcavoy J, Schenkenberg E, Icva D, Spiegel P. From slow boil to breaking point: A real-time evaluation of UNHCR ' s response to the Syrian refugee emergency. Geneva, Switzerland; 2013.
41. UNHCR. UNHCR Global Appeal 2011 Update Egypt [Internet]. 2011. p. 142–5. Available from: <http://www.unhcr.org/4cd96bae2c.html>
42. Eidenier EK. Providing Health Care Information to Refugees in Cairo : Questions of Access and Integration. 2006;2005:1–35.
43. Grabska K. Who Asked Them Anyway? Rights , Policies and Wellbeing of Refugees in Egypt. *Forced Migration and Refugee Studies*, American University in Cairo; 2006. p. 1–60.
44. Samy S. The Impact of Civil Society on Refugee Politics in Egypt. CARIM Research Reports, Robert Schuman Centre for Advanced Studies, European University Institute; 2009.

45. World Health Organisation (WHO). Health of Migrants - The Way Forward Report of a Global Consultation. Madrid, Spain; 2010 p. 3–5.
46. Search [Internet]. [cited 2013 Aug 31]. Available from: <http://dar.aucegypt.edu/discover>
47. CMRS Masters Theses [Internet]. [cited 2013 Aug 31]. Available from: <http://www.aucegypt.edu/GAPP/cmrs/Graduate/Pages/Theses.aspx>
48. De Savigny, Don, and Adam T. Systems Thinking for Health Systems Strengthening. 2009.
49. Berman, Peter and Bitran R. Health Systems Analysis for Better Health System Strengthening [Internet]. 2011. Available from: <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/HealthSystemsAnalysisForBetterHealthSysStrengthening.pdf>
50. Rashad AC. Catastrophic Health Expenditure and Poverty in Egypt: an Analysis of Household Survey Data. School of Business, Economics Department. The American University in Cairo; 2011.
51. Abdel Latif A. Improving the Quality of Public Health Services in Lower Income Areas in Cairo, Egypt. Public Policy and Administration Department. The American University in Cairo; 2013.
52. Rafeh, Nadwa; Williams, Julie and Hassan N. Egypt National Health Accounts 2008/2009. 2011.
53. (WHO) WHO. Country Cooperation Strategy for WHO and Egypt 2010 - 2014. Cairo, Egypt; 2010.
54. UNHCR Cairo. UNHCR Partners Caritas & Refuge Egypt Health Care Services Beneficiaries , Type of Services , Clinics Locations and Serving Hours. Cairo, Egypt; p. 8–10.
55. UNHCR Cairo. UNHCR Partners Health care services for Syrian PoCs in 2013 Type of services , clinics locations and serving hours. 2013. p. 8–10.
56. Psycho-Social Training Institute in Cairo (PSTIC) [Internet]. Available from: [http://www.aucegypt.edu/GAPP/cmrs/psychosocial/Pages/\(PSTIC\).aspx](http://www.aucegypt.edu/GAPP/cmrs/psychosocial/Pages/(PSTIC).aspx)

57. UNHCR Cairo. Standard Operating Procedures for Prevention of and Response to Sexual and Gender Based Violence Cairo – Egypt. 2012 p. 1–29.
58. Hussain R. HIV Services for Refugees in Egypt. The Center For Migration and Refugee Studies. The American University in Cairo; 2010.
59. The International Organisation for Migration Cairo Projects [Internet]. 2010. Available from: <http://www.egypt.iom.int/projects.htm>
60. United Nations High Commissioner for Refugees (UNHCR). UNHCR 's Principles and Guidance for Referral Health Care for Refugees and Other Persons of Concern Public Health. Geneva, Switzerland; 2009.
61. United Nations High Commissioner for Refugees (UNHCR). UNHCR Policy on Refugee Protection and Solutions in Urban Areas. 2009.
62. Ismail I. Co-ordinating "Humanitarian Aid" for Refugees in Egypt. [Cairo, Egypt]: Center for Migration and Refugee Studies (CMRS) Periodicals, The American University in Cairo; 2001.
63. International Organisation for Migration (IOM). Counter Trafficking and Assistance to Vulnerable Migrants Annual Report of Activities 2011. Geneva, Switzerland; 2011.
64. UNHCR. UNHCR Global Appeal 2013 Update - Egypt [Internet]. 2013. p. 134–8. Available from: <http://www.unhcr.org/50a9f826b.html>
65. Asgary R, Segar N. Barriers to Health Care Access among Refugee Asylum Seekers. *Journal of health care for the poor and underserved*. 2011 May;22(2):506–22.
66. Psycho-Social Training Institute in Cairo (PSTIC). PSTIC 2012 statistics. Cairo, Egypt; 2013.
67. Ministry of Health and Population (MOHP). National Essential Drug List & Guidelines. Cairo, Egypt; 2006.
68. United Nations High Commissioner for Refugees (UNHCR). UNHCR Essential Medicines List Valid from June 2013- till June 2015. 2013.

69. Coker EM. "Traveling pains": embodied metaphors of suffering among Southern Sudanese refugees in Cairo. *Culture, medicine and psychiatry*. 2004 Mar;28(1):15–39.
70. Health Equity [Internet]. [cited 2013 Aug 30]. Available from: <http://www.aucegypt.edu/research/src/Pages/Health-Equity.aspx>
71. Coutts A, Stuckler D, Batniji R, Ismail S, Maziak W, Mckee M. The Arab Spring in Health Policy The Arab spring and health: Two Years On. *International Journal of Health Services*. 2013;43(1):49–60.
72. Devi S. Women's health challenges in post-revolutionary Egypt. *The Lancet*. Elsevier Ltd; 2013 May;381(9879):1705–6.
73. United Nations High Commissioner for Refugees (UNHCR). *Displacement The New 21st Century Challenge UNHCR Global Trends 2012*. Geneva, Switzerland; 2013.
74. United Nations High Commissioner for Refugees (UNHCR). *Istanbul Protocol Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*. New York and Geneva; 2004.
75. *A New Egyptian Healthcare Model for the 21st Century*. 1999.
76. Stadelmann J. *Assessing Readiness for E-Health in Egypt: A Case Study of Cairo University Hospitals*. The American University in Cairo; 2012.
77. (WHO) WHO. *Country Cooperation Strategy at a Glance Egypt* [Internet]. 2009. Available from: http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_egy_09_en.pdf
78. El-Zanaty, Fatma and Way A. *Egypt Demographic and Health Survey 2008*. Cairo, Egypt; 2009.
79. El Rabbat, Maha and Bossert T. *Health Sector Reform and the Family Health Model*. 2009.
80. Fabos, Anita; Deng, Albino Ajuac and Elias JG. *Counsellors' Handbook of Resources for Refugees and Displaced Persons*. [Cairo, Egypt]: (CMRS) Periodicals, The American University in Cairo; 1991.

81. Irin News. EGYPT: Refugees hit by discrimination, violence amid heightened nationalism [Internet]. 2011. Available from: <http://www.irinnews.org/report/94294/egypt-refugees-hit-by-discrimination-violence-amid-heightened-nationalism>
82. Witte G. Egypt sees Ethiopian dam as risk to water supply [Internet]. the guardian. 2013. Available from: <http://www.theguardian.com/world/2013/jun/18/egypt-ethiopia-dam-blue-nile>
83. Feinstein International Center. Refugee Livelihoods in Urban Areas: Identifying Program Opportunities Case Study Egypt. Boston, USA; 2012.
84. Grabska K. Living on the Margins The Analysis of the Livelihood Strategies of Sudanese Refugees with Closed Files in Egypt. Forced Migration and Refugee Studies, The American University in Cairo; 2005.
85. Howedy S. Syrian Refugees in Cairo: Livelihood Strategies and Coping Mechanisms. The American University in Cairo; 2013.
86. Meffert SM, Marmar CR. Darfur refugees in Cairo: mental health and interpersonal conflict in the aftermath of genocide. Journal of interpersonal violence. 2009 Nov;24(11):1835–48.
87. Petrus J. NGO Outreach to Priority Refugee Population Demographics in Cairo. The American University in Cairo; 2011. p. 1–140.
88. Thomas C. Migrant Domestic Workers in Egypt: A Case Study of the Economic Family in Global Context. The American Journal of Comparative Law. 2010;58:987–1022.
89. Convention relating to the Status of Refugees Geneva, 1951. Refugees and Stateless Persons. Geneva, 28 July 1951; 1954.
90. IOM Cairo. IOM and UNHCR joint briefing for the Community Health Volunteers. Cairo, Egypt; 2013.
91. International Organisation for Migration (IOM). Health Vulnerabilities Study of Mixed Migration Flows From the East and Horn of Africa and the Great Lakes Region to South Africa. Geneva, Switzerland; 2013.

92. (UNHCR) UNHC for R. Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol relating to the Status of Refugees. Geneva, Switzerland; 1992.
93. Kobia K, Cranfield L. Literature Review : Urban Refugees. 2009.
94. (UNHCR) UNHC for R. UNHCR Summary 2012 - The State of the World's Refugees. Ecos. 2012.
95. Adapting to Urban Displacement. Forced Migration Review. 2010;(34).
96. Fouad MF. The Syrian Crisis : " One death is a tragedy , one million is a statistic ."[Beirut, Lebanon]: American University of Beirut; 2013.
97. El Nadeem Center for Rehabilitation of Victims of Violence [Internet]. Available from: <http://alnadeem.org/en/node/23>
98. AMERA Africa and Middle East Refugee Assistance [Internet]. Available from: <http://www.amera-egypt.org/>
99. WPRO | Governance [Internet]. WPRO | WHO Western Pacific Region; [cited 2013 Sep 7]. Available from: <http://www.wpro.who.int/topics/governance/en/index.html>
100. Azer, Ashraf and El Hennawy H. WHO & UNHCR jointly suggested steps for mainstreaming Refugees and other Persons of Concern to UNHCR in Public health care services. Cairo, Egypt; 2011.

Appendices

Appendix 1. Syrian Refugees' Specific Needs by Gender

Specific Needs	F		M		Total	Total in (%)
	Total	%	Total	%		
Serious medical condition	1048	25.71%	1268	31.10%	2316	56.81%
-	15	0.37%	28	0.69%	43	1.05%
Chronic illness	326	8.00%	495	12.14%	821	20.14%
Critical medical	138	3.38%	191	4.68%	329	8.07%
Difficult pregnancy	56	1.37%			56	1.37%
Malnutrition	1	0.02%	4	0.10%	5	0.12%
Mental illness	11	0.27%	31	0.76%	42	1.03%
Other medical condition	501	12.29%	519	12.73%	1020	25.02%
Disability	220	5.40%	449	11.01%	669	16.41%
-	7	0.17%	13	0.32%	20	0.49%
Hearing Impairment (including deafness)	29	0.71%	55	1.35%	84	2.06%
Mental disability - moderate	43	1.05%	87	2.13%	130	3.19%
Mental disability - severe	30	0.74%	56	1.37%	86	2.11%
Physical disability - moderate	34	0.83%	120	2.94%	154	3.78%
Physical disability - severe	35	0.86%	40	0.98%	75	1.84%
Speech impairment/disability	25	0.61%	33	0.81%	58	1.42%
Visual impairment (including blindness)	17	0.42%	45	1.10%	62	1.52%
Child at risk	264	6.48%	20	0.49%	284	6.97%
-			1	0.02%	1	0.02%
Child at risk of not attending school	4	0.10%	9	0.22%	13	0.32%
Child carer	1	0.02%			1	0.02%
Child engaged in other forms of child labour			3	0.07%	3	0.07%
Child parent	11	0.27%			11	0.27%
Child spouse	246	6.03%	4	0.10%	250	6.13%
Child with special education needs			3	0.07%	3	0.07%
Teenage pregnancy	2	0.05%			2	0.05%
Older person at risk	130	3.19%	144	3.53%	274	6.72%
-	45	1.10%	58	1.42%	103	2.53%
Older person unable to care for self	45	1.10%	35	0.86%	80	1.96%
Older person with children	17	0.42%	33	0.81%	50	1.23%
Unaccompanied older person	23	0.56%	18	0.44%	41	1.01%
Unaccompanied or separated child	52	1.28%	207	5.08%	259	6.35%
-	5	0.12%	12	0.29%	17	0.42%

Child headed household	3	0.07%	3	0.07%	6	0.15%
Child in foster care			1	0.02%	1	0.02%
Separated child	41	1.01%	113	2.77%	154	3.78%
Unaccompanied child	3	0.07%	78	1.91%	81	1.99%
Woman at risk	105	2.58%			105	2.58%
-	5	0.12%			5	0.12%
Lactating	1	0.02%			1	0.02%
Single woman	58	1.42%			58	1.42%
Woman at risk	41	1.01%			41	1.01%
Single parent	94	2.31%	5	0.12%	99	2.43%
-	2	0.05%			2	0.05%
Single HR - parent	92	2.26%	5	0.12%	97	2.38%
Specific legal and physical protection needs	10	0.25%	41	1.01%	51	1.25%
-	1	0.02%	7	0.17%	8	0.20%
At risk due to profile	2	0.05%	2	0.05%	4	0.10%
At risk of removal			1	0.02%	1	0.02%
Detained/held in country of asylum			4	0.10%	4	0.10%
Detained/held in country of origin			3	0.07%	3	0.07%
In hiding			1	0.02%	1	0.02%
Marginalized from society or community			1	0.02%	1	0.02%
No access to services			1	0.02%	1	0.02%
No legal documentation	1	0.02%	4	0.10%	5	0.12%
Unmet basic needs	4	0.10%	15	0.37%	19	0.47%
Urgent need of physical protection			1	0.02%	1	0.02%
Violence, abuse or neglect	2	0.05%	1	0.02%	3	0.07%
Torture			14	0.34%	14	0.34%
-			2	0.05%	2	0.05%
Forced to egregious acts			2	0.05%	2	0.05%
Psych. and/or physical impairment due to torture			9	0.22%	9	0.22%
Witness of violence to other			1	0.02%	1	0.02%
SGBV	5	0.12%			5	0.12%
-	3	0.07%			3	0.07%
Exposure to SGBV	1	0.02%			1	0.02%
Harmful traditional practices	1	0.02%			1	0.02%
Family unity	1	0.02%			1	0.02%
Tracing required	1	0.02%			1	0.02%
Grand Total	1929	47.31%	2148	52.69%	4077	100.00%

Source: UNHCR Egypt, Weekly Statistical Update, 9-14 July 2013. (27)

Appendix 2. Egypt's Memorandum of Understanding with the UNHCR.(18)

Egypt's Memorandum of Understanding with the UNHCR

TRANSLATION ON

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

PREAMBLE

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

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

Article 1

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

Article 2

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

a) Cooperate with the governmental authorities in view of undertaking the census of and identifying the refugees eligible under the mandate of the High commissioner:

b) Facilitate the voluntary repatriation of refugees;

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

Article 3

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

Article 4

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

Article 5

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

Article 6

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

Article 7

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

Article 8

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

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

Made in double copies in French language.

Cairo, 10 February 1954.

UNHCR Cairo
Unofficial translation
Date

Appendix 3. Community Health Volunteers Training Schedule.(90)

IOM and UNHCR joint briefing for the Community Health Volunteers

Venue: Gamyet El Said – El Quobeisy st. El Daher

Date: Wednesday June 26th 2013 (for a CHV group of 30 participants)

Time	Session	Trainer
8:30 9:15	- Arrival and registration	
9:15 09:45	- Quick refresher on the CHVs main tasks toward migrants and refugees as per the TOR	Dr. Rahma Al Turkey
09:45 10:45	- UNHCR Protection mandate	Ms. Rasha El Shehawy
10:45- 12:00	Counter human trafficking and national referral mechanism	Dr. Sandy Shinouda
12:00- 13:15	Refuge Egypt health care services for Women of reproductive age group, under five children, TB patients and Persons living with HIV	Dr. Eman Kamal
13:15 13:45	- Lunch break	
13:45- 15:00	Counseling	Dr. Rahma Alturky
15:00- 16:15	Medical support mechanisms medical committee and exceptional care committee and HIV and Protection	Dr. Ashraf Azer
16:15- 17:00:	Caritas health services	Dr. Magdy Francis
17:00	IOM, UNHCR and Partners closing remarks for a way forward	



Appendix 4. List of Informants

List of informants:

❖ *Governmental, Inter-governmental and UN organizations:*

- A. From UNHCR: two persons interviewed
 - Public Health Department, UNHCR Regional Office Cairo
 - Field Medical Coordinator, UNHCR Saloum Field Office
- B. From IOM: three persons interviewed
 - Migration Unit, IOM Cairo
 - Victims of Trafficking Project, IOM Cairo
 - North and South Sinai Project, IOM Cairo
- C. From WHO Representative Office, Egypt: two persons from management interviewed
- D. From MOHP Egypt: one person interviewed
 - Specialized Medical Centres and Medical Convoys, Ministry of Health and Population Egypt

❖ *UNHCR implementing partners:*

- A. From Psycho-Social Training Institute in Cairo (PSTIC): one person interviewed
 - 1. Specialist Psychiatrist and Mental Coordinator, Psycho-Social Training Institute in Cairo (PSTIC)
- B. From Refugee Egypt: one person
 - 1. Medical Team, Refugee Egypt
- C. From Caritas: one person interviewed
 - 1. Sexual and Gender Based Violence Team, Caritas Egypt

❖ *UNHCR operating partners:*

- A. From Africa and Middle East Refugee Assistance (AMERA Egypt): three persons interviewed
 - 1. Management, AMERA Egypt
 - 2. Sexual and Gender Based Violence Officer, AMERA Egypt
 - 3. Psychosocial Team, AMERA Egypt
- B. From International Medical NGO operating in Cairo (organization prefers to remain anonymous): one person from management

❖ *Local Service Providers:*

- A. From El Nadim, local NGO: one person interviewed
 - 1. Community Psychologist and Researcher, El Nadim Cairo
- C. From charity hospital, Mahmoud Specialised Charity Hospital: one person from management

Appendix 5. Topic Guides

Topic Guide 1: UNHCR

❖ *General Questions:*

1. What are the characteristics of the general migrant population? What is their financial situation? Are there official statistics about this group? What services are available to them?
2. How do you differentiate between migrants and closed files? Do they face the same challenges in accessing healthcare?
3. What is the difference between a camp (Saloum) and an urban setting when it comes to healthcare provision?

❖ *Leadership and Governance:*

4. How do stakeholders differentiate between a migrant and a refugee and how does status and country of origin affect access to healthcare?
5. Does Egypt have a clearly stated health strategy in place? Does it include refugee and migrant population?
6. What is the relationship between the WHO, MOHP, Ministry of Finance, Ministry of Foreign Affairs, the UNHCR, IOM and other service providers? Is there a coordinating body between different stakeholders ensuring successful implementation of strategies and progress? Is there a policy dialogue between different stakeholders?
7. What does the UNHCR-Egypt Memorandum of Understanding entail?
8. What are the main observable challenges and constraints facing the Egyptian government and its health system in responding to its growing refugee population in a post-revolutionary era?
9. Does the Egyptian government display a strong will in alleviating refugee and migrant health? Do they display a strong ownership of policies in place?
10. What are the policies governing people living with HIV in Egypt and what do different stakeholders' take on it? Effect on resettlement, repatriation of refugees.

❖ *HIS:*

11. What are the data systems in place to monitor refugee health and access to healthcare?
12. What sources of information are available on health system response to refugee and migrant health - how feasible, valid, and reliable are they?
13. Who keeps track of refugee health, using which data bases and are they shared among stakeholders? Is the information taken into

- account in Egypt's healthcare strategy and monitoring and evaluation? How is progress monitored?
14. Where are the gaps in information and how do they affect the overall health system in responding to refugee and migrants' health needs?
- ❖ *Financing*
15. How are funds raised? Who are the principal donors?
 16. Are funds able to ensure financial risk protection to recognized refugees? What about migrants? Can the funds be allocated more efficiently and how?
 17. What interventions are made available for existing resources? How do you decide which services to be provided by the public sector and which should be purchased from the private sector?
 18. How should service providers be paid to ensure quality and efficiency; and whether specific types of services or incentives should be targeted at this population in specific?
 19. What can be done to can be done raise more funds, or raise them more efficiently domestically? What can be done to increase efficiency?
- ❖ *Health Workforce:*
20. Who are the main service providers who respond to refugee and migrant population healthcare needs? Are they different depending on refugee status and nationality?
 21. What is the availability (*public and private healthcare services*), type and distribution of health workforce catering to refugee and migrant population in Cairo?
 22. Are there specific health challenges faced by service providers when dealing with refugee and migrant population? Do health providers need further training in dealing with this specific population?
 23. What role can community health volunteers play?
 24. What are the mechanisms in place to ensure coordination between stakeholders?
- ❖ *Medical Products:*
25. How does the Egyptian government contribute to refugee and migrant population access to medical products and vaccines?
 26. Is there a list of essential drugs available to refugees? Is it affordable? Who monitors quality and dosage?
 27. Can you tell me more about the generic substitution refugees complain about?
 28. How do you ensure continuity of treatment for communicable diseases such as Malaria, TB and HIV? Is the funding sustainable? Are ARV treatments available life-long?

29. Are there specific pharmacies refugees have access to? Do they offer discounted prices and for whom?
30. How do you ensure patients' adherence to medicine since a proportion of medical treatment relies on out of pocket expenditure? How do refugees pay for their medicine?

❖ *Service Delivery:*

31. What services are covered, by whom and for how long?
32. What is the capacity of service provision and how do you choose which cases to treat?
33. Do different refugee communities use healthcare services differently? Preference to either public or private and reasons behind it?
34. How do you manage routine and emergency preparedness during political upheavals in Egypt?
35. What are the barriers of accessing healthcare for refugee and migrant population? Are there barriers of cost, language, culture, or geography?
36. What is the degree of cooperation between different organizations? How are referral made and how can they help and/or hinder refugee access to healthcare?
37. What role does advocacy have in service delivery? Does it facilitate access to healthcare and is it feasible in the long run?
38. How do you monitor quality of care? Is there a perceived or real difference in healthcare depending on whether a refugee has access to a governmental facility, an NGO or a religious organization? How is it different from the general population?
39. Is clients' satisfaction taken into account in the assessment of health services? How do you ensure "consumer voice"? How is service delivery monitored?
40. How do you disseminate info to refugee population given that they are scattered in the city? Is there an on-going dialogue with migrant communities and representatives and for what purpose?

Topic Guide 2: International Organization for Migration (IOM)

❖ *General Questions:*

1. Can you tell me more about the role of IOM and specifically its role in alleviating healthcare responses to migrants?

❖ *Service Delivery:*

2. How does IOM differentiate itself from other stakeholders? What particular role does it serve in terms of migrants' access to healthcare?
3. What are the specific programs/activities, recent interventions pertaining to health?
4. What is your scope/capacity in terms of healthcare provision? What are the limitations that come with a case by case scenario?
5. How do you differentiate between refugees and migrants? How does refugee status affect access to healthcare?
6. How is investing in the health infrastructure contributing positively to the health of migrants?
7. Can you tell me more about political instability in Cairo affecting the migrant population? What about their access to healthcare services?
8. Difference in treatment of Syrians compared to others? Services they have access to that others don't?

❖ *Leadership and Governance:*

9. How can the lack of accurate statistics affect planning? How can the lack of data affect healthcare in the long run for this population?
10. With refugees and migrants becoming settled in Egypt long term – How do you see the policies/healthcare strategy changing?
11. If you can tell me more about the role of advocacy? Did advocacy efforts increase after the revolution? Is advocacy sustainable in the long run?
12. Do you see mainstreaming refugees and migrants in national health services as feasible in the future and why?
13. How can we optimize positive synergies between private public and humanitarian actor?
14. Is it possible to expand the national insurance system to include refugees and migrants?
15. What is the level of coordination between the different stakeholders? Is there a coordinating body?
16. What are the measures which you took on the 30th of June in terms for emergency preparedness?

❖ *Financing:*

17. What are the recent trends in funding coming to Egypt for refugees? How do you prioritize allocation of funds?

❖ *HIS:*

18. How does the HIS keep track of refugees and migrants?

❖ *Health Workforce:*

19. Do you see an increased need for PS workers at this point in time?
20. Are there specific interventions needed to support the health workforce dealing with bigger number of refugees and migrants?
21. When was your CHVs programme established? How do CHVs help existing health workforce in responding to migrants' and refugees' healthcare needs? What particular role can they play at this particular moment in time?

❖ *Recommendations:*

22. What are your recommendations for the future of healthcare responses to refugees and migrants in Egypt? What are the interventions needed for the future?

Topic Guide 3: World Health Organization – EMRO office

❖ *General Questions:*

1. As a public health advisor to the MOHP, what role does the WHO have in alleviating healthcare responses to refugees and migrants in Egypt?
2. How do you differentiate between refugees and migrants? How does refugee status affect access to healthcare?
3. What does the WHO facilitate? Is it a mediator between different stakeholders and the MOHP/Egyptian government?

❖ *Leadership and Governance:*

4. Does Egypt have a clearly stated health strategy in place and does it include refugees and migrants?
5. With refugees and migrants becoming settled in Egypt long term – how is Egypt going to deal with this population in the long run? (In terms of rights and access to healthcare)
6. How can we optimize positive synergies for both refugees and local communities at the same time? What interventions are needed to alleviate access to quality healthcare for both populations?
7. How is the political instability after the revolution affecting the policy dialogue for refugees and migrants?
8. How can the WHO influence mainstreaming of refugees and migrants into the national health system? Do you see mainstreaming as feasible in the future? What would be the role of the WHO?
9. What role does advocacy play in policy-making and mobilization of resources?
10. How do you manage routine and emergency preparedness?
11. What is the degree of cooperation with other organizations and stakeholders?
12. Is there a plan to include this population in the national health insurance scheme? How can this be done and how would it be useful?

❖ *HIS:*

13. What are the improvements needed in the HIS? How can it capture refugees and migrants when there is a gap in statistics about this population?
14. One of WHO's aims is to build an integrated HIS in Egypt – does it include refugees and migrants?

❖ *Financing:*

15. Who are your main funders for refugees and migrants?
16. What are the recent trends in funding coming to Egypt hosting a big number of refugees and migrants?
17. How can the WHO further enhance aids effectiveness and greater alignment to national health agenda? How can funds be allocated more efficiently?

❖ *Health Workforce:*

18. How does a shortage of staff affect WHO's advocacy efforts and technical support role?

❖ *Medical Products:*

19. How does the MOHP contribute to refugees' and migrants' access to medical products and vaccines?

❖ *Recommendations:*

20. What efforts are feasible now to improve refugees' and migrants' access to healthcare?

Topic Guide 4: MOHP, Specialized Medical Centres

❖ *General Questions + Leadership and Governance:*

1. What is your role dealing with the UNHCR regarding refugees and migrants?
2. Can you tell me what is the Egyptian government's stance regarding healthcare provision for refugees and migrants?
3. Are there specific conventions, policies in place?
4. Why is there a persistent gap in statistics about this population? And how can it affect healthcare delivery and outcomes?
5. Were there efforts made to quantify this population?
6. Is the Egyptian Health system including refugees and migrants in its healthcare provision? What services are available? Is there a plan to involve this population in the future?
7. Who monitors coordination between the MOHP, charity organizations, and NGO's responding to refugees' needs? What is the degree of communication between the MOHP and all the different stakeholders?
8. What role does the WHO play? Is there a coordinating body?
9. In which areas does the MOHP need help in improving healthcare delivery? Who do you think should support the MOHP in addressing refugees' and migrants' healthcare needs?
10. How is the MOHP dealing with the recent challenges brought about by the revolution? Does the increase in refugee numbers and their geographical presence represent a challenge? How does the MOHP plan to address these challenges in the long run?
11. Is there a plan to include this population in the national health insurance scheme? How can this be done and how would it be useful?

❖ *Service Delivery:*

12. How can we optimize healthcare provision for both nationals and refugees at the same time? What interventions are needed? Is mainstreaming refugees into the national health system an option? How would it be useful?
13. How is the political instability after the 30th of June events affecting policy dialogue pertaining to Syrian refugees? How is it affecting healthcare provision for this population?

❖ *HIS:*

14. What are the improvements needed in the HIS of Egypt? What are the gaps in information about refugees and migrants' health and impact? What are the consequences for Egyptian Health System strategic planning for health?

❖ *Financing:*

15. How can the MOHP play a role in aids effectiveness and a greater alignment with national health agenda (while including refugees and migrants)?

❖ *Health Workforce:*

16. What are the challenges faced by the Egyptian health workforce when dealing with refugees and migrants? What interventions are needed – incentives, trainings?

❖ *Medical Products:*

17. How does Egypt ensure there is enough medical procurement for both nationals and migrants if there are no accurate numbers?

❖ *Recommendations:*

18. What are your recommendations for the future of healthcare responses to refugees and migrants in Egypt?
19. What is your opinion about mainstreaming refugees in public health services in the future? Can it be a solution and is it feasible?

Topic Guide 5: Medical Service Providers

❖ *General Questions:*

1. How do you differentiate between a recognized refugee, a closed file and an irregular migrant in your service provision?
2. How does refugee status and/or country of origin affect access?

❖ *Service Delivery:*

3. Have you seen a recent change in your caseload? Change in characteristics (age, gender, nationality) and health concerns?
4. What services do you offer to your PoCs?
5. What is the capacity of service provision and how do you choose which cases to treat?
6. What's the degree of cooperation between stakeholders, the public and private sector? How are referrals and follow up done? Are there any challenges?
7. What is your relationship with the UNHCR and local authorities?
8. What challenges do your clients face when trying to access healthcare in Egypt? Are there specific barriers related to cost, language, culture or geographical location?
9. Is there a perceived or real difference in healthcare depending on where they access healthcare? (in the public, private or NGO/faith based organizations)
10. Do migrants, asylum seekers and closed files have a problem in accessing healthcare compared to recognized refugees?
11. How is the current situation of instability in Cairo affecting refugee and migrant population health and wellbeing? How are the two related?

❖ *HIS:*

12. How do you record medical history, services provided and follow up? What do you do with this information? How can this information help in the health information system on refugees and migrants in Egypt?
13. Do you see a problem with service providers not sharing the same data systems?

❖ *Health Workforce:*

14. What are the specific challenges faced by your staff? Is there an increased demand after the revolution?
15. Are there specific interventions needed for the health workforce (Trainings, capacity building)?
16. What are the advantages of having refugees as part of your workforce? How can this be reproduced at other organizations? Do you have a problem of lack of interpreters? And if yes how do you deal with it?

17. Do you have access to community health volunteers (CHVs)? If yes; what role do CHVs play in service delivery? How do they add to the existent health workforce?
18. What role does advocacy play? Do you see an increased need for advocacy? Is it sustainable?
- ❖ *Medical Products:*
19. Do you use a particular drug list? Is it affordable? Who monitors quality and dosage?
20. How do you facilitate refugees' access to medication? Are there any challenges faced by refugees when purchasing their medication/adherence to treatment? How do refugees pay for their medicine?
- ❖ *Financing:*
21. Who are your principal donors? How do you prioritize you fund allocation? How can funds be allocated more efficiently? How do you ensure continuity of funding? What can be done to raise more funds or raise them domestically?
- ❖ *Leadership and Governance:*
22. How do you manage emergency preparedness in time of political upheavals? Is there an on-going dialogue with the refugee community?
- ❖ *Recommendations:*
23. What are your recommendations for the future of healthcare responses to refugees and migrants in Egypt?
24. What is your opinion about mainstreaming refugees in public health services in the future? Can it be a solution and is it feasible?

Topic Guide 6: Mental Health Service Providers

❖ *General Questions:*

1. Can you give me a brief history of organization and projects in Cairo? How did it come about and what services do you offer?
2. Do you make a distinction between an Egyptian national, a recognized refugee, a closed file and an irregular migrant in your service provision? How is refugee status and/or country of origin taken into account?

❖ *Service Delivery:*

3. What is the capacity of service provision and how do you choose which cases to treat?
4. Do your clients display specific characteristics (demographics: men, women, children?) and health concerns?
5. How is the current situation of instability in Cairo affecting refugee and migrant population health and wellbeing? How is safety and mental health of your clients related?
6. How is mental and physical illness related and how do service providers make the distinction between the two?
7. As a service provider, do you see an increased need/demand for psycho-social services and for which population?
8. What challenges do your clients face when trying to access healthcare in Egypt?
9. What is the degree of cooperation between different stakeholders and organization serving the refugee and migrant population in Egypt? How are referrals/follow-ups made?

❖ *Health Workforce:*

10. What role does advocacy play in your project? Is there a limit to advocacy?
11. What are the particular challenges faced by mental health service providers at this particular time? Do health providers need further training in dealing with this specific population and why?
12. Do you have access to community health volunteers (CHVs)? If yes; what role do CHVs play in service delivery? How do they add to the existent health workforce?

❖ *HIS:*

13. How do you keep track of your caseload and services offered? Which database do you use? Is this information shared among stakeholders and under which circumstances? How can this information help in the health information system on refugees and migrants in Egypt?

14. Is there a way to gather patients' satisfaction? How can it help with improving the services for this population?
❖ *Medical Products:*
15. Do you use a particular drug list? Is it affordable? Who monitors quality and dosage?
16. How do you ensure continuity of treatment and adherence? How do refugees pay for their medicine?
❖ *Leadership and Governance:*
17. How do you manage emergency preparedness in time of political upheavals? Is there an on-going dialogue with community leaders?
18. How do you disseminate info to refugee population given that they are scattered in the city?
❖ *Financing:*
19. Who are your principal donors? How do you prioritize you fund allocation? How can you ensure continuity of funding for this particular project? What can be done to raise more funds or raise them domestically?
❖ *Recommendations:*
20. What are your recommendations for the future of healthcare responses to refugees and migrants in Egypt?
21. What is your opinion about mainstreaming refugees in public health services in the future? Can it be a solution and is it feasible?

Topic Guide 7: Local Charity Hospital

❖ *General Questions:*

1. What are the demographic and health characteristics of Syrian refugees? Is their general health condition different than Egyptian nationals?
2. How are they aware of services offered at Mahmoud hospital?
3. How does information reach them? Is there an on-going dialogue with a community leader?
4. Compared to the health system in Syria; are Syrians satisfied with healthcare services received in Egypt? Same quality/observed differences?

❖ *Health Workforce:*

5. Are there particular challenges faced when working with this population compared to Egyptians? Is there a need for training, capacity building?
6. How did service provision for a new caseload (Syrians) affect your work? (services to nationals and other refugees)
7. What is the capacity of service provision? How many medical practitioners are available for Syrians specifically?

❖ *Service Delivery:*

8. Does Mahmoud hospital cover all levels of care? Do you collaborate with other hospitals for referrals?
9. Is client satisfaction taken into account in service delivery and how?
10. How do you maintain communication with the UNHCR? How do you report back? Are you in touch with other service providers?

❖ *Financing:*

11. How did the additional funding from UNHCR affect you? (Consequences on service delivery and general health infrastructure)
12. What does the funding cover? Are there unmet healthcare needs which are not able to cater for? How do you prioritize your funds?
13. Can you tell me of cases which displayed need for emergency costly treatment – how do you negotiate with the UNHCR over these cases?

❖ *Medical Products:*

14. Are there certain guidelines you have to abide by for this population?
15. Do you follow a particular drug list?
16. Do you provide medication? At what cost?

❖ *Recommendations:*

17. If the Syrian population remains in Egypt indefinitely, will you continue to provide services? Under which circumstances?
18. What is your opinion about mainstreaming refugees in public health services in the future? Can it be a solution and is it feasible?

Appendix 6. Breakdown of Medical and PS Services for Refugees and Migrants in Parallel System

Service Provider/ Organization	Types of services	Beneficiary populations	Clinics Locations	Important notice
Caritas	1. General clinical and chronic conditions consultations 2. Health Education 3. Referrals to specialized consultations 5. Referrals to 2ry and 3ry level hospitalization	All recognized refugees and asylum seekers above 5 years - Services not open to migrants	1. Garden City Clinic (main branch) 2. Coptic hospital clinic - Ramses 3. St. Mary clinic - Nasr City 4. Anba Barsoum Clinic - Al Masara 5. Anba Takla hospital clinic - Alexandria	1. Health services subsidized with a user contribution fee - consultation 5 EGP per visit 2. Referral 2ry and 3ry prioritized based on ECC decisions
Refugee Egypt	1. Under-five consultations 2. Gynaecology/obstetric consultation 3. Antenatal and postnatal consultations 4. Family Planning 5. Well-baby clinic (0-2 years) 6. Well-child clinic ($\geq 2-5$ years) 7. Nutrition support 8. Prevention and health education 9. Emergency contraception, PEP for HIV, STDs presumptive treatment 10. TB and HIV 11. Anonymous voluntary testing and counselling 12. Access to condoms 13. Prevention of mother-to-child transmission (PMTCT)	1. All under 5 refugee and asylum seeker children 3. All pregnant refugee and asylum seeker women 4. All Refugees and asylum seekers seeking family planning, Tuberculosis and HIV voluntary counselling and testing and treatment 5. Refugee children with malnutrition service for free 6. Services open to migrants requiring consultation fees	1. All Saints Cathedral - Zamalek (main branch) 2. Kilo Arbaa we nus Clinic 3. Sanabel Clinic - Hadayek el Koba	1. PHC services subsidized with a user contribution fees of 3 EGP (with possibility of waiving) 2. Referral 2ry and 3ry prioritized based on ECC decisions 3. Registers ration within 1st 6 months of arrival to Egypt - card valid up to 2 years - after 2nd year those who can keep on receiving services are: TB and HIV, malnutrition and children up to 5 - pregnancy costs only covered once

	<p>14. Self-help groups</p> <p>15. Referrals to 2ry and 3ry level hospitalization</p>			
Mahmoud Specialised Charity Hospital	<p>1. PHC</p> <p>2. Antenatal, natal, post natal care and family planning services</p> <p>3. Well baby (0-2 years) and well child (2-5 years) clinics</p> <p>4. Outreach health awareness care and home visits</p> <p>5. Emergency care</p> <p>6. 2ry & 3ry specialized care</p>	<p>1. All Syrian persons of concern (POCs)</p> <p>2. Other refugees referred by AMERA receive a 20% discount voucher</p>	<p>Mahmoud charity hospital & clinic – El Mohandessin, Cairo</p>	<p>1. Specialists’ consultation fees 5 EGP</p> <p>2. Charity fund available at hospital for vulnerable cases</p> <p>3. Referral to 3ry care prioritized based on ECC decisions</p>
IOM	<p>1. VOTs and closed files chronic cases (maximum 6 months treatment)</p> <p>2. Referral to National Bank Hospital for trafficked women, domestic workers and rape survivors</p>	<p>1. Victims of Trafficking (VOTs)</p> <p>2. Victims/survivors of SGBV</p> <p>3. Closed Files</p> <p>4. Migrants</p>	<p>Main branch: Zamalek, Cairo</p> <p>Referral to: National Bank Hospital, Al Moalemin Hospital</p>	<p>1. IOM provides healthcare on a case by case basis following particular vulnerability criteria and assessment</p> <p>2. Closed files assisted for a maximum period of 6 months notified prior to treatment</p>
PSTIC	<p>1. Psychiatric assessments, counselling and psychosocial support</p> <p>2. Community based psychosocial needs assessment</p> <p>3. Accompaniments</p> <p>4. Psychiatric home visits and follow up</p> <p>5. Conflict mediation for individuals and families</p>	<p>1. Recognized refugees</p> <p>2. Asylum seekers,</p> <p>3. Migrants prior to UNHCR registration</p>	<p>1. Garden city clinic (for assessment and referrals)</p> <p>2. 6th of October clinic (established in 2013 for Syrians – for treatment)</p>	<p>1. Treatment free of charge</p> <p>2. Referrals to Behman and Dar el Mokatam private hospitals for in-patient care (only available for POCs)-</p> <p>3. Referrals to “International Medical NGO” and Abassia hospital –</p>

	<p>6. Referrals to specialized psychological and mental health support and in-patient care</p> <p>5. Community based “psycho-education” awareness workshops</p>			<p>consultation for 1 EGP at Abassia hospital – Follow up and medication free of charge</p> <p>4. use “strengths” in each partner to improve service; refer to each organization depending on specialization</p>
El Nadim	<p>1. Mental health services: psychotherapy, listening, counselling</p> <p>2. Medical services: check-ups, referral to hospitals</p> <p>3. Emergency contraception</p>	<p>Non-discriminatory accept:</p> <p>1.Nationals</p> <p>2.Refugees</p> <p>3.Asylum seekers</p> <p>4. Migrants</p> <p>Focus: Victims/survivors of torture and rape</p>	E Nadim Centre – Ramses, Cairo	<p>1. Treatment free of charge</p> <p>2. Transportation cost reimbursed</p>
AMERA	<p>1. Information about healthcare services available</p> <p>2. Individual Case Management: follow up, medical inquiries, internal and external advocacy</p> <p>3. Health Education Workshops</p> <p>2. In-house counselling programme</p> <p>3. Doctors’ network: free consultations, limited free services, dentistry, second opinion, medical reports</p>	<p>1. Refugees</p> <p>2. Asylum seekers</p> <p>3. Closed files</p> <p>4. Migrants</p>	<p>1. Hadaye’ El Maadi Office</p> <p>2. Doctors dispersed around Cairo</p>	<p>Referral to doctors’ network on a first come first served basis depending on waiting list</p>

International Medical NGO	1. Psycho-therapy and psychiatric services 2. Emergency contraception, Post Exposure Prophylaxis (PEP) for HIV, STDs presumptive treatment 3. Hepatitis and Tetanus vaccination (office based)	1. Refugees, 2. Asylum seekers, 3. Closed files 4. Migrants Focus on: victims/survivors of SGBV and mental health patients	confidential	1. Referral to PS at AMERA or PSTIC if needed 2. All services including treatment free of charge
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Source: UNHCR Egypt, Health Standard Operating Procedures, 2011 (14) - UNHCR Partners Caritas & Refuge Egypt Healthcare Services 2013 (54) - UNHCR Healthcare services for Syrian PoCs, 2013 (55) – Interviews with key-informants.

Appendix 7. Breakdown of Medical Services for Refugees and Migrants in MOHP

Public Service Provider	Types of services	Beneficiary populations	Locations	Important notice
MOHP Health Centres	<ol style="list-style-type: none"> 1. PHC consultations 2. Routine vaccinations and immunization campaigns 3. Vertical programs TB, HIV procurement of treatment 4. During Libyan crisis: mobile clinics at the borders providing all levels of healthcare and treatment for free for 2, 5 months 	<ol style="list-style-type: none"> 1. EPI programme covers everyone present in Egypt irrespective of status 2. Sudanese, Somalis, Iraqis, Yemeni, Palestinians and Syrians pay same fees as Egyptians when accessing public sector 3. Mobile clinics at Libyan borders open to everyone including migrants 	PHC centres across Egypt	ID required for TB treatment and vaccination for under 5 - Migrants subjected to foreigners fees
MOHP Specialized Medical Centres – Joint Programme with UNHCR	<p>Following the Libyan crisis:</p> <ol style="list-style-type: none"> 1. Free PHC, 2ry and 3ry healthcare (including kidney transplants and oncology treatment) 2. Treatment of all repercussions of war including trauma and chronic cases 3. Reproductive health 	Egyptians, Libyans, Syrians, Palestinians, Sudanese irrespective of refugee status	43 hospitals and healthcare centres across Egypt	excluding TB and vaccination offered at MOH Health Centres – due to shortage of funding after 3 months, program continued only for Libyans excluding other nationalities (9 months in total)
MOHP Specialized Medical Centres – Joint Programme with WHO	Free specialized care for chronic diseases – 2ry and 3ry care	Iraqi refugees and migrants	Sheikh Zayed hospital – 6 th of October (concentration of Iraqis)	On-going from 2012 till present

Source: Interviews with Key-Informants.

Appendix 8. Secondary and Tertiary Care Hospitals for UNHCR POCs Referrals

Secondary Health Care Hospitals	Location
• El Sanabel	• Hadaek el Coba, Cairo
• Coptic Evangelical Medical Centre (CEMC)	• Ataba, down town Cairo
• Coptic Hospital	• Ramsis, Cairo
• Virgin Mary Hospital	• Kilo Arbaa we nus, Nasr City
• St. Mary Hospital	• Nasr City, Cairo
• St. Teresa Hospital	• El Shobra, Cairo
• Misr Science & Technology Hospital (MST)	• 6 th of October
• 6 th of October University Hospital	• 6 th of October
• Behman	• Helwan, Greater Cairo
• Amba Bassum	• Helwan, Greater Cairo
• AnbaTakla	• Alexandria

Tertiary Health Care Hospitals	Location
• Nasr Institute (cardiology)	• Cairo
• Oncology Institute (cancer)	• Cairo
• French Kasr el Aini Hospital	• Cairo
• Cairo University Reference Hospital	• Cairo
• Abud Resh (pediatric)	• Cairo

Source: UNHCR Egypt, Health Standard Operating Procedures, 2011.(14)

Appendix 9. Organizations' Health Workforce, Funding and Coverage Details

Service Provider/ Organization	Health workforce	Daily/Monthly/Yearly Coverage (upon information available)	Funding Source
Caritas	8 doctors 12 interpreters 4 CHVs	Reported captured population of 40,000 –7,114 individuals during May 2013 – per day a reported 200 to 250 clients at main branch	UNHCR (70%), Tear Fund, Anglican Aid, Irish Aid
Refugee Egypt	65 staff – 20 Egyptian medical doctors and the rest refugees (mainly Sudanese)	A reported 11,000 consultations in the past 6 months – during May 2013, 48 women newly enrolled for antenatal care, 304 continued antenatal care services while 16 gave birth through referrals - Tuberculosis treatment extended to 39 individuals, including five newly enrolled – 40 patients receiving ARVs (from 2008 to 2013 cumulatively)	UNHCR
Mahmoud Specialized Charity Hospital	Complete floor dedicated to Syrians and one GP who refers to specialists	A reported 120 to 150 consultations per day	UNHCR – 3 Million EGP per 6 months period
IOM	62 CHVs	109 closed files and vulnerable migrants and 156 VOTs assisted with healthcare services in 2013	2,0 to 2,3 million dollars in 2013 - all major implementing partners for health USAID, Japan Embassy, Swiss Embassy, EU

PSTIC	five psychiatrists 30 to 35 psycho-social workers	supported 1,475 cases with 3,872 beneficiaries in 2012	UNHCR
El Nadim	psychiatrists, psychologists and listeners + one psycho-social worker	To date, SGBV caseload: approximately 40 clients	Funding very limited - don't accept funding from USAID or governments - Partners: Open Society Foundation, Sigrid - funders with same morals, background and are not politically affiliated
AMERA	17 psycho social workers, two AUC Masters level counselling students, 43 doctors	Eight clients per week receiving counselling sessions	Funding very limited – don't meet eligibility criteria of bilateral donors like USAID , EU and foreign embassies - Partners: Swiss Embassy, Comic Relief PRM, formerly Open Society Foundation, Flora Foundation
International Medical NGO	One gynaecologist and a psychologist for SGBV victims/survivors	SGBV and mental health clinic receive 10 to 15 cases per day	Confidential
MOHP Health Centres	PHC centres across Egypt		MOHP Mobile clinics at Libyan orders: 2,5 months
MOHP Specialized Medical Centres – Joint Programme with UNHCR	42 specialized hospitals	reported hospitalization for 800 cases	UNHCR budget: 4,0 to 4,5 million EGP – MOHP contributed extra 1.127 million EGP Time-span: April to end December 2011 – 9 months
MOHP Specialized Medical Centres – Joint Programme with WHO	42 specialized hospitals	average of 100 patients per day at medical centres – inpatient 5 to 6 per	WHO budget: 1,600, 000 EGP - will increase by 250,000 EGP

		week	Time-span: March 2012 – present
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Source: UNHCR Egypt, Fact Sheet, May 2013 (25) and Interviews with Key-informants.

Appendix 10. UNHCR Non-Referral Conditions

Non-referable conditions:

- High cost treatment when less costly alternative is available
- Self-referrals referrals from “outside” doctors and referrals for “second opinion” (unless medically indicated)
- Experimental, non-evidence based treatment
- Organ transplant
- Infertility treatment
- Cosmetic treatment/surgery
- Hepatitis B and C

Source: UNHCR Egypt, Health Standard Operating Procedures, 2011.(14)

Appendix 11. Highlights IOM MENA-Based Projects

- **Capacity building and training efforts** for government and civil society actors, including areas such law enforcement, investigation techniques, judicial prosecution, shelter management, identification, assistance and protection of VOTs, overseas workers, and vulnerable migrants, media and communication, data collection and management (MENA-wide)
- Mapping, technical assistance and coordination of **identification, referral and protection mechanisms** (MENA-wide)
- **Comprehensive direct assistance**, including targeted livelihood support initiatives, educational opportunities, vocational training, emergency kits, psychosocial care, shelter (Egypt, Iraq, Jordan, Lebanon, Libya, Syria, Yemen)
- **Technical assistance to enhance cooperation** and improve internal governmental coordination on trafficking, including inter-ministerially, between criminal justice and victim assistance agencies, between criminal justice agencies (MENA-wide)
- Assistance to ministries of labour in enhancing their **reporting mechanisms** for cases of forced labour among migrant workers (MENA-wide)
- Comprehensive **awareness raising** activities to alert the general public, vulnerable communities, employers, and recruitment agencies to the presence of trafficking in persons (MENA-wide)
- Technical expertise to **enhance counter-trafficking legislation** and assist in its implementation (MENA wide, including regional bodies such as the League of Arab States)

Source: IOM, Annual Report of Activities, 2011.(63)

Appendix 12. Inter-agency Working Groups (IAWGs), Cairo, 2013

The following table summarizes all IAWGs, the organization leading those groups, whether they are active or inactive and further information on the role of UNHCR.

Inter-agency working group	Led by	Active/Inactive	Role of UNHCR/Important notice
Inter-agency coordination meetings – one for Syrians, one for non-Syrians	UNHCR	Active: Syrian working group every week and non-Syrian working group every month	-
Technical health working group	UNHCR	Active: meet on a monthly basis	Operational since November 2012: health coordination and info exchange for all nationalities - scaling up Syrian crisis with creation of health working group for Syrians to which WHO, UNICEF, UNFPA, Save the Children, Mahmoud Specialized hospital, Arab Medical Union, Caritas and Refuge Egypt participate
PS working group	PSTIC	Active: meet on a monthly basis	-
VOTs working group	IOM	Active: meet on a monthly basis	-
HIV/AIDS working group	UNAIDS through the UN Joint Programme of Support UNJPS	Active	UNHCR active member of the UNJPS since 2004 at the technical focal point level
Pandemic preparedness working group	MOHP and WHO	Inactive	UNHCR active member of the UN Pandemic Influenza System - not active after the Avian Human Influenza pandemic was

			brought to a halt, will be revived as needed
CHVs working group	IOM	monthly meeting (to be enacted)	UNHCR not invited to these meetings if taking place
SGBV working group	UNHCR	Inactive	UNHCR Syria operation Protection and SGBV focal point will take the lead for Syrians POCs SGBV responses

Source: Interviews with key-informants and follow-up email to double-check on accuracy.

Appendix 13. Health Care Spending in Egypt in Comparison to MENA region 2008

Country	Population (Million)	public spending as % total health spending	Public health spending per capita (\$)/ 2008
Algeria	33.3	83.8	172.0
Egypt	80.3	33.0	37.0
Iran	65.3	45.7	134.0
Jordan	6.0	62.2	170.0
Lebanon	3.9	48.9	270.0
Libya	6.0	75.8	291.0
Morocco	33.7	34.9	47.0
Syria	19.3	45.1	34.0
Tunisia	10.2	49.5	106.0

Source: NHA, 2007-08 and CIA World Fact book.(50)

Appendix 14. 2013 Budget for UNHCR Operations in Egypt

2013 Budget for UNHCR Operations in Egypt

Pillar	Beneficiary Population	Budget US\$
Pillar I	Refugees and Asylum Seekers in Egypt	10,209,666
Pillar 1 (Salloum)	Refugees and Asylum Seekers from Libya	1,448,653
Pillar II	Stateless Persons in Egypt	39,171
SYRIA	Assistance for refugees from Syria	9,700,000
Total Indicative Budget Target	US \$ 21,358,320	

Source: UNHCR Egypt Fact Sheet, May 2013. (25)

Appendix 15. Consequences of UNHCR Funding Shortfall

- Primary and secondary health care costs for POCs subsidized at the rate of 60% instead of 75% (not yet implemented)
- Assistance for tertiary health has become increasingly limited to asylum seekers but still available to all recognized refugees
- Not immediately life threatening cases costing more than 30,000 EGP not approved. Instead, an Exceptional Care Committee (ECC) makes recommendation for resettlement
- ECC prioritization of one-off or short-term interventions over long-term treatments
- Livelihood activities reduced by 50%
- Financial assistance not available for 500 vulnerable cases
- Only life-saving assistance maintained in Saloum; activities in other areas discontinued.

Source: UNHCR Egypt, Health Standard Operating Procedures, 2011 (14) - UNHCR Global Appeal 2013 Update, Egypt (64)

Appendix 16. Service Coverage, Limits and Cost Sharing – UNHCR Egypt

Services	Provided by	User contribution/ service (EGP)	Limit/ service (EGP)	Limit/ annum (EGP)
General consultations	Caritas, Refuge Egypt	5	-	-
Under-five clinic consultations (including Well-baby/child clinics, nutrition)	Refuge Egypt	3	-	-
Reproductive health services (including Anti-natal, post-natal care delivery, Family planning)	Refuge Egypt	150	3,000	5,000
Specialist consultations	By referral	25%	200	1,000
Diagnostics (laboratory, imaging)	By referral	25%	200	1,000
Drugs and medical consumables	Prescription only	25%	60	500
Drugs for chronic conditions	Prescription only	-	300	5,000
Referral care at secondary hospital	Referral hospitals	25%	500	2,000
Referral care at tertiary hospital	Specialised hospitals	25%	Approval from ECC only	Approval from ECC only

Source: UNHCR Egypt, Health Standard Operating Procedures, 2011.(14)